Southeast Texas OB/GYN Associates, P.A.

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SS#: ______________________________

Appointment Date:________________________ DOB: ______________________________

PLEASE PRINT, SIGN AND DATE THIS CONSENT/ASSIGNMENT Age: ______________________________

Patient Information: Referring Physician:______________________________

Name:____ Preferred Name:______________ Marital Status __________
Last First Middle Maiden

Address:____City, State, Zip ________________________________

Home Phone:(____)______________________ Cell Phone (____)______________________ Email Address ______________________

Employer:____Employer Phone(____) ______________________

Employer Address:_____________________________________City, State, Zip ______________________________

Spouse's Name:______________________________________Spouse's Date of Birth ______________________________

Spouse's Employer:__________________________________Address ____________________________________

City, St., Zip:______________________________________ Spouse's Employer Phone (____) ______________________

PRIMARY INSURANCE

NAME INSURANCE CO #1________________________________POLICY #______________________GROUP # __________________

INSURED NAME____ INSURED DOB ______________________________

Address____City, State, Zip ____________________________________

Phone(____)____________________Relation to Patient________________________INSURED S.S.# ______________________

INSURED Employer__________________________Employer Address ____

SECONDARY INSURANCE

NAME INSURANCE CO #2________________________________POLICY #______________________GROUP # __________________

INSURED NAME (if different)______________________________RESPONSIBLE PART'S DOB ______________________________

Address (if different)____City, State, Zip ________________________

Phone(____)____________________Relation to Patient________________________S.S.# ______________________________

Employer______________________________Employer Address ____

Emergency Notification

Name:____ Relationship:______________________________

Cell Phone:(____)__________________________ Work Phone (____)__________________________

Assignment of Benefits/Consent for Treatment

I hereby agree to pay in full for medical services unless otherwise contractually or statutorily prohibited. I understand that I will be financially responsible for any charges not paid by my insurer, employer, or other third party. I also agree that any payment due from me will be made at the time services are rendered or promptly upon billing. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result or outcome of treatments, examinations, or testing by SETX OB/GYN.

I authorize and request payments of medical benefits directly to SETX OB/GYN. I further authorize SETX OB/GYN to release to my insurance company(s) any and all medical information (including that of confidential nature) necessary to process my insurance claims, and to any healthcare provider for continuation of my healthcare.

Sign:____ Date:______________________________________