

# FLOWER MOUND WOMEN'S CARE

GUY VAN DELL, M.D., P.A.

Obstetrics & Gynecology

400 Parker Square Suite 245 Flower Mound, TX 75028

Tel. 972-899-9787 Fax. 972-899-9786 <http://www.fmwomenscare.com>

## Patient Information

Last Name		First Name			Middle Initial
DOB	Social Security Number	Marital Status <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> widowed <input type="checkbox"/> legally separated <input type="checkbox"/> partner		Name of Partner/Spouse	
Address					
City		State	Zip	Email Address	
Home Phone Number			<input type="checkbox"/> OK to leave message with detailed information <input type="checkbox"/> Leave message with call-back number only		
Cell Phone Number			<input type="checkbox"/> OK to leave message with detailed information <input type="checkbox"/> Leave message with call-back number only		
Drivers license number		Issuing state	How did you hear of/Who recommended you to the doctor?		
Employer		Employment Status <input type="checkbox"/> full-time <input type="checkbox"/> part-time <input type="checkbox"/> not-employed <input type="checkbox"/> self-employed <input type="checkbox"/> retired <input type="checkbox"/> active military duty			
Address					
City		State	Zip	Occupation	
Work Phone Number			<input type="checkbox"/> OK to leave message with detailed information <input type="checkbox"/> Leave message with call-back number only		
Student Status <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Not a student		Name of School			

## Emergency Contact Information

Name		Relation to Patient		
Home Phone Number	Cell Phone Number	Work Phone Number		
Address				
City		State	Zip	Email Address

## Responsible Party

(insurance policy holder or person in charge of payments)

Same As Patient Y N	Last Name		First Name		Middle Initial
DOB	Social Security Number	Relation to Patient			
Address					
City		State	Zip	Email Address	
Home Phone Number			Cell Phone Number		
Employer		Employment Status <input type="checkbox"/> full-time <input type="checkbox"/> part-time <input type="checkbox"/> not-employed <input type="checkbox"/> self-employed <input type="checkbox"/> retired <input type="checkbox"/> active military duty			
Address					
City		State	Zip	Occupation	Work Phone Number

### Insurance Information

Primary Insurance Carrier				Plan Type <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> medicare <input type="checkbox"/> medicaid	
Billing Address					
City		State	Zip	Benefits phone #	
Policy (ID/Subscriber) #			Group #		Copay/Coinsurance
Effective Date	Termination Date		Lab Contracted		

  

Secondary Insurance Carrier				Plan Type <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> medicare <input type="checkbox"/> medicaid	
Billing Address					
City		State	Zip	Benefits phone #	
Policy (ID/Subscriber) #			Group #		Copay/Coinsurance
Effective Date	Termination Date		Lab Contracted		

### Primary Care Physician Information

Physician/Practice Name		
Phone Number		Fax Number
Address		
City		State Zip

### Preferred Pharmacy Information

Pharmacy Name		
Phone Number		Fax Number
Address		
City		State Zip

### Consent for General Practice

By signing this form, you authorize employees, including physicians, physician assistants, and nurse practitioners of Guy Van Dell, MD, PA to render routine care to you during your office visits and to fulfill the orders of your physicians, including consultants, associates, and assistants of your physician's choice.

Signature of patient or legal representative	Date
--	------

### Consent to Treat a Minor

\_\_\_\_\_ (name of minor) has an appointment to see  Guy Van Dell, MD on \_\_\_\_\_ (date) for examination and treatment. The reason for the visit is: \_\_\_\_\_

I, \_\_\_\_\_ (parent/guardian) give  Dr. Van Dell my permission to examine and treat the above named minor.

Signature of patient or legal representative	Date
--	------

### Assignment of Insurance Benefits

By signing this form, I authorize payment of medical and/or surgical benefits, including Medicare, private insurance, PPO plans, and all other health plan benefits, directly to Guy Van Dell, MD, PA. The duration of this consent is indefinite and continues until revoked 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 not covered by my insurance plan and/or any claims denied by my insurance. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete any insurance claim.

Signature of patient or legal representative

Date

### Acknowledgment of Receipt of Notice of Health Information Practices

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

Guy Van Dell, MD, PA is furnishing you with the attached notice, which provides information about how our office may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of this office's notice of Health Information Practices.

Signature of patient or legal representative

Date

### Acknowledgement of Receipt of Notice of Office Policies and Procedures

Guy Van Dell, MD, PA is furnishing you with the attached notice, which provides information regarding our office protocols and policies which we have developed in order to optimize our ability to deliver your care. By signing this form, you acknowledge that you have received a copy of our office policies and will try, to the best of your ability, to adhere to them.

Signature of patient or legal representative

Date

### Communication of Information

I give permission to Guy Van Dell, MD, PA to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s), and/or close personal friend(s).

Name	Relation to Patient
Name	Relation to Patient
Name	Relation to Patient

Signature of patient or legal representative

Date