Date: _____ **Acct. No.:** _____

HOUSTON WOMEN'S CARE ASSOCIATES

R. THOMPSON, M.D. T. SAMUELS, M.D. J. SAMORA-MATA, M.D. C. HOLSTE, M.D. L. SWAIM, M.D. J.C. MILLER, M.D. N. TRAN, M.D. R. DIMINO, M.D. T. TARRANT, M.D. D. ELLISON, M.D.

Patient Information

Patient's Last Name _____ First Name _____ M.I. _____

Street Address _____ Email _____

City _____ State _____ Zip _____ County _____

Sex (M / F) Marital Status M W D S

Employed (Y / N) Employer _____

Occupation _____ Shift _____ Work # ( ) _____

Home Phone # ( ) _____ Cell # ( ) _____

Date of Birth ____ /____ /_____ Age _____ Social Security No. _____ /____ / _____

Referring Dr. _____

Spouse / Parent Information

Last Name _____ First Name _____ M.I. _____

Street Address _____

City _____ State _____ Zip _____ County _____

Sex (M / F) Employed (Y / N) Employer _____

Home Phone # ( ) _____ Work # ( ) _____

Date of Birth ____ /____ /_____ Social Security No. _____ /____ / _____

Primary Insurance Information

Insured Name _____

Insured Date of Birth ____ /____ /_____

Insured's ID / SSN _____ /____ / _____

Primary Medical Insurance Co. _____

Insured's Employer _____ Group / Policy No. _____

What is the relationship of the patient to the insured?

☐ Self, ☐ Wife, ☐ Husband, ☐ Child, ☐ Special Dependent, ☐ Parent

********** OVER → **********

Secondary Insurance Information

Insured Name _____ Insured's ID / SSN _____

Secondary Medical Insurance Co._____

Insured's Employer _____ Group / Policy No. _____

What is the relationship of the patient to the insured?

☐ Self, ☐ Wife, ☐ Husband, ☐ Child, ☐ Special Dependent, ☐ Parent

Emergency Contact

Relative to Contact
in Emergency: _____ Relation: _____ Phone No. ( ) _____

Pager / Cell Phone: ( ) _____

Alternate Person to
Contact in Emergency: _____ Relation: _____ Phone No. ( ) _____

Pager / Cell Phone: ( ) _____

This medical practice works with its patients to minimize difficulty in the payment of fees for service. Upon leaving from your appointment, you will be asked to pay those minimal unmet deductible amounts and co-insurance amounts which your insurance company authorizes to be collected. Please ensure that primary and secondary insurance information above is correct.

Authorization to Release Information: **The undersigned hereby authorizes said Provider to release all information pertaining to patient's treatment to his/her insurance company or companies and to any other physician or health care provider to whom the undersigned may be referred.**

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plan to: *Houston Women's Care Associates.*

_____ _____/_____/_____

Patient Signature **Date**

_____ _____ _____/_____/_____

Responsible Party **Relationship** **Date**