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

PATIENT INFORMATION

Please print and complete ALL sections below!

larital Status: Single Married Widowed Divorced Age: Allergies: Business POUSE INFORMATION OR RESPONSIBLE PARTY (IF PATIENT IS A MINOR): ame: (Last)	ATIENT INFORMATION:					Da	ite;	
ome Address: (Steed) (Apt. No.) (City) (Stee) (Zip Code) mployer Address: (Steed) (Apt. No.) (City) (City) (Stee) mployer Address: (Steed) (Stee) (St	ame:	····				Physician:		***************************************
mployer Address: orne: (ome Address:		(First)		(Middle)			
imployer Address: Cell Phone: State: Ctip Code	mployer:	(Street)	(Apt. No.)		(City) Occupation:		(State)	(Zip Code)
ome: (•				ooopadotti			, , , , , , , , , , , , , , , , , , ,
Allergies:		(Street)	Rusiness Phone: /	1	(City)	Call Phone: ((State)	(Zip Code)
Age:Allergies:								
POUSE INFORMATION OR RESPONSIBLE PARTY (IF PATIENT IS A MINOR): lame:								
POUSE INFORMATION OR RESPONSIBLE PARTY (IF PATIENT IS A MINOR): lame: (Last) (First) (Misdle) dome doffess: (Street) (Apt. No.) (City) (State) (Zip Code) reproyer. (State) (Zip Code) former: (Doty) (State) (Zip Code) former: (Date of Birth: RIMARY INSURANCE CARRIER: lame of Insured: DOB: Social Security No.: Insurance Group No.: Insurance Carrier Address: ECONDARY INSURANCE CARRIER: ame of Insured: DOB: Social Security No.: Insurance Group No.: Insurance Group No.: Insurance Carrier Address: MERGENCY CONTACT: Name of person not living with you: Relationship: ddress: Home: MERGENCY CONTACT: Name of person not living with you: Relationship: MERGENCY CONTACT: Name of person not living with you: Relationship: MERGENCY CONTACT: Name of person not living with you: Relationship: MERGENCY CONTACT: Name of person not living with you: Relationship: MERGENCY CONTACT: Name of person not living with you: Relationship: MERGENCY CONTACT: Name of person not living with you: Relationship: MERGENCY CONTACT: Name of person not living with you: Relationship: MERGENCY CONTACT: Name of person not living with you: Relationship: MERGENCY CONTACT: Name of person not living with you: Relationship: MERGENCY CONTACT: Name of person not living with you: Relationship: MERGENCY CONTACT: Name of person not living with you: Relationship: MERGENCY CONTACT: Name of person not living with you: Relationship: Work: () Assignment of Benefits - Financial Agreement hereby give lifetime authorization for payment of insurance to be made directly to Women's Health Specialist of Dallas, P.A. and any assisting thysicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the unto of default, Jagree to pay all casts of collection, and reasonable attorney's fees. I hereby authorize this health provider to release all formation nec				-	-	_		
lame: (Lael) (First) (Middle)								
lame:	POUSE INFORMATION OR R	ESPONSIB	LE PARTY (IF PAT	IENT IS A M	INOR):			
tome coddress:	lame:							
Agriculture of Benefits - Financial Agreement Agreement of Benefits - Financial Agreement Assignment of Benefits			(First)	(Middle)				
imployer:								
imployer Address: (Street)	mployer:	(Street)	(Apt. No.)		* //			(Zip Code)
tome: (000apanom			
RIMARY INSURANCE CARRIER: ame of Insured: DOB: Social Security No.: Insurance Group No.: Social Security No.: Social Security No.: Social Security No.: Insurance Group No.: Social Security No.: Insurance Group No.: Social Security No.: Insurance Group No.: Social Security No.: Social Security No.: Insurance Group No.: Social Security No.: Insurance Group No.: Social Security No.: Insurance Group No.: Insurance Group No.: Social Security No.: Insurance Group No.: Social Security No			Rueingee Dhana: (1	(City)	Coll Bhana: ((State)	(Zip Code)
RIMARY INSURANCE CARRIER: ame of Insurance Policy No.:						·	•	
ame of Insured:						Date V	I DINI	
ame of Insured:	RIMARY INSURANCE CARR	IER:						
Insurance Group No.:						Social Security No.:		
ECONDARY INSURANCE CARRIER: ame of Insured:								
ame of Insured:								
ame of Insured:				F # 1				
surance Carrier Address: MERGENCY CONTACT: Name of person not living with you:	ECONDARY INSURANCE CA	RRIER:						
MERGENCY CONTACT: Name of person not living with you:	ame of Insured:		D(OB:		Social Security No.:		
MERGENCY CONTACT: Name of person not living with you:	surance Policy No.:				Insurance	Group No.:		
MERGENCY CONTACT: Name of person not living with you:	surance Carrier Address:	74.						***************************************
LEASE BE ADVISED THAT YOU MAY RECEIVE BILLS FOR ANY LAB TESTS, PAP SMEARS, CULTURES, AND BIOPSIES, AS THEY MAY ENT TO AN OUTSIDE SOURCE FOR ANALYSIS. Assignment of Benefits – Financial Agreement nereby give lifetime authorization for payment of insurance to be made directly to Women's Health Specialist of Dallas, P.A. and any assisting nysicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the vent 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 formation necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.				P A				
LEASE BE ADVISED THAT YOU MAY RECEIVE BILLS FOR ANY LAB TESTS, PAP SMEARS, CULTURES, AND BIOPSIES, AS THEY MAY ENT TO AN OUTSIDE SOURCE FOR ANALYSIS. Assignment of Benefits – Financial Agreement nereby give lifetime authorization for payment of insurance to be made directly to Women's Health Specialist of Dallas, P.A. and any assisting hysicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the vent 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 formation necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.	MERGENCY CONTACT:	Name of per	son not living with y	ou:			Relation	ship:
Assignment of Benefits – Financial Agreement nereby give lifetime authorization for payment of insurance to be made directly to Women's Health Specialist of Dallas, P.A. and any assisting hysicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the vent 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 formation necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.	ddress:			Home: (_)	Work:	()_	
Assignment of Benefits – Financial Agreement nereby give lifetime authorization for payment of insurance to be made directly to Women's Health Specialist of Dallas, P.A. and any assisting hysicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the vent 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 formation necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.				# * I				
Assignment of Benefits – Financial Agreement hereby give lifetime authorization for payment of insurance to be made directly to Women's Health Specialist of Dallas, P.A. and any assisting obscious, 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.	LEASE BE ADVISED THAT Y	OU MAY RE	ECEIVE BILLS FOR	ANY LAB T	TESTS, PAP SMEAI	RS, CULTURES, AN	ID BIOPSIES	S, AS THEY MAY
Assignment of Benefits – Financial Agreement nereby give lifetime authorization for payment of insurance to be made directly to Women's Health Specialist of Dallas, P.A. and any assisting hysicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the vent 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 formation necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.								
nereby give lifetime authorization for payment of insurance to be made directly to Women's Health Specialist of Dallas, P.A. and any assisting hysicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the vent 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 formation necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.			<u> </u>				2	
nysicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the vent 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 formation necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.			Assignment	of Benefits	- Financial Agreer	nent		
	nysicians, for services rendered vent of default, I agree to pay a	d. Fundersta ill costs of co	and that I am financial collection, and reason	ially responsi nable attorne	ble for all charges w y's fees. I hereby a	hether or not they a uthorize this health o	re covered by care provider	r insurance. In the to release all
				=		•		Ü

Thank you for your careful completion of this important form!