Buxbaum Medical

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New Patient Packet — Printable Form

Please print, complete by hand, sign, and bring to your visit — or fax to 713-533-1708.

This combined form includes New Patient Registration, HIPAA Acknowledgment, Medical Records Release (optional), and Financial Policy — a single signature covers all sections.

1. Demographics

First Name: _____ **Last Name:** _____

Date of Birth: _____ **Sex (M / F / Other):** _____

Street Address: _____

City: _____ **State / Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____ **Preferred Contact (Phone / Email / Text):** _____

2. Emergency Contact

Name: _____

Relationship: _____ **Phone:** _____

3. Insurance Information

Insurance Company: _____ **Policy / Member ID:** _____

Group #: _____ **Policyholder Name:** _____

Policyholder DOB: _____ **Relationship to Patient:** _____

Secondary Insurance (optional): _____ **Secondary Policy #:** _____

4. Medical History

Check all conditions that apply:

- ☐ **Diabetes**
- ☐ **Hypertension**
- ☐ **Heart Disease**
- ☐ **COPD / Asthma**
- ☐ **Cancer**
- ☐ **Stroke**
- ☐ **Arthritis**
- ☐ **Depression / Anxiety**
- ☐ **Thyroid Disorder**
- ☐ **Kidney Disease**
- ☐ **Liver Disease**
- ☐ **Seizure Disorder**
- ☐ **Other**

Other Conditions: _____

Prior Surgeries (and approx. dates): _____

Allergies (medications, food, environmental): _____

Family Medical History: _____

5. Current Medications & Pharmacy

Medications (name, dose, frequency): _____

(continued): _____

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____

6. Medical Records Release (optional)

☐ I would like records transferred from a prior provider — complete this section

Prior Provider / Facility Name: _____

Address: _____

Phone: _____ **Fax:** _____

Records requested (check all that apply):

- ☐ **Complete Medical Records**
- ☐ **History & Physical**
- ☐ **Lab Results**
- ☐ **Imaging / Radiology**
- ☐ **Operative Reports**
- ☐ **Discharge Summary**
- ☐ **Immunization Records**
- ☐ **Medication List**

Date Range — From: _____ **Date Range — To:** _____

Purpose of Release (Continuity of Care / Patient Request / Legal / Insurance / Other): _____

7. HIPAA Privacy Acknowledgment

I acknowledge that I have been provided with or offered a copy of the Notice of Privacy Practices for Michael E. Buxbaum, D.O., P.A. I understand Buxbaum Medical may use and disclose my protected health information (PHI) for treatment, payment, and healthcare operations; that I may request restrictions on certain uses and disclosures of my PHI; and that I may revoke any authorization I provide in writing at any time.

☐ I have received / been offered the Notice of Privacy Practices.

8. Financial Policy & Assignment of Benefits

Responsible Party (if not patient): _____ **Relationship:** _____

It is the policy of Michael E. Buxbaum, D.O., P.A. to bill your insurance carrier as a courtesy. If insurance does not remit payment within 60 days, the balance is due in full from you. Payment of your estimated share is due at the time of service.

I assign all medical and surgical benefits to Michael E. Buxbaum, D.O., P.A. and authorize my insurance carrier(s) — including Medicare, private insurance, and any other health plan — to issue payment directly to the practice. I authorize release of information necessary to process insurance claims and the use of a photocopy of my signature for that purpose. I understand I am responsible for any amount not covered by insurance, including collection costs and attorney fees upon default.

☐ I have read and agree to the Financial Policy and Assignment of Benefits.

Attestation & Signature

By signing below I certify that the information provided in this packet is true and complete, and my signature applies to ALL sections above:

(1) Consent to medical treatment at Buxbaum Medical
(2) Receipt of the HIPAA Notice of Privacy Practices
(3) Authorization for release of medical records (if Section 6 is completed)
(4) Agreement to the Financial Policy and Assignment of Benefits

_____ _____

Patient Signature Date