plaza OB/GYN www.plazaobg.com PH: 713.522.3333 FX: 713.522.4434 1801 BINZ STREET, SUITE 500 HOUSTON, TEXAS 77004

PATIENT REGISTRATION FORM Date: _____

Name: _____ Social Security #:_____/_____/_____

(Last, First, Middle I.)

Address: _____

City: _____ State _____ Zip Code _____

Marital Status: S / M / D / W DOB: _____

Race: __American Indian/Alaska Native __Asian __Black/African American __National Hawaiian/Pacific Islander

___Other race ___White ___Unknown ___Declined

Ethnicity ___Declined ___Hispanic or Latino ___Not Hispanic or Latino ___Unknown

Home Number:(_____)_____ Cell Number:(_____)_____Preferred: ___Home ___Cell

Pharmacy Name/Phone#:_____

Employer _____ Work Number (_____)_____

Email address _____ Driver License /State #_____

Emergency Contact_____ Relation _____Phone (_____)_____

REFERRAL INFORMATION

Referring physician or Primary Care Provider (PCP) _____

PCP Phone#:_____

Who referred you to our office: _____

INSURANCE INFORMATION

(Payment required at time of service)(PLEASE PROVIDE INSURANCE CARD)

Insurance Company _____ Insurance Telephone Number_____

Policy Holder Name_____ Policy Holder SS # _____

Relationship to Patient: ___Self ___Parent ____Legal Guardian ___Spouse Their DOB: _____

Policy Number_____ Group Number:_____

Claims Address:_____

City _____ State _____Zip Code_____

As a courtesy to our patients, our office will assist you in obtaining the maximum benefit from your insurance. Our expectation of you as the owner of the policy is to make payment in full of fees or co-payments not covered by your insurance plan at the time services are rendered. We ask that you take responsibility for payment of your visit should your insurance company not pay within 60 days of your appointment date. In order to avoid this situation, we ask that you keep our office informed of any changes in your insurance coverage and/or employment. On the date of your office visit, you are responsible for your deductible and the portion we estimate the insurance will not cover. However, if our estimates are inaccurate, there will be a need to send you a statement for the balance due.
I authorize the release of any medical information necessary to process this claim. A copy of this authorization may be used in place of the original.

Signature _____ Date _____

In order to serve you properly, all information on this form should be filled out completely.

Please provide the receptionist with your Insurance Card(s) and Driver's License. Thank You.