Welcome to Las Colinas OB/GYN

Date: _____

PATIENT INFORMATION

PATIANT 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 EMRGENCY WHO CAN WE CONTACT (PLEASE INCLUDE NAME, ADDRESS, AND PHONE#)				
WHOM WERE YOU REFERRED BY				

Attention All Paitents

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 coverd by insurance.

Initials _____

Signature of Authorized Person _____ Date _____