

WSOP Plano

Patient Last Name \_\_\_\_\_
First Name \_\_\_\_\_ Middle \_\_\_\_\_
Address \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Emergency Contact \_\_\_\_\_

Home Phone \_\_\_\_\_
Work Phone \_\_\_\_\_
Date of Birth \_\_\_\_\_
Sex \_\_\_\_\_ Marital Status \_\_\_\_\_
Social Security No. \_\_\_\_\_
Driver's License \_\_\_\_\_
Women's Specialists Physician \_\_\_\_\_

Patient's Employer \_\_\_\_\_
Address \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_
Phone \_\_\_\_\_ Fax \_\_\_\_\_
E-Mail \_\_\_\_\_
Contact \_\_\_\_\_

Provide the following information if the guarantor is different than the patient.

Guarantor's Last Name \_\_\_\_\_
First Name \_\_\_\_\_ Middle \_\_\_\_\_
Address \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_
Employer \_\_\_\_\_
SS # \_\_\_\_\_ DOB \_\_\_\_\_
Patient's Relationship to Guarantor \_\_\_\_\_

Primary Insurance, Circle One: PPO HMO Other Don't Know

Company Name \_\_\_\_\_
Claims Address \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Member Services Phone \_\_\_\_\_
Policy No \_\_\_\_\_ Group No \_\_\_\_\_
Group Name \_\_\_\_\_
Insured Name \_\_\_\_\_
Address \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Phone \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_
Insured Employer \_\_\_\_\_
Address \_\_\_\_\_
Phone \_\_\_\_\_ Fax \_\_\_\_\_
Patient's Relationship to Insured \_\_\_\_\_

Secondary Insurance, Circle One: PPO HMO Other Don't Know

Company Name \_\_\_\_\_
Claims Address \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Member Services Phone \_\_\_\_\_
Policy No \_\_\_\_\_ Group No \_\_\_\_\_
Group Name \_\_\_\_\_
Insured Name \_\_\_\_\_
Address \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Phone \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_
Insured Employer \_\_\_\_\_
Address \_\_\_\_\_
Phone \_\_\_\_\_ Fax \_\_\_\_\_
Patient's Relationship to Insured \_\_\_\_\_

Provide the following information:

Referred by: \_\_\_\_\_
Has any member of your family ever been treated at this office: Circle One: Yes No
List Current Medications \_\_\_\_\_
Are you allergic to any medicine: Circle One: Yes No Don't Know
Pharmacy Name \_\_\_\_\_ Pharmacy Phone \_\_\_\_\_ Pharmacy Fax \_\_\_\_\_
I plan to make payment of my medical expenses as follows: (Circle one or more) Cash/Check MasterCard/Visa AE Discover

Financial Agreement & Authorization for Treatment

All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance with our office manager. Necessary forms will be completed to help expedite insurance carrier payments. The patient is responsible for any amount not covered or paid by insurance. If the coverage is through an HMO/PPO in which this office participates, the patient's responsibility is within the guidelines of the contractual agreement.

Insurance Authorization & Assignment

I hereby authorize Women's Specialists of Plano, LLP and/or Dennis C. Eisenberg, M.D., P.A., Murray E. Fox, M.D., P.A., Daryl T. Greebon, M.D., P.A., Jules C. Monier, M.D., P.A., Jon T. Ricks, M.D., P.A. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. It is further agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims. When this office agrees to file insurance, it does not assume responsibility for collection thereof.

Signature (Responsible Person) \_\_\_\_\_ Date \_\_\_\_\_