



3900 Junius Street Ste 145  
Dallas TX 75246  
Phone 214-377-1699  
Fax 214-824-8365

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name & MI: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/ZIP: \_\_\_\_\_  
DOB & AGE: \_\_\_\_\_ SSN: \_\_\_\_\_  
Email: \_\_\_\_\_ Race: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Spouse Name: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work/ Cell Phone: \_\_\_\_\_

**EMPLOYMENT INFORMATION**

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

**RESPONSIBLE PARY**

Last Name: \_\_\_\_\_ First Name & MI: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
DOB/ AGE: \_\_\_\_\_ SSN: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Work #/Ext: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Ins: \_\_\_\_\_ Claims Address: \_\_\_\_\_  
ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Secondary Ins: \_\_\_\_\_ Claims Address: \_\_\_\_\_  
ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Phone #: \_\_\_\_\_  
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.**