



110 E. Savannah, Bldg. B, Suite 103
McAllen, TX 78503
Office #: (956) 687-2693



Esteban Ortega Brown, M.D.

Date: _____

PATIENT INFORMATION

Please print and complete all entries:

NAME: _____
(LAST) (FIRST) (MIDDLE)

MAILING ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

HOME #: (_____) _____ **WORK #:** (_____) _____ **CELL#:** (_____) _____

E-MAIL ADDRESS: _____

DATE OF BIRTH: _____ **SOC. SEC.#:** _____ **OCCUPATION:** _____

EMPLOYER: _____ **ADDRESS:** _____

REFERRED BY: DOCTOR YELLOW PAGES TV FRIEND MAGAZINE COUPON

NAME OF DOCTOR: _____ **OTHER:** _____

SPOUSE / PARTNER / GUARANTOR INFORMATION

NAME: _____
(LAST) (FIRST) (MIDDLE)

DATE OF BIRTH: _____ **SOC. SEC.#:** _____

EMPLOYER: _____ **ADDRESS:** _____

OCCUPATION: _____ **WORK #:** (_____) _____ **CELL#:** (_____) _____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY {Someone not living with you}

NAME: _____ **RELATIONSHIP:** _____

ADDRESS: _____

HOME #: (_____) _____ **WORK #:** (_____) _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____ **POLICY HOLDER NAME:** _____

POLICY #: _____ **GROUP #:** _____

SECONDARY INSURANCE: _____ **POLICY HOLDER NAME:** _____

POLICY #: _____ **GROUP #:** _____

INSURANCE & MEDICAL RECORDS AUTHORIZATION: I hereby authorize **Esteban Ortega Brown, M.D.** to furnish or request information to/from my insurance carriers, other physicians, or facilities concerning my illness and treatment.

ASSIGNMENT OF BENEFITS: I hereby authorize Esteban Ortega Brown, M.D. all payments for medical services rendered to me or my dependants. I understand that I am responsible for any amount not covered by my insurance.

I have received a copy of the Privacy Notice and have had an opportunity to object to the disclosure of my health information.

SIGNATURE: _____

DATE: _____