Women Caring for Women OB/GYN
8335 Walnut Hill Ln., Ste. 215
Dallas, TX 75231
214-221-2227

REGISTRATION INFORMATION

Date _____ Home Phone _____ Cell Phone _____
Name _____
Last First M.I.
Birthday _____ SS# _____
Address _____ Apt# _____
City _____ ST _____ Zip _____
Sex □ M □ F Age _____ □ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Partnered for ___ years
Patient Employer/School _____ Phone _____
How did you learn of our practice? _____
Emergency Contact _____ Phone _____
Email _____

INSURANCE INFORMATION

Do you have insurance? □ NO □ YES If yes, please complete the following section:
Insurer Name (policy holder) _____ Phone _____
Last First MI
Birthday _____ SS# _____ Relationship to patient _____
Insurance Company _____
ID# _____ Group# _____ Contact # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependants have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

The above named doctor may use my healthcare information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent with end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, or Guardian Date

_____ _____
Printed name of Patient, Parent or Guardian Relationship to Patient