# SUGAR LAND OB/GYN ASSOCIATES

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**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)

Company Name:__________________________
ID#_____________________________________

**INSURANCE** (SECONDARY)

Company Name:_______________________
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:____________________________