PATIENT INFORMATION

(PLEASE PRINT)

Patient name ____
Last First Middle

Address ____

City ____________ State _____ Zip ________ Home phone _______-____________

Work phone ________- ___________ Ext________ Cell Phone ________-____________

Email address ____

Date of birth _______/_______/_______ Age ________ Soc. Sec. # ________-________-________

Marital status : ❒Single ❒Married ❒ Separated ❒ Divorced ❒ Widow

Patient's employer ______________________ Occupation ______________________

Spouse's name ______________________ Occupation ______________________

Spouse's employer ______________________ Work phone ______________ Ext ________

Spouse's date of birth _______/_______/____________ Soc. Sec. # ________-________-________

Referred by ______________________ Phone # ________-____________

Preferred pharmacy name ______________________ Phone number ________ - ________

❒ Please list the family members or other persons, if any, whom we may inform you about your general medical condition and your diagnosis, including treatment, payment, and health care operation.

______________________ Relationship ______________ Phone #______________

❒ Please list the family members or other persons, if any, whom we may inform you about your general medical condition only in an emergency

______________________ Relationship ______________ Phone # ______________

Insurance # 1 ______________________ Insurance # 2 ______________________

If you have only one insurance and your spouse is the primary insured, please sign NO OTHER INSURANCE FORM

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I have reviewed the brochure entitled "Notice of Privacy Policies and Practices" and give my permission to Sugar Land Advanced OB/GYN Center, P.A. to use and disclose my health information in accordance with the notice provided.

Name of patient ______________________Signature ______________Date ________

Name of patient representative ______________________Signature ______________Date ________

In an effort to keep medical cost down, we ask that you pay for the office visit and lab tests at the time of the service rendered unless your insurance will cover for the service. We will file insurance claims as the courtesy to our patients. When we verify the insurance benefit on your behalf, the insurance company informs us that the benefit is not always guaranteed until the claims are actually received and reviewed by them.

❒ I understand that I am responsible for any amount that is not covered by my insurance company in 90 days.

❒ Person responsible for the bill ____

Signature ______________________________ Date ______________________________