SUGAR LAND OB/GYN LLP

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NEW PATIENT INFORMATION

DATE :_____/_____/_____ Account #_____

Name:_____SS#_____-_____-_____

Address:_____

City:_____State: _____Zip Code_____

Phone: _____ Cell:_____

Birth Date:_____/_____/_____ Drivers License #_____ State_____

Marital Status: S ( ) M ( ) S ( ) D ( ) W ( ) Email:_____

Patient's Occupation:_____ Work Phone:_____

Employed By:_____Address:_____

Name of Spouse/Parent:_____SS#_____-_____-____DOB:_____

Employed By:_____ Occupation:_____

Employer's Address: _____Work Phone:_____

Primary Care Physician (PCP)_____

Referred By:_____

INSURANCE (PRIMARY) **INSURANCE** (SECONDARY)

Company Name:_____ Company Name:_____

ID#_____ ID#_____

PLEASE READ CAREFULLY AND SIGN

IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. ALL **PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS.THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE**

INSURANCE AUTHORIZATION

I HEREBY AUTHORIZE FORTBEND OB/GYNLLP TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY MEDICAL HISTORY.I ALSO AUTHORIZE PAYMENT BENEFITS TO THE PHYSICIAN OR SUPPLIER FOR SERVICES RENDERED.

Signature:_____ Date of Signature:_____