Victoria Women's Clinic

(361)578-5233 Fax (361)573-5803

Please Print

Patient's Name: _____ DOB: _____/____/_____ Age: _____

Social Security #:_____ Driver's License Number: _____

Mailing Address: _____City: _____

State: _____ Zip Code: _____ Home Phone: ( )_____ Cell Phone: ( )_____

Race: Caucasian___ African American___ Asian___ Pacific Islander ___ American Indian___ Other_____

Email: _____ Marital Status (circle one): S M D W PCP: _____

Employer: _____ Phone: ( )_____

Spouse's Name: _____ Spouse's DOB _____/_____/_____

Spouse's Employer: _____ Daytime Phone #:_____

If Patient is under 18, Please enter Name of Parent or Guardian: _____

Social Security #: _____ Date of Birth: _____/_____/_____

In Case of Emergency please notify: _____

Phone Number: ( )_____ Relationship to Patient: _____

Insurance: ***Please provide receptionist with your insurance card.***

Primary Insurance Company:_____

Policy/ ID#: _____ Group #: _____

Person Insured: _____ Relationship to Patient: _____

Insured's SS#: _____-_____-_____ Insured's DOB: _____/_____/_____

Secondary Insurance Company: _____

Policy/ ID#: _____ Group #: _____

Person Insured: _____ Relationship to Patient: _____

Insured's SS#: _____-_____-_____ Insured's DOB: _____/_____/_____

AUTHORIZATION FOR CARE, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I the undersigned, by presenting for services, request and authorize evaluation, diagnosis and treatment by my physician and/or his/her designee. I further hereby authorize the release of any information relating to all claims for benefits submitted on my behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I acknowledge and understand that I am responsible for all the charges for all the services rendered to me or any member of my family.

Signed:_____ Date:_____