Print Form

NEW PATIENT ACCOUNT INFORMATION

Please print and fill out this form to register as an Austin Regional Clinic patient. All fields with an asterisk (*) are required fields. We cannot register you as an ARC patient without that information. Please fax the completed form to our Central Registration Department at (512) 406-6228.

Call our Central Registration line at 407-6446 for any questions.

Appointment Location: _____ Appointment Date: _____

Patient Information:

*First/Last Name: _____

*Address: _____ Patient ID #: _____

*City, State, Zip: _____ *DOB: _____

*Home Phone: _____ Alt. Phone: _____ Sex: ☐ M ☐ F

*Employer/School: _____ *Marital Status: ☐ Single ☐ Married

Address: _____ Emp. Status ☐ FT ☐ PT ☐ UN ☐ Ret ☐ FT/PT Student

City, State, Zip: _____ Work Phone: _____

Occupation: _____ Extension: _____

Guarantor Information (person responsible for the bill)

*First/Last Name: _____

*Address: _____ *DOB: _____

*City, State, Zip: _____ Sex: ☐ M ☐ F

*Home Phone: _____ Alt. Phone: _____ *Marital Status: ☐ Single ☐ Married

*Employer/School: _____ Emp. Status ☐ FT ☐ PT ☐ UN ☐ Ret ☐ FT/PT Student

Address: _____ Work Phone: _____

City, State, Zip: _____ Extension: _____

Occupation: _____ *Rel to Patient: _____

Subscriber Information (person that has the policy)

*First/Last Name: _____

*Address: _____ *DOB: _____

*City, State, Zip: _____ Sex: ☐ M ☐ F

*Home Phone: _____ Alt. Phone: _____ *Marital Status: ☐ Single ☐ Married

*Employer/School: _____ Emp. Status ☐ FT ☐ PT ☐ UN ☐ Ret ☐ FT/PT Student

Address: _____ Work Phone: _____

City, State, Zip: _____ Extension: _____

Occupation: _____

Primary Coverage

*Subscriber: _____

*Insurance Company: _____ Plan Type: _____

*Claims Address: _____ Policy ID: _____

*City/State/Zip: _____ *Patient ID: _____

*Phone: _____ *Group #: _____

*Patient's PCP: _____ Primary Co-Pay Amount $ _____

Effective Dates: _____ Specialty Co-Pay Amount $ _____

Secondary Coverage

*Subscriber: _____

*Insurance Company: _____ Plan Type: _____

*Claims Address: _____ Policy ID: _____

*City/State/Zip: _____ *Patient ID: _____

*Phone: _____ *Group #: _____

*Patient's PCP: _____ Primary Co-Pay Amount $ _____

Effective Dates: _____ Specialty Co-Pay Amount $ _____

Emergency Contact

*First/Last Name: _____

Address: _____

City, State, Zip: _____

*Home Phone: _____ Alt. Phone: _____

*Relation to Patient: _____

Address: _____

For Internal Use Only

Information Obtained by: _____ Date: _____

Account Created by: _____ Date: _____