Women's Health Consultants

Obstetrics and Gynecology

Robert E. Schorlemer, MD • Lisa B. Gurwitz, MD
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San Antonio, Texas 78229
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********PLEASE FILL OUT FORM COMPLETELY********

INSURANCE INFO IS VERY IMPORTANT

CLAIM #'S & ADDRESS NEEDS TO BE COMPLETED

YOU WILL BE BILLED!!! IF NOT FILLED OUT CORRECTLY!!!

Referred by: ____ Patient Age: __________

Allergies: ____

Does the patient have an Advance Directive (living will)? ____Yes ____No

PATIENT INFORMATION

Name: ____ Date of Birth ____/____/____

Last First MI

Address: ____ Social Security # ______/____/______

________________ _____ ___________ E-Mail ____________________________________

City State zip

PLEASE LIST THE BEST 2 DAY TIME #'S

Home phone __________________ Cell/pager ____________________

Emergency Contact :___________________ Phone _______________________

Pharmacy Name:______________________ Phone _______________________

Marital Status: ___ Single ____Married ____Divorced ___Other

PATIENT EMPLOYER

Employer: __________________________ Work Phone_____________

Occupation:__________________________

SPOUSE INFORMATION (or PARENT if Minor)

Name: ____ Date of Birth ____/____/____

First Last MI

Employer ______________________________ Social Security # ___/___/___

Occupation _____________________________ Work Phone _____________

PRIMARY INSURANCE INFORMATION

Relationship to PATIENTS: ____Self ____Spouse ___ Parent ____Other

INSURED SS #_____/_____/___________

Insured D.O.B. _______________________

POLICY ID# __________________________

GROUP # _____________________________

INSURANCE NAME ______________

Claims Address ____

____

SECONDARY INSURANCE INFORMATION;

Relationship to PATIENT: ____Self ____Spouse ____Parent ____Other

INSURED SS# _________/______/___

Insured D.O.B ____________________

INSURANCE NAME _____________________________

Claims ADDRESS ____

____

POLICY ID# _________________________

GROUP # ___________________________

INSURANCE AUTHORIZATION FOR ASSIGNMENTS OF BENEFITS AND INFORMATION RELEASE

I certify that the following information is true and correct and I agree to pay all fees and bills incurred for the medical and professional services of Robert E. Schorlemer, M.D., Lisa B. Gurwitz, M.D., and/or Dr. Beatriz Garcia Stamps, M.D. I also agree that all bills are due at the time of service and payable at 4499 Medical Drive, Suite 119, San Antonio, Texas 78229. I will pay all collection agency fees and court costs in addition to the total amount due on my account should such proceedings be required for failure to keep my account in good standing. I understand that statements may go to the insured party unless otherwise specified.

SIGNATURE _______________________________ DATE____________________________

I authorize the release of any medical information necessary to process any medical insurance claim and I authorize payment of medical benefits to the physicians of Women's Health Consultants.

SIGNATURE ________________________________ DATE _____________________________