DALLAS Center for Pelvic Medicine

Amount Collected:_____
Cash:_____ **Check /#** _____**MC / Visa #**_____

Patient Information ACCOUNT #_____ Date:_____

Patient's Name (First, Middle, Last):_____
Address: _____Apt #:_____
City: _____State:_____Zip Code:_____
Home Phone#_____Cell #_____Work#_____
Primary Preferred contact number: ☐ Home ☐ Cell ☐ Work ☐ Other _____
Email:_____ Sex: ☐ Male ☐ Female ☐ Other:☐ M to F or ☐ F to M
Date of Birth:_____ Age:_____ SSN# (Optional)_____
Driver License #:_____ State:_____ Occupation:_____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Partner
Number of Children:_____ Ages:_____
Spouse/Partner's Name:_____ Date of Birth:_____ Phone #:_____

Referring Physician: _____Specialty:_____ Phone #:_____
Reason for Visit:_____
Primary Care Physician:_____ Phone #:_____
Pharmacy Name: _____ Phone#:_____
Emergency Contact: _____Relationship:_____ Phone #:_____
Emergency Contact:_____Relationship:_____Phone#:_____

Whom may we thank for referring you to our practice?

Doctor:_____ Another DCPM Patient:_____
☐ Internet Search ☐ ER Presbyterian ☐ ER Other:_____
☐ DCPM Website ☐ DCPM Employee:_____ ☐ Ins Company_____
☐ Other Website:_____ ☐ Other:_____
☐ DMagazine ☐ Radio

Power of Attorney

Have you executed a Durable Power of Attorney, Directive to Physician, and/or Living Will? ☐ Yes ☐ No
Would you like additional information regarding these documents? ☐ Yes ☐ No
If you have signed on of these legal documents, please bring a copy with you to your appointment and speak to your nurse regarding your decisions.

Other Patient Information

Which racial category does the patient most closely identify?
☐ African American ☐ Hispanic ☐ Pacific Islander
☐ Asian ☐ Native American ☐ Other:_____(Please Specify)
☐ Caucasian ☐ Native Hawaiian

Ethnicity: What is the patient's ethnicity? ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused to Report

Have you recently been outside the USA in the last 3-months?
☐ No ☐ Yes When & Where_____

What is the patient's language of preference? ☐ English ☐ Spanish ☐ Other_____

Patient Name:_____ **Date of Birth:**_____

Is this illness the result of an accident? ☐ YES ☐ NO If Yes, please see the receptionist.

Where did the accident occur? ☐ Work ☐ Auto ☐ Home ☐ Other:_____

Insurance Information

Primary Insurance:_____ Policy ID#_____

Employer:_____ Group Account #_____

Name of Policy Holder:_____ Date of Birth:_____

Employer's address:_____ Phone #_____

City:_____ State:_____ Zip Code:_____

Secondary Insurance:_____ Policy ID#_____

Employer:_____ Group Account #_____

Name of Policy Holder:_____ Date of Birth:_____

Employer's address:_____ Phone #_____

City:_____ State:_____ Zip Code:_____

☐ I have no secondary insurance:

Complete – Only if Patient is a Minor

Father's/Guardian Name:_____ Relationship:_____ Phone#_____

Mother's/Guardian Name:_____ Relationship:_____ Phone#_____

Assignment to Pay Insurance Benefits

I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare, private insurance and any other health plans to DCPM. This assignment is for services rendered to me by DCPM. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment for services rendered. I understand that failure to notify DCPM of any changes or insurance coverage will result in the financial obligation to rest fully on myself regardless of any contract between the insurance company and DCPM. _____

Initial

Consent for Treatment

By signing this consent, I am authorizing my physician and/or other individuals he or she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I a make to DCPM unless revoked by me orally or in writing. _____

Initial

_____ Date:_____

Signature of Patient / Legal Representative

_____ Date:_____

Relationship to Patient

_____ Date:_____

Witness