LEXES
Obstetrics and Gynecology

PATIENT INFORMATION

Name: _____
First Middle Last

Street: _____ PO/Apt: _____

City/State/ZIP: _____

Telephone: _(_____)_____-_____ Cell: _(_____)_____-_____ Work: _(_____)_____-_____

Date of Birth: _____/_____/_____ Social Security No.: _____-_____-_____

Email: _____

____ Minor / ____ Single / ____ Married / ____ Divorced / ____ Widowed / ____ Separated

Employer / Unemployed / or Student: _____ Occupation: _____

Spouse / Parent (if Minor): _____ Telephone: _(_____)_____-_____

Primary Care Physician: _____ Telephone: _(_____)_____-_____

Referring Physician: _____ Telephone: _(_____)_____-_____

INSURANCE INFORMATION

Primary Insurance : _____ Telephone(_____)_____-_____

Policy Number/Member ID: _____ Group Number: _____

Policy Holder: _____ Policy Holder Date of Birth: _____/_____/_____

Policy Holder Address: _____ Telephone(_____)_____-_____

Policy Holder Employer: _____

Relationship to Patient: _____ Policy Holder SS#: _____-_____-_____

Secondary Insurance: _____ Telephone(_____)_____-_____

Policy Number/Member ID: _____ Group Number: _____

Policy Holder: _____ Policy Holder Date of Birth: _____/_____/_____

Policy Holder Address: _____ Telephone(_____)_____-_____

Policy Holder Employer: _____

Relationship to Patient: _____ Policy Holder SS#: _____-_____-_____

I understand that I am responsible for payment of services provided to me regardless of any insurance that I carry.

Dr. Schexnaydre does not accept MEDICAID as a secondary INS on surgical procedures at the Hospital.

I understand that any copays, deductible, or co-ins are due at the time of service. I understand that I am responsible for getting any referral authorizations needed for appointments, testing and procedures prior to service. I understand I am responsible for some services or testing that are not covered by my insurance company. I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to Dr. Evon Schexnaydre/Lafayette Women's Health DBA: Lexes Obstetrics and Gynecology for services rendered to me. To the best of my knowledge all information given by me is to be true.

Patient Signature(or Parent/Guardian if Minor): _____

Today's Date: _____/_____/_____

Evon L. Schexnaydre, MD, FACOG

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LEXES
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EMERGENCY CONTACT:

Name: _____ Relationship: _____

Telephone#: _(_____)_____-_____ Cell: _(_____)_____-_____

Name: _____ Relationship: _____

Telephone#: _(_____)_____-_____ Cell: _(_____)_____-_____

PERMISSION FOR DISCLOSURE:

I, _____, give my permission for Dr. Schexnaydre and her staff to discuss my case including test results and overall general welfare with my primary care physician and/or referring physician and also send test results and consult/office notes:

Dr: _____Telephone# (_____)_____-_____

Dr. _____Telephone# (_____)_____-_____

May the office speak with family members or friends regarding your test results or visit?: Yes_____(please list below) / NO _____

Name:_____Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

May we leave a message on your home/cell phone / email / TEXT? Re: appointment reminders Y / N - - - test results Y / N

May we leave a message with family member/person at your home? Re: appointment reminders Y / N - - - test results Y / N

May we contact you by email / TEXT and/or fax with test results and/or correspondence?: YES / NO initial:_____

I will contact the office myself if this needs to be changed or updated.

Patient Signature: _____ Date: _____/_____/_____

Patient Printed Name: _____

Or Signature of Legal Representative: _____ Date: _____/_____/_____

Printed name of Legal Representative: _____

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