Premier
OB/GYN of West Houston, L.L.P.

Annual Patient Information Update

Patient Name_______________________________________Date___________________________

Address____City/State/Zip______________________

Check One: Employed _____ Student _____ Other _____ State Drivers Lic. #__________________

Check One: Single _____ Married _____ Other _____ SSN _______________________

Employer ______________________________________ Employer Phone #__________________

Spouse's Name ____________________________________Spouse's DOB _______________

Spouse's Employer and Phone # ____

Current Insurance Information

Insurance Company ____

ID # _________________________________ Group # ______________________________

Insured Person ______________________________________ SSN _______________________

Medical History

Any pregnancies, deliveries, miscarriages or abortions since your last visit?

Preg _____ Del _____ Miscarriages _____ Abortions _____ Number of living children _____

Current Contraception ____

Current Medications ____

Medication Allergies ____

Surgery since last visit ____

Last Menstrual Period _____________ Last Mammogram _____________ Bone Density Test _______________

Major Medical Problems or Hospitalizations Since Last Visit _______________________________

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Assignment of Insurance Benefits: I authorize payment of medical benefits to Premier OB/GYN of West Houston.

Authorization to release information: I authorize Premier OB/GYN of West Houston to release any medical information s may be necessary for the completion of my insurance claim to any insurance carrier, health or hospital plan.

Acceptance of Financial Responsibility: I accept financial responsibility for any services not covered by my insurance.

Premier Ob/Gyn of West Houston does not accept any form of Medicaid.

Patient Signature ____Date _______________

Patient's Legal Guardian/Agent ______________________________________ Date _______________