NORTH TEXAS
OB-GYN ASSOCIATES

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.

PERSONAL INFORMATION:

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 # ( ) _____

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's Employer: _____ Insured's Member ID#: _____

Insured's SS#: _____Insured's DOB: _____ Relationship to Patient: _____

Secondary Insurance _____ Insured's Name _____

Insured's Employer: _____ Insured's Member ID#: _____

Insured's SS#: _____Insured's DOB: _____ Relationship to Patient: _____

CONTACT INFORMATION:

Primary Emergency Contact _____ Phone # ( ) _____

Secondary Emergency Contact (not living with you) _____ 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. If North Texas Ob-Gyn Associates does not receive payment from my insurance company within 120 days, I may be responsible for payment of my treatment fees and collection of my benefits directly from my insurance carrier. 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.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____