



Austin Integrative Medicine, P.A.

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PATIENT DEMOGRAPHIC INFORMATION

Name _____
Last Name First Name MI Date

Address _____

City, State, Zip _____

Home phone # _____ Cell phone # _____

What is the best # to use for contacting you? _____

May we leave a message at this #? _____

Sex M F Birthdate _____ Marital status _____

Parent/Guardian (if under 18) _____

Employer _____ Occupation _____

Business address _____

Work phone # _____ Alternate # _____

Emergency contact _____ phone _____

How did you hear about Austin Integrative Medicine? _____

Email Address _____

Would you like to be added to our newsletter email list? ___ Yes ___ No

MEDICAL RECORD INFORMATION RELEASE***

***Even though we do not file your insurance claims, your insurance company may request information in order to determine benefits.

I, the undersigned, do hereby authorize Dr. Manzanero to release to _____
name of insurance company

any and all medical information, of whatever nature, now in their possession or later acquired, from whatever source, which pertains or relates to my medical care. This authorization and consent is granted for the sole and limited purpose of facilitating the quality assurance and quality improvement activities conducted by the health plan. I understand and agree that by consenting to and granting this authorization, I am releasing those rights and claims of confidentiality and privilege concerning the information described which may otherwise exist, when used for the purposes described. I further understand and agree that I may withdraw my authorization and consent at any time by written notice of withdrawal to the health plan, provided, however, that any such withdrawal will not affect any information disclosed prior to receipt by the health plan of the written notice of withdrawal.

Signature

Date