TRE Medical, Ltd.
Obstetrics and Gynecology

PLEASE PRINT

PATIENT

Name ______________________ **Status** [ ] **S**ingle **M**arried **D**ivorced **W**idowed

Address ______________________
Street City Zip

Birth Date [ ] [ ] [ ]
Mo Day Year

Cell Phone [ ] [ ] [ ]
Home Phone [ ] [ ] [ ]
Work Phone [ ] [ ] [ ]

Social Security Number [— —]

E-Mail Address [ ]

Employer Name ______________________

Insurance Company Name ______________________
☐ Primary

Primary Language ______________________

Ethnicity: (Circle) Not Hispanic/Latino Hispanic/Latino

Race: (Circle) White Asian Black/African American American Indian/Alaska Native
Native Hawaiian/Pacific Islander Other Race ______________________

SPOUSE

Name ______________________

Birth Date [ ] [ ] [ ]
Mo Day Year

Cell Phone [ ] [ ] [ ]
Home Phone [ ] [ ] [ ]
Work Phone [ ] [ ] [ ]

Social Security Number [— —]

Employer Name ______________________

Insurance Company Name ______________________
☐ Primary

Assignment and Release

My signature below authorizes the release of medical information to my primary care physician, and as necessary for the processing of insurance claims and prescriptions. I authorize payment of medical benefits to TRE Medical, Ltd. I also understand that I will be held responsible for payment of all co-payments, co-insurance, deductibles and non-covered service.

______________________ ______________________
Signature Date