NEW PATIENT / ANNUAL REGISTRATION INFORMATION

(Please read and complete all pages)

NAME: D.O.B. AGE

LAST FIRST MIDDLE

ADDRESS: APT#

CITY: STATE: ZIP CODE:

HOME PHONE: CELL PHONE:

WORK PHONE: EMAIL:

EMPLOYER/SCHOOL: OCCUPATION:

SOCUAL SECURITY: DRIVER'S LICENSE: MARITAL STATUS:

EMERGENCY CONTACT NAME:

PHONE: RELATIONSHIP TO THE PATIENT:

NAME OF PRIMARY INSURANCE: INSURANCE PHONE #

GROUP # ID #

SUBSCRIBER / POLICY HOLDER'S NAME: D.O.B.

S.S.N.: RELATIONSHIP TO THE PATIENT

PHONE: EMPLOYER:

DO YOU HAVE SECONDARY INSURANCE COVERAGE? ☐ YES ☐ NO

PRIMARY CARE PHYSICIAN:

WHO MAY WE THANK FOR REFERRING YOU TO THIS PRACTICE?

ARE YOU HERE TODAY FOR: ☐ ROUTINE ANNUAL EXAM ☐ PREGNANCY ☐ PROBLEM ☐ OR OTHER

IF YOUR VISIT IS FOR A PROBLEM OR OTHER, PLEASE DESCRIBE:

PHARMACY NAME: ZIP CODE:

PHONE: FAX:

Consent for Healthcare and Treatment:

I voluntarily consent to healthcare treatment from the physicians and staff of The ObGyn Centre. I consent to any lab work (including HIV testing and drug testing, cultures, pathology, and medication administration that the physician(s) deem necessary. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of treatments or examinations by my care givers.

NAME: DATE:

SIGNATURE:

THE OB/GYN CENTRE

6400 FANNIN, SUITE 1900, HOUSTON, TEXAS 77030 | PHONE 713.796.2200 | FAX 713.796.2232 | WWW.THEOBGYNCENTER.COM