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.

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Signature of Patient

____

Date