SUGAR LAND OB/GYN

Deanna D. McDonald M.D., Niraj C. Patel M.D. , Duc B. Le M.D.

Patient Questionnaire

Date	Account #		
Patient Information			
Full Name (First + Last)	Date of Birth	Social Security Number	
Billing Address	City	State	Zip Code
Home Phone / Cell Phone	E-Mail Address		
Driver's License (State) / Driver's License (Number)	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Employer Name	Occupation		
Employer Address	City	State	Zip Code
Primary Care Physician (PCP)	Referred By:		
Insurance Information			
Primary Insurance Company Name	Group Code	ID #	
Secondary Insurance Company Name	Group Code	ID #	
Pharmacy Information			
Pharmacy Name / Pharmacy Address		Phone #	
Spouse / Parent Information			
Full Name (First + Last)	Date of Birth	Social Security Number	
Employer Name	Occupation		
Employer Address	City	State	Zip Code
Work Phone Number / Cell Phone	Work E-Mail Address		

Please read carefully and sign: It is customary to pay for services when rendered unless other arrangements have been made in advance. All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage insurance authorization. I hereby authorize Fort Bend OB/GYN LLP to furnish information to insurance carriers concerning my medical history. I also authorize payment benefits to the physician or supplier for services rendered.

Signature ____ Date ____________________