Steven D. Eggleston, M.D., P.A.
208 Oak Drive South, Ste 602
Lake Jackson, TX 75566

Patient's Name: _____

Date of Birth: _____ DL# _____ Gender: Male ☐ Female ☐

Mailing Address: _____ City: _____ Zip Code: _____

Home #: ( ) _____ Cell #: ( ) _____

E-Mail: _____ S.S.#: _____

Emergency Contact Information: Name: _____

Phone #: _____ Relationship to patient: _____

Patient Occupation: _____ Employer: _____
Employer Address: _____ City: _____ Zip Code: _____

Please Circle: Married Single Divorced Widowed

If patient is under 18 years of age or a full-time student, please complete the following:

Parent or Guardian Name: _____ S.S.# _____
Address (if different from above): _____ Date of birth: _____
Phone #: _____

Insurance Information

Card Holder's Name: _____ Date of Birth: _____ S.S. #: _____
Employer: _____ Phone#: _____
Primary Insurance: _____ Secondary Insurance: _____

How did you hear about Dr. Eggleston? _____ **Referring Doctor** _____
What is the reason for seeing Dr. Eggleston? : _____
How did the injury occur? _____ **Where?:** _____
Is this injury work related? Yes or No Date of Injury: _____
If not an injury or accident, when did symptoms first appear? _____
Have X-rays been taken? Yes or No Where were x-rays taken? : _____

***Please read carefully**

I authorize the office of Dr. Steven D. Eggleston to furnish information to insurance companies concerning my condition and treatment. I hereby assign all payments directly to Dr. Steven D. Eggleston for medical services rendered to me or my dependants. I understand that I am responsible for **ANY** charges not covered by my insurance company and that these charges are due at the time services are rendered. This authorization will remain in effect unless revoked by me in writing. A photocopy of my signature will serve as an original. The information I have provided above is true, accurate and complete to the best of my knowledge.

Signature of Patient or guardian: _____ Date: _____

STEVEN D. EGGLESTON, MD, PA
Orthopaedic Surgery
208 OAK DRIVE SOUTH, SUITE 602
LAKE JACKSON, TX 77566

PERMISSION TO SHARE HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient Name _____ DOB _____

By signing this paper below, I give permission to the person(s) listed in the table documented to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information that does not pertain to assisting with my health care and any copies of medical records will require a signed HIPAA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

Date of Permission	Name of Individual & Relationship to Patient	DOB	Comments/Instructions (i.e. may pick up meds, may disclose test results, etc)	Patient/ Guardian Initials

THE PHYSICIANS/STAFF HAS MY PERMISSION TO: (Please check all boxes that apply)

☐ Leave message at home with my spouse or other: NAME: _____ RELATIONSHIP: _____ DOB: _____

☐ Leave message on cell phone; Cell phone #: _____

☐ Leave message at work; Work phone #: _____

☐ Leave a message on voicemail; Phone #: _____

☐ Leave a detailed message on answering machine; Phone #: _____

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____ _____
Printed Name of Patient or Legal Guardian Relationship *(if not self)*

Co-pays & Deductibles are due at time of visit. All fractures will go towards the deductible. Most X-rays, Injections and Boots will go toward the deductible. If you do not have a co-pay, your office visit may go toward your deductible.

Attention Medicare Patients. $183.00 is the 2018 deductible. This amount goes towards office visits, fractures, x-rays, injections, and boots. Until this amount has been met, you will be responsible for your visit. See handout.

I understand and agree to pay any co-pay, co-insurance and/or deductible in FULL at time of service. We accept MC, Visa, Cash and Checks. If unable to meet this financial agreement we will need to reschedule your appointment.

Signature: _____ Date: _____