

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#)										
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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 \_\_\_\_\_