Oak Hills Women's Center, P.A.
Bernard R. Cavazos, Jr., M.D.
Allison R. Cavazos, M.D.
Sarah Lewis, FNP-C

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: _____

Phone: (210) 692-3636
Fax: (210) 692-3668
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Email: info@oakhillswomenscenter.com