LALA M. STAWOWY, MD
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Fax (210) 692-1814

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Kerrville, TX 7802
(830) 257-5733
Fax (830) 257-5771

Last Name_____ First _____ Mi _____

Address _____ Gender Male _____ Female_____

City _____ Date of Birth _____

State _____ Zip _____ SS# _____

Home Phone _____ Martial Status: S M W D SEP

Cellular Phone _____ Drivers Lic. _____

Fax # _____ Pharmacy Name _____

Pharmacy #_____

Employer _____ Pharmacy Fax #_____

Work Phone _____

Email _____

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NAME OF RESPONSIBLE PARTY/BILL TO:

Name _____ SS# _____

Address _____ Date of Birth _____

City, State, Zip _____ Employer _____

Home Phone _____ Work Phone _____

Cell Phone _____ Relation _____

****

Referred By _____ Phone _____

Address _____ City_____ State _____ Zip _____

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INSURANCE INFORMATION

Medicare # _____ Insurance # 1 _____

Policy # _____ Insurance # 2 _____

Policy # _____ Policy Holder _____

Relation to Policy Holder _____

Payment Policy: All professional services rendered are charged to the patient. The patient is responsible for payment regardless of insurance coverage. Full payment is expected at the time of each office visit unless arrangements have been made in advance. Billing information will be provided to expedite payment reimbursement from private carriers.

Authorization of Payment: I hereby authorize the provider to release medical information concerning my examination and/or treatment for insurance purposes and to receive direct payment for medical benefits payable to me for services rendered.

SIGNED _____ DATE _____

Signature of Patient or Parent if minor