

# C.C. Hutton, M.D.

500 Medical Center Blvd., Suite 300, Conroe, Texas 77304  
936-539-5000 metro 936-441-0226 fax 936-539-5027

Patient's full name \_\_\_\_\_ Age \_\_\_\_\_ Birth date \_\_\_\_\_  
(last) (first) (MI)

Social security number \_\_\_\_\_ Spouse's name \_\_\_\_\_ Phone \_\_\_\_\_

Complete mailing address \_\_\_\_\_  
(street) (city) (zip)

Patient's employer \_\_\_\_\_  
(name, address, and phone number)

Guarantor's employer \_\_\_\_\_  
(name, address, and phone number)

Nearest relative not living with you \_\_\_\_\_  
(name, address, and phone number) (relationship)

Primary insurance \_\_\_\_\_  
(Medicare) (Medicaid) (Blue Cross)

Other primary \_\_\_\_\_  
(name, address, and phone number) (ID/policy number)

Secondary insurance \_\_\_\_\_  
(name, address, and phone number) (ID/policy number)

Tertiary insurance \_\_\_\_\_  
(name, address, and phone number) (ID/policy number)

Today's date \_\_\_\_\_ Referred by \_\_\_\_\_

Current medications \_\_\_\_\_  
\_\_\_\_\_

All known medication allergies \_\_\_\_\_

Do you smoke? No ( ) Yes ( ) Amount \_\_\_\_\_

I agree that the information supplied on this form is accurate and up to date to the best of my knowledge. I hereby authorize C.C. Hutton, M.D., to release any information acquired in the course of my examination and treatment for insurance purposes. I hereby authorize any payment of medical or surgical benefits to be paid directly to the above named physicians for their services. I understand that I am financially responsible for any charge not covered by this authorization. A photostatic/fax copy of this authorization may be exhibited as proof of my consent.

Patient or responsible party \_\_\_\_\_ (continues on the back)

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In order to be in compliance with HIPAA, the Health Insurance Portability and Accountability Act, we request the following information:

Please note that all information given to this office or obtained by this office from the patient, referring, physicians, and/or hospitals will be shared with other physicians, insurance companies, hospitals and/or hospital employees, pharmacies, or support groups such as Mended Hearts, if this sharing is appropriate to provide treatment, receive payment, or continue our operation of business.

If your information can be shared with those mentioned above, please initial: \_\_\_\_\_

Do you EXCLUDE any person from being present during consultation or examination when sensitive information may be discussed? Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, please list: \_\_\_\_\_

For purposes of convenience, all contact information is needed. We will attempt to contact you through the following options unless you specify otherwise. We will only leave a general message on an answering machine or with someone answering other than the patient.

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Pager: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

If there is a need to obtain copies of your medical records for any reason, we reserve the right to charge \$25.00 for this service. We will bill your insurance companies for you. Any additional forms needing completed may incur a \$25.00 charge as well.

\*Please understand that if you restrict our ability to treat you by limiting our ability to communicate with the appropriate associates, we may not be able to treat you as a patient. If this occurs, you would need to be referred to another surgeon. Thank you for your cooperation.

I have read and understand the above information. This agreement will remain in effect until revised or revoked by the patient or other legal representative.

Patient or patient's representative: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_