



## 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 \_\_\_\_\_