Byron L. Limmer, M.D. and Rachel L. Limmer, M.D., P.A.
14615 San Pedro Ave, Ste 210, San Antonio, Texas 78232

Referred By: _____

Patient Information Record

_____ _____ _____ _____
Last Name First Name MI

_____ _____
Street Address Zip Code

_____ _____ _____ _____
City State Home Phone Work Phone

_____
Employed By

_____ _____
Cell Phone Email Address or Fax #

_____ _____ Male ( ) Female ( )
Birth Date Social Security #

Single ( ) Married ( ) Other ( )

_____ _____ _____
Spouse's Name Spouse's Employer Spouse's Work Phone

_____ _____
Person Responsible for payment Relationship

_____ _____
Street Address Zip Code

_____ _____ _____
City State Home Phone

_____ _____ _____
Emergency Contact/ Relationship Home Phone Work Phone

WE ONLY FILE MEDICARE AND A SUPPLEMENT; PLEASE PRESENT CARD FOR COPYING.
This is required to keep your signature on file, authorizing us to file claims to Medicare for you and to release information that the payor requires for proper consideration of a claim. Please read and sign the following statement:
I authorize any holder of medical or other information about me to release of the Social Security Admin and Health Care Financing Admin any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place or the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment to benefits only.

_____ _____
Signature as on Medicare Card Date

If you have a secondary policy to Medicare, we are required to keep a separate signature on file.

_____ _____
Signature as on Insurance Card Date

NON-MEDICARE PATIENTS: I understand that payment is due at time of service. I authorize the release of any information pertinent to my case to my insurance company to process my claims or to any outside party that I so designate in a record release.

_____ _____
Signature of patient or legal guardian Date

Approved 4/29/2014