Oak Hills Women's Center, P.A.
Allison R. Cavazos M.D.
Bernard R. Cavazos Jr. M.D.
Carolyn L. Cavazos M.D.

Patient Information

Name: ____________________________ D.O.B. __________ SS#: ___________

Address: ______________________ City, State: _______________ Zip: ________

Home Phone: ____________________ Work Phone: _________________________

Email: ____

Employer: __________________________ Employer Phone: ___________________

Emergency Contact

Name: __________________________________ Phone: ______________________

Address: _______________________ City, State: ______________ Zip: ________

Relationship: ____

Insurance Information

Primary Insurance: ____

Insurance Id Number: ______________________ Group Number: ____________

Ins. Phone Number: _______________ Ins. Address: _______________________

Insured: ___________________ D.O.B _____________ Relationship: __________

Secondary Insurance: ____

Insurance Id Number: ______________________ Group Number: ____________

Ins. Phone Number: _______________ 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 deposit payment for medical benefits payable to me for services rendered.

Patient Signature: ________________________________ **Date**: ________________

Phone: 210-692-3636
Fax: 210-692-3668
Website: www.oakhillswomenscenter.com
Email: info@oakhillswomenscenter.com