Women's OBGYN Care, PLLC

7777 Southwest Freeway, Suite # 454, Houston, TX - 77074 Tel: 281-953-1710, Fax: 281-953-1714

PATIENT INFORMATION

Dr. ☐ Miss ☐ Mrs ☐ Ms ☐ Marital Status: ☐Single, ☐Married, ☐Widowed, ☐Divorced

Patients Name: (Last) _____________________________ (First) _____________________________(Middle) _________________

Date of Birth: _______________ (MM/DD/YYYY) SSN: __________________ Email Address: _____________________________

Address: ____

City: ____________________State: _____________ZIP: __________Home Phone: __________________Cell No: _______________

Race:

☐American Indian or Alaska Native African ☐American ☐Caucasian

☐Native Hawaiian or Other Pacific Islander ☐Asian ☐Other___________________________

Ethnicity:

☐Hispanic or Latino ☐Not Hispanic or Latino

Language:

☐English ☐Spanish ☐Indian ☐Japanese ☐Chinese ☐Korean ☐French

☐German ☐Russian

Employer Name : ____________________ Primary Care Provider (PCP) : __________________________

Employer No : ____________________ Referring Doctor/Provider : __________________________

Rendering Provider Name (This Practice): ____

Pharmacy Name: ______________________, Address: _____________________________________Tel____________________

EMERGENCY CONTACT INFORMATION

Name: ____________________ Phone No: ____________________ Relation: ____________________

PRIMARY INSURANCE INFORMATION

Insurance Name: ______________________________ Insured Name : _____________________________

Policy No : ______________________________ Relation to Insured : ☐Self, ☐Spouse, ☐Child, ☐Parent

Insurance Type : ______________________________ SSN : _____________________________

Group No : ______________________________ DOB : _____________________________

Insured Address : ____

SECONDARY INSURANCE INFORMATION

Insurance Name: ______________________________ Insured Name : _____________________________

Policy No : ______________________________ Relation to Insured : ☐Self, ☐Spouse, ☐Child, ☐Parent

Insurance Type : ______________________________ SSN : _____________________________

Group No : ______________________________ DOB : _____________________________

Insured Address : ____

Patient Signature: ______________________________________ **Date:** ______________________________

AUTHORIZATION

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance; however you are responsible for your co-pay and/or percentage, which the insurance company is not liable for on the day of your visit. In the event you're insurance company has not paid within 60 days you are responsible for the balance due. It is also the patient's responsibility to obtain referrals from your primary care physicians when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor we will place your account with a collection agency, which will leave you liable for additional expenses incurred if applicable. I _________________________ have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, to be paid to the physicians. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant and nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

Signature & Date: _______________________________

I authorized this facility to release information to (Please check all that apply):

☐Spouse (Name)____________________ ☐Others (Name)____________________

☐Children (Name)____________________ ☐No One

Signature & Date: _______________________________

MEDICARE PATIENTS

I request that payment of authorized Medigap (Medicare Supplement) benefits be made on my behalf to the provider for any services furnished me by the provider. I authorize any holder of medical information about me; to release Medigap Insurer ____ any information needed to determine those benefits payable for related services.

Signature & Date: _______________________________

MEDICARE LIFETIME AUTHORIZATION

HIC# (Health Insurance Claim/Policy No.) _________________________________

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct and authorize any holder of the medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the physician or organization furnishing the services or authorized such physician or organization to submit a claim to Medicare for payment to me. I request that this authorization also apply to all other insurances.

Signature : ___________________________________ Date: ____

Print Name : ___________________________________ Title or Relationship: ____________________________

Witnessed by : ___________________________________ Address: _______________________________________

If signed by other than beneficiary, state reason the patient was unable to sign:

____

Signature & Date: _______________________________