

**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: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Work Phone: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_

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: \_\_\_\_\_