

LEE V. ANSELL, M.D., P.A.

5420 West Loop South, Suite 1100
Bellaire, TX 77401

PATIENT INFORMATION – (PLEASE PRINT)

Date: _____

Full Name: _____ Birth Date: ____/____/____
Last First MI

Age: _____ Sex M F Soc. Sec.#: _____ - _____ - _____ Married Single Divorced Widowed

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Home Address: _____ City: _____

State: _____ Zip: _____ Driver's License #: _____ State: _____

Employer Name: _____ Occupation _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Employment Status: Full Time Part Time Retirement Date: _____

Emergency Contact: _____ Phone: _____

Relationship to Patient:: _____ Cell Phone: _____

PERSON RESPONSIBLE FOR PATIENT ACCOUNT

Full Name _____ Birth Date: ____/____/____

Soc. Sec.# _____ - _____ - _____ Drivers License No. _____ State: _____

Home Address: _____

Phone Number: _____ Relationship to patient: _____

Signature: _____

PLEASE READ THE FOLLOWING:

- Please give your insurance card and driver's license to the receptionist to be copied.
- It is very important that you have your X-Rays with you today, unless other arrangements have been made.
- **Because of the tremendous number of forms to be filled out by the physician, please allow ten (10) working days for their return.**
- **Allow three (3) working days for all prescription refills.**