3600 Gaston Ave Ste 601 Dallas, TX 75246-1806 (214) 377-1699

Erin K. Newman, MD Casey E. Roth, MD Lindsey Jackson, MD

PATIENT INFORMATION

Last Name: ______________________________ First Name & MI: ________________________________

Address: ________________________________ City/State/ZIP: ___________________________________

DOB & AGE: __________________ SSN: __________________ Email: ________________________________

Marital Status: _________________________ Spouse Name: ____________________________________

Home Phone: ___________________________ Work/ Cell Phone: _________________________________

Emergency Contact Name____________________Phone______________________Relationship_____________

PATIENT EMPLOYMENT INFORMATION

Employer: ____________________________ Occupation: ___________________ Race: _____________

RESPONSIBLE PARTY

[ ] Self [ ] Other (minor): Name: _________________________ Relationship to patient: ____________________

Responsible party DOB/AGE: ________________________ Resp party SSN: ____________________

Occupation: ____________________ Work#/Ext: ___________________ Cell #: _________________________

INSURANCE INFORMATION

Primary Ins: ____________________________ Claim Address: ________________________________

Insured Person [ ] Self [ ] Other: Relationship to Patient:____

Insured Person's Name: __________________ Insured DOB: ___________ Insured Employer: _____________

Insured Address: ___________________________ ID and Group#: _____________________________________

Secondary Ins: __________________________ Claim Address: ________________________________

Insured Person [ ] Self [ ] Other: Relationship to Patient:____

Insured Person's Name: __________________ Insured DOB: ___________ Insured Employer: _____________

Insured Address: ___________________________ ID and Group#: _____________________________________

Signature: ____ Date: _______________________________________

I UNDERSTAND AND AGREE THAT PAYMENT FOR SERVICES RENDERED IS DUE AT THE TIME OF SERVICE. ANY OTHER ARRANGEMENTS MUST BE MADE PRIOR TO SERVICE. I AUTHORIZE PAYMENT OF ANY MEDICAL BENEFITS TO THE CONTRACTED PROVIDERS WITH MAGNOLIA OBSTETRICS AND GYNECOLOGY ASSOCIATES, L.L.P FOR CHARGES WHICH MAY BE BILLED ON MY BEHALF. I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY ACCOUNT. I UNDERSTAND THAT ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE AND THAT I MAY BE BILLED FOR ANY BALANCE REMAINING AFTER MY INSURANCE PROCESSES ANY AND ALL CLAIMS.