Lufkin
Women's Center
OBSTETRICS, GYNECOLOGY & INFERTILITY

LUFKIN WOMEN'S CENTER
102 WESTSIDE MEDICAL BLVD.
LUFKIN, TX 75904

Patient Information

Name: _____

Address: _____

Home#: _____ Cell #: _____ Work#: _____

Email Address: _____

Birth Date: _____ Social Security: _____

Religious Preference: _____

Occupation: _____ Employer: _____

Marital Status (circle one): Single Married Widowed Divorced Separated

Spouse/Parent: _____ Birth Date: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Medical Profile

Allergies to Medications: _____

Medications/Strength: _____

Previous Surgeries/Dates: _____

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Insurance Authorization and Assignment

I hereby authorize Lufkin Women's Center to furnish information to insurance carriers concerning any illness and/or treatment. I request payment of medical benefits to Lufkin Women's Center with regards to hospital services and realize I am responsible for any amount not covered. I also understand that this office will attempt to contact me via email on any study ordered by this office. If I have not been notified of the result within 21 days, it is my responsibility to contact the office.

_____

Signature of Patient

_____

Date