JORGE A. SARAVIA, MD*2829 BABCOCK RD, STE. 436
SAN ANTONIO, TX 78229*(210)614-3557

PATIENT INFORMATION RECORD DATE: ________________________________

PATIENT NAME: ________________________________ SOCIAL SECURITY #________________________________

DATE OF BIRTH: ________________________________ WISHED TO BE CALLED________________________________

MALE______FEMALE______SINGLE_____MARRIED_____DIVORCED______WIDOWED______SEPERATED_____

ADDRESS________________________________ CITY,STATE,ZIP CODE________________________________

HOME PHONE________________________________ WORK PHONE________________________________

CELL PHONE________________________________ DRIVER'S LICENSE # AND STATE________________

EMPLOYER________________________________ PHONE NUMBER________________________________

PRIMARY DOCTOR________________________________ OFFICE NUMBER________________________________

REFERRING DOCTOR________________________________ OFFICE NUMBER________________________________

PARENT INFORMATION (IF PATIENT IS A MINOR)

FATHER'S NAME: ________________________________ MOTHER'S________________________________

SS#________________________________ SS#________________________________

DATE OF BIRTH________________________________ DATE OF BIRTH________________________________

ADDRESS________________________________ ADDRESS________________________________

CITY,STATE,ZIP CODE________________________________ CITY,STATE,ZIP CODE________________________________

HOME PHONE________________________________ HOME PHONE________________________________

EMPLOYER________________________________ EMPLOYER________________________________

PHONE NUMBER________________________________ PHONE NUMBER________________________________

DRIVER'S LICENSE # & STATE______________________ DRIVER'S LICENSE # & STATE____________________

E**MERGENCY CONTACT**: If there is an emergency and you cannot contact me through the above number, I give you permission to contact: Please give of someone that is **not** in your household.

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NAME PHONE NUMBER RELATIONSHIP

(CONTINUED ON BACK PAGE)

PRIMARY INSURANCE

NAME OF INSURED_______________________________

RELATIONSHIP__________________________________

INSURED'S DOB_________________________________

SS#____

INSURED'S EMPLOYER___________________________
PRESENTLY EMPLOED? YES________ NO_____
IF NOT, TERMINATION DATE? ____________

NAME OF INSURANCE____________________________

GROUP ID NO__________________________________

INS ID/POLICY NO______________________________

SECONDARY INSURANCE

NAME OF INSURED_______________________________

RELATIONSHIP__________________________________

INSURED'S DOB_________________________________

SS#____

INSURED'S EMPLOYER___________________________
PRESENTLY EMPLOED? YES______ NO_____
IF NOT, TERMINATION DATE? ____________

NAME OF INSURANCE____________________________

GROUP ID NO__________________________________

INS ID/POLICY NO______________________________

AUTHORIZATION OF PAYMENT

I authorize and request my insurance company to pay directly to Dr. Jorge A. Saravia, MD all payments for medical services rendered to myself of my dependents:

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment (s) of all services rendered on my behalf of myself of my dependents:

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SIGNATURE OF INSURED DATE

AUTHORIZATION AND RELEASE

I authorized, Jorge A. Saravia, MD to furnish information to may insurance carrier (s) concerning my or my dependents treatment and diagnosis rended by Dr. Saravia.

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SIGNATURE OF INSURED DATE

ACKNOWLEDGEMENT REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to received a copy of this documentation.

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SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

____

NAME OF PATIENT OR PERSONAL REPRESENTATIVE

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DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY