

# LONE STAR OB/GYN ASSOCIATES

## REGISTRATION INFORMATION

PLEASE PRINT

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Marital Status    M    S    W    D    Sep \_\_\_\_\_ Spouse's name \_\_\_\_\_

Address: Street \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

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

Social Security Number \_\_\_\_\_ Email address \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/Business \_\_\_\_\_ Work/Daytime Phone \_\_\_\_\_

Address of employer \_\_\_\_\_

Referred by \_\_\_\_\_

## CLOSEST RELATIVE OR FRIEND IN CASE OF EMERGENCY

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address: Street \_\_\_\_\_ Phone \_\_\_\_\_

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

## INSURANCE INFORMATION

PRIMARY INSURANCE: \_\_\_\_\_

Policy and Group number \_\_\_\_\_

Member's name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Employer's name \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_

Insurance company address \_\_\_\_\_

Policy number \_\_\_\_\_ Group \_\_\_\_\_

Member's name \_\_\_\_\_ Employer \_\_\_\_\_

Employer's address \_\_\_\_\_ D.O.B. \_\_\_\_\_

I request that payment of authorized Medicare and/or insurance benefits be made either to me or on my behalf to LONE STAR OB/GYN for any services furnished to me by that physician group. I authorize any holder of medical information about me to release to the Health Care Financing Administration/or insurance companies and their agents any information needed to determine these benefits payable. I permit a copy of this authorization to be used in place of the original.

Sign here \_\_\_\_\_ Date \_\_\_\_\_