

# Frisco Obstetrics AND Gynecology, P.A.

## PATIENT DEMOGRAPHICS

Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Please indicate below the preferred number to contact you, including location (i.e. Hm, Wk and Cell)

#1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Sex: Female \_\_\_\_\_ Male \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Phone # \_\_\_\_\_ Alternate Phone # \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

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### Responsible Party of Minors

Name \_\_\_\_\_ DL # \_\_\_\_\_ Issuing State \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Contact Number \_\_\_\_\_ Secondary Contact Number \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Other Authorized Persons \_\_\_\_\_

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### Primary Insurance Information

Policy Holders Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Company \_\_\_\_\_ Address \_\_\_\_\_

Member ID# \_\_\_\_\_ Group \_\_\_\_\_ Phone # \_\_\_\_\_

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### Secondary Insurance Information (if applicable)

Policy Holders Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Company \_\_\_\_\_ Address \_\_\_\_\_

Member ID# \_\_\_\_\_ Group \_\_\_\_\_ Phone # \_\_\_\_\_

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### Assignment of Benefits and Financial Agreement

I hereby consent to treatment by the physicians and/or associates of Frisco Obstetrics and Gynecology, P.A.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize payment of insurance benefits to be made to Frisco Obstetrics and Gynecology, PA 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 collections and reasonable attorney fees. I also authorize Frisco Obstetrics and gynecology, PA to release any and all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement or electronic signature is as valid as an original.

Date \_\_\_\_\_ Signature \_\_\_\_\_