Said Bina, M.D., P.A., F.A.C.S.
21212 Northwest Freeway Suite 655
Cypress, Texas 77429
Tele: (281)469-0596 Fax: (281)807-9480

Referring physician:_____

Patient Information:

Patient Name:_____ Spouse Name:_____

DOB:_____ Age:_____ Sex:_____ Social Security Number:_____

Address:_____
City State Zip Code

Home Phone:(___)_____ Work Phone:(____)_____

Emplyer:_____

Address:_____

PLEASE COMPLETE IF THE PERSON RESPONSIBLE FOR BILL IS OTHER THAN THE ABOVEPATIENT

Name:_____ Relationship to patient:_____

Home Phone:(___)_____DOB_____ Social Security Number:_____

Employer:_____ Work Phone:(___)_____

Address:_____
City State Zip code

Emergency Contact

In Case of Emergency Please contact:_____

Health Insurance Information

Name of Insurance:_____ Phone:(___)_____

Policy Holder:_____ Relationship to Patient:_____

Policy Number:_____ Group Number:_____

Medicare Number:_____ Medicaid Number:_____

Authorization and Consent of the Medical Treatment of a Minor:

Parent or Guardian Signature:_____ Relationship:_____

Patient Agreement:

I authorize payment of medical insurance benefits to Said Bina M.D.,P.A.,F.A.C.S. and release of any medical or other information necessary to process any claim filed for benefits.

I understand that payment is expected at the time services are rendered according to the provisions of my insurance plan. I accept full financial responsibility for any such fees incurred.

Signature:_____ Date:_____