

Welcome to Las Colinas OB/GYN

Date: \_\_\_\_\_

### PATIENT INFORMATION

PATIENT NAME (PLEASE PRINT) LAST NAME, FIRST NAME, MIDDLE				BIRTH DATE	AGE	
SOCIAL SECURITY #		MARITAL STATUS		HOME PHONE #		
STREET ADDRESS		CITY AND STATE			ZIP CODE	
PATIENT'S OR PARENT'S EMPLOYER (circle one)		OCCUPATION (INDICATE IF STUDENT)		BUSINESS PHONE # AND EXT #		
EMPLOYER'S STREET ADDRESS		APT. #	CITY AND STATE			ZIP CODE
SPOUSE OR PARENT'S NAME (circle one)		SS#	DATE OF BIRTH	HOME PHONE#		
SPOUSE OR PARENT'S EMPLOYER (circle one)		OCCUPATION (INDICATE IF STUDENT)		BUSINESS PHONE #		
EMPLOYER'S STREET ADDRESS		CITY AND STATE			ZIP CODE	
*SPOUSE'S STREET ADDRESS, IF DIVORCED OR SEPARATED		CITY AND STATE			ZIP CODE	
INSURANCE COMPANY NAME & ADDRESS		INS PHONE #	CERTIFICATE #	GROUP #	ID # OR SS #	
SECONDARY INS CO (IF APPLIES)		INS PHONE #	CERTIFICATE #	GROUP #	ID # OR SS #	
IN CASE OF AN EMERGENCY WHO CAN WE CONTACT ( PLEASE INCLUDE NAME, ADDRESS, AND PHONE#)						
WHOM WERE YOU REFERRED BY						

#### Attention All Patients

CONSENT TO TREATMENT: I consent to all necessary testing and treatment while I am a patient at this facility.

Initials \_\_\_\_\_

INSURANCE AUTHORIZATION: I hereby assign Las Colinas Ob/Gyn all payments for medical services rendered to myself or my dependants. I understand that I am responsible for any amount not covered by insurance.

Initials \_\_\_\_\_

ASSIGNMENT OF BENEFITS: I hereby assign Las Colinas Ob/Gyn all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Initials \_\_\_\_\_

Signature of Authorized Person \_\_\_\_\_ Date \_\_\_\_\_