Sweetwater Ob/Gyn Associates • 16545 Southwest Freeway Suite 150 • Sugar Land • Texas 77479
Ph: 281-242-1400/Fax: 281-207-2200

Patient Demographic Form

Date_____

Patient Name:_____Date of Birth:_____SS#:_____

Address:_____Apt#_____

City_____State_____Zip_____

Phone No 1:_____Phone No 2:_____

Email: _____-

Emergency Contact_____Phone#_____

Insurance Company_____

Who is the primary subscriber on this insurance policy? _____DOB: _____

Pharmacy Name:_____Pharmacy No.:_____

PCP Name:_____Referring Physician:_____

I grant permission to Sweetwater OB GYN Associates to release information to the above insurance company upon request for the purpose of claims processing and payment. I also authorize insurance payment directly to the clinic for surgical and/or medical benefits for the services provided by Sweetwater OB GYN Associates. I understand that I am financially responsible for charges not covered by my insurance company.

Signature of Patient/Guardian

▶ ×_____**Date**_____

I voluntarily consent to medical care, treatment, and diagnostic tests that are believed to be necessary for me by my provider at Sweetwater OB GYN Associates, and his/her associates, assistants.

Signature of Patient/Guardian

▶ ×_____**Date**_____

I authorize Sweetwater OB/GYN Associates to email my Test results. ☐ Yes ☐ No

Signature of Patient/Guardian

▶ ×_____**Date**_____