-Abigail R. Neiman M.D., P.A.

902 Frostwood Drive, Suite # 311 Houston, TX 77024 ♥ Phone (713) 932-0054 ♥ Fax (713) 932-0413

PATIENT INFORMATION:

Name:_____
Last First Initial

DOB: _____ Age: _____ Sex: ____M ____F Marital Status: S____ M____ W____ D____

Address:_____
Street City State Zip Code

SSN#_____ Employer_____ Occupation_____

Home#_____ Work#_____ Cell#_____

Email: _____

If Student, School Name_____ Full-Time_____ /_____Part-Time

Referring Physician:_____ Physician's Phone#:_____

SPOUSE / INSURED PARTY INFORMATION:

Name: _____ DOB:_____ Relationship to Patient:_____

Address (if different from above)_____City_____ Zip Code_____

Home#_____ Work#_____ SSN#_____

Employer_____ Occupation_____ Driver's License#_____

EMERGENCY CONTACT INFORMATION:

Friend or Relative (not living with you)

Name_____Relationship_____Phone#_____

Name_____Relationship_____Phone#_____

PRIMARY INSURANCE INFORMATION

Please Note that all insurance will be subject to verification of benefits and our participation in the plan. Payment for non-covered services, co-payments and deductibles will be collected at the time of service.

Insurance Company Name_____ Please Circle One: HMO PPO POS

ID#_____Group#_____

Insurance Company Phone#_____Effective Date_____

Policy Holders Name_____Relationship to Patient_____

SECONDARY INSURANCE INFORMATION

Insurance Company Name_____ Please Circle One: HMO PPO POS

ID#_____Group#_____

Insurance Company Phone#_____Effective Date_____

Policy Holders Name_____Relationship to Patient_____

PHARMACY INFORMATION

Local Pharmacy Name _____ Phone # _____

Mail Order Pharmacy _____ Phone # _____

Pharmacy Benefit Manager _____

Rx Bin# _____ Rx PCN# _____ Rx Group# _____

ASSIGNMENT OF BENEFITS

I hereby assign, transfer, and set over to **Abigail Neiman M.D., P.A.**, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking this authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. Furthermore, I understand and have been informed that I will be responsible to pay a $25.00 fee if I do not call to cancel any scheduled appointments within 24hrs from the appointment. I also understand that I cannot receive adequate medical treatment if I neglect to keep scheduled appointments.

Patient's Signature_____Date_____