Boerne ob/gyn

Paul H. Kocay, M.D.

Patient's Name: _____
(Last) (First) (Middle)

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

Marital Status: (check one) _____ Single _____ Married _____ Divorced _____ Widowed

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer: _____ Work Phone: _____

Preferred Pharmacy for Prescriptions: _____

Spouse's Name: _____
(Last) (First) (Middle)

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

Employer: _____ Work Phone: _____

Authorization to treat minor child: _____ Mother ____ Father ____ Guardian ____
(Signature) (Relationship to patient under the age of 16)

Person to notify in case of emergency: _____

Home Phone: _____ Cell: _____ Relationship: _____

Insurance Information: (Please give insurance card to the receptionist so we may keep a copy on file)

Primary Insurance: _____ Secondary Insurance: _____

Policy Holder's Name: _____ Relationship to you: _____

Social Security #: _____ Date of Birth: _____

Place of Employment: _____

I hereby authorize Boerne Ob/Gyn, P.A. to furnish all information to insurance carriers and other health care providers concerning my health & medical treatments, and assign all payments for medical services rendered to myself or my dependents to Boerne Ob/Gyn, P.A. I understand that I am responsible for any amount not covered by insurance. This information includes Protected Health Information.

Signature: _____ Date: _____