NORTH TEXAS
OB-GYN ASSOCIATES

328 W. Main St., Lewisville, TX 75057
P: 972-436-7557 F: 972-221-8246
3424 Long Prairie Rd, Suite 200, Flower Mound, TX 75028

PERSONAL INFORMATION:

The information below will be used for your medical records. Communications are addressed to your address listed in your medical records. We also rely upon the telephone information in your medical records when we contact you by telephone. If you believe this method of communication could endanger you, please request an Alternate Means form.

Patient's Name ________________________________ Age ______ DOB _________ SS# ______________________

Home Address ____ Apt# _______________________

City ____________________________ State _______ Zip __________ Driver License #________________________

Home # ( ) _______________________ Work # ( ) ___________________ Cell # ( ) __________________

Email ____ Okay to send results or notices: Yes _____ No ______

Employer ____ Occupation __________________________________

Spouse or Guardian's Name ______________________________________ Cell # ( ) _______________________

Spouse or Guardian's Employer ___________________________________ SS # _____________________________

Are you a student? ☐ No ☐ Yes(Full Time _____ Part Time ______) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Race: ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ African American ☐ Hispanic or Latino ☐ Caucasian ☐ More than one race ☐ Refused

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refused Language: ☐ English ☐ Spanish ☐ French ☐ Burmese ☐ Other

INSURANCE INFORMATION:

Primary Insurance _________________________________ Insured's Name ___________________________________

Insured ID #_______________________________________ Group # ____

Insured's Employer _________________________________ Effective Date: ____________________________________

Insured's DOB ________________ Relationship to Patient: Spouse ______ Father ______ Mother ______ Self ________

Secondary Insurance _______________________________ Insured's Name ___________________________________

Insured ID #_______________________________________ Group # ____

Insured's Employer _________________________________ Effective Date: ____________________________________

Insured's DOB __________________ Relationship to Patient: Spouse _______ Father _______ Mother ______ Self ______

Contact Information:

Nearest Relative not living with you ______________________________ Phone # ( ) _______________________

Nearest Friend not living with you _______________________________ Phone # ( ) _______________________

Primary Care Physician ____ Phone # ( ) _______________________

Person to contact for an emergency _______________________________ Phone # ( ) _______________________

Person financially responsible for all charges ________________________ Phone # ( ) ______________________

Person whom we may thank for referring you to us ____

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, Private insurance and any other health plan to: North Texas Ob-Gyn Associates. This assignment will remain in effect until revoked by me in writing. A photocopy of my assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize and agree to release all information necessary to secure the payment. I understand that I may incur charges that are allowable but not covered by my insurance company and that I am financially responsible for these charges.

By signing below, you certify that the information given on the office forms is true and correct to the best of your knowledge and have no other insurance. You will notify us of any changes in your health status or any other information given to our office.

Signed: ____ Date: __________________________