Bernard R. Cavazos, Jr., M.D.
Carolyn Lewallen Cavazos, M.D.
Dr. Yadira A. Anca, M.D.
9639 Huebner Road
San Antonio, TX 78240

Patient Information

Name: ______________________ D.O.B. __________ SS#: ______________

Address: ______________________ City, State: ______________ Zip: __________

Home Phone: (   ) __________ Work Phone: (   ) __________ Email: ______________

Employer: ______________________ Employer Phone: (   ) __________

Employer Address: ______________________ City, State: ______________ Zip: __________

Emergency Contact

Name: ______________________ Phone: ______________

Address: ______________________ City, State: ______________ Zip: __________

Relationship: ______________________

Insurance Information

Primary Insurance: ______________________

Insurance #: ______________________ Group: ______________

Ins. Phone: (   ) __________ Ins. Address: ______________________

Insured: ______________________ D.O.B. __________ Relationship: __________

Secondary Insurance: ______________________

Insurance #: ______________________ Group: ______________

Ins. Phone: (   ) __________ Ins. Address: ______________________

Insured: ______________________ D.O.B. __________ Relationship: __________

Payment/Authorization:
I understand that I am ultimately responsible for any balance that accumulates and agree to pay any balance due after insurance has paid or responded.
I hereby authorize Oak Hills Women's Center to release medical information concerning my examination and/or treatment for insurance purposes and to receive direct payment for medical benefits payable to me for services rendered.

Patient's Signature: ______________________ Date: __________

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Email: info@oakhillswomenscenter.com