

Dear New Patient,

Welcome! Attached are the **New Patient** forms. Please do your best to fill out this requested information completely and accurately. If you cannot fill this out completely, please call our office and our staff will be happy to assist you. The thoroughness and completeness of this information is very important and improves our ability to help you.

We also ask that patients arrive on time for appointments. Please find out where our office is located before your first appointment and, if necessary, make any transportation arrangements. Please be aware of the following policies concerning your first appointment with our physician. Please completely fill out and return the attached paperwork to our staff at your earliest opportunity in order to schedule your first appointment.

There are several options available to return completed paperwork to our office ~ fax, email, or mail or personal delivery:

Address:

Christopher Caragan, DO  
1611 South 1st Street  
Austin, TX 78704

Fax: (512) 233-2701

Email: [newpatient@drchriscaragan.com](mailto:newpatient@drchriscaragan.com)

Once our staff receives your completed paperwork, you will be contacted within 48-hours to schedule your initial appointment. If you do not receive a call from a staff member within this time period, please do not hesitate to contact us to schedule your appointment. Please be advised that we do not schedule New Patient appointments without completed paperwork.

Please arrive 15 minutes before your first scheduled appointment.

**Please bring originals** of completed paperwork (if not mailed). A copy can be made for you if desired.

If you need to reschedule or cancel your appointment, please call our staff at your earliest opportunity. Twenty-four(24)-hour notice is a reasonable request if you need to cancel or reschedule your initial consultation. If we do not receive 24-hour cancellation notice or if you miss your appointment, we reserves the right to bill you up to fifty percent of the consultation fee.

**Acknowledgement: I have read and understand the above information.**

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Patient (Responsible Party) Signature

Date

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Printed Name

**PATIENT INFORMATION**

Please print clearly and complete all requested information.

Prefix (circle):                    Mr.        Mrs.        Miss        Ms.        Dr.

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt/Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work/Other Phone: \_\_\_\_\_ Okay to Leave Message?  Yes         No

**Primary Care Doctor:**

(Last Name) \_\_\_\_\_ (First Name) \_\_\_\_\_ MI: \_\_\_\_\_

Practice/Group: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

**Referring Doctor: (if applicable)**

(Last Name) \_\_\_\_\_ (First Name) \_\_\_\_\_ MI: \_\_\_\_\_

Practice/Group: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

**Marital Status:**

Single    Married    Life Partner    Divorced    Widowed    Legally Separated

Date of Birth: \_\_\_\_\_ Social Security No: \_\_\_\_\_ Email: \_\_\_\_\_

Driver's License: \_\_\_\_\_ Gender:  Female    Male

**Employment Status:**

Employed:    Full-Time         Part-Time         Not Employed    HomeMaker  
 Retired             Active Military

**Student Status:**       Full-Time       Part-Time

Employer: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work/Other Phone: \_\_\_\_\_

**Reason for Appointment (Chief Complaint):**

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How did you hear about Dr. Caragan?

- Friend       Family       Primary Doctor       Workshop/Seminar  
 Internet       Church

**PHARMACY INFORMATION**

Pharmacy Name: \_\_\_\_\_

Address: \_\_\_\_\_ Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_ Fax Number \_\_\_\_\_

Medication Allergies?       Yes       No      If yes, please list in following space:

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Other Allergies?       Yes       No      If yes, please list in following space:

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**RESPONSIBLE PARTY (GUARANTOR)**

**If Patient is NOT responsible party, Guarantor MUST SIGN spaces under Payment Policy and Assignment and Release.**

*Please initial if responsible party is the Patient and skip to the next section.* \_\_\_\_\_

**Last Name:** \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt/Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work/Other Phone: \_\_\_\_\_ Okay to Leave Message?  Yes  No

Email: \_\_\_\_\_ Gender:  Female  Male

Relationship to Patient: \_\_\_\_\_

Social Security No: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Driver's License: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

**ADDITIONAL INFORMATION**

Is Patient a Medicare Beneficiary?  Yes  No If **No**, skip next question.

If patient a Medicare Beneficiary, has Patient (and/or Guarantor) been advised of Opt-Out Status?

Yes  No

(An Opt-Out Agreement will be provided to Medicare Beneficiaries and must be signed prior to any treatment.)

Is Patient a Medicaid Beneficiary?  Yes  No If **No**, skip next question.

If patient has Medicaid, has the patient been advised that Dr. Caragan does not accept Medicaid?

Yes  No