WOMEN'S HEALTH SPECIALIST OF DALLAS, P.A.

PATIENT INFORMATION

*Please print and complete **ALL** sections below!*

Date: ____________________

PATIENT INFORMATION:

Name:______________________________ Physician:______________
(Last) (First) (Middle)

Home Address:______________________________
(Street) (Apt. No.) (City) (State) (Zip Code)

Employer:____________________ Occupation:____________________

Employer Address:______________________________
(Street) (City) (State) (Zip Code)

Home: (_____)______________ Business Phone: (_____)______________ Cell Phone: (_____)______________

Driver's License No.:______________ Social Security No.:______________ Date of Birth:______________

Marital Status: Single Married Widowed Divorced Age:_____ Allergies:______________

Your E-Mail Address:______________________ ☐ Home ☐ Business

SPOUSE INFORMATION OR RESPONSIBLE PARTY (IF PATIENT IS A MINOR):

Name:______________________________
(Last) (First) (Middle)

Home Address:______________________________
(Street) (Apt. No.) (City) (State) (Zip Code)

Employer:____________________ Occupation:____________________

Employer Address:______________________________
(Street) (City) (State) (Zip Code)

Home: (_____)______________ Business Phone: (_____)______________ Cell Phone: (_____)______________

Driver's License No.:______________ Social Security No.:______________ Date of Birth:______________

PRIMARY INSURANCE CARRIER: ______________________________

Name of Insured: ______________ DOB:______________ Social Security No.:______________

Insurance Policy No.:______________ Insurance Group No.:______________

Insurance Carrier Address:______________________________

SECONDARY INSURANCE CARRIER: ______________________________

Name of Insured: ______________ DOB:______________ Social Security No.:______________

Insurance Policy No.:______________ Insurance Group No.:______________

Insurance Carrier Address:______________________________

EMERGENCY CONTACT: Name of person not living with you:______________ Relationship:______________

Address:______________ Home: (_____)______________ Work: (_____)______________

PLEASE BE ADVISED THAT YOU MAY RECEIVE BILLS FOR ANY LAB TESTS, PAP SMEARS, CULTURES, AND BIOPSIES, AS THEY MAY BE SENT TO AN OUTSIDE SOURCE FOR ANALYSIS.

Assignment of Benefits – Financial Agreement

I hereby give lifetime authorization for payment of insurance to be made directly to Women's Health Specialist of Dallas, P.A. and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date:______________ **Your signature:**______________________________

Thank you for your careful completion of this important form!