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

Annual Patient Information Update

Patient Name_____Date_____

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 _____

_____

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 _____