



REGISTRATION INFORMATION

PLEASE PRINT

Name _____ Date of Birth _____ Age _____

Marital Status: M S W D Sep Spouse's Name _____

Address _____ Apt _____ 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 _____ Apt _____ Phone _____ Cell _____

City _____ State _____ Zip _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

Policy Number _____ Group _____

Insurance Company Address _____

Member's Name _____ D.O.B. _____

Employer's Name / Address _____

SECONDARY INSURANCE: _____

Policy Number _____ Group _____

Insurance Company Address _____

Member's Name _____ D.O.B. _____

Employer's Name / Address _____

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 the release of my medical information to the Centers for Medicare and Medicaid Services/or insurance companies and their agents all 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 _____