FLOWER MOUND WOMEN'S CARE

GUY VAN DELL, M.D., P.A. & Beth Dickens,R.N.,C.N.M.

Obstetrics & Gynecology

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Patient Information

Last Name	**First Name**		**Middle Initial**
DOB	**Social Security Number**	**Marital Status** □single □married □divorced □widowed □legally separated □partner	**Name of Partner/Spouse**
Address			
City	**State**	**Zip**	**Email Address**
Home Phone Number			□ **OK** to leave message with detailed information □ Leave message with call-back number only
Cell Phone Number			□ **OK** to leave message with detailed information □ 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** □ full-time □ part-time □ not-employed □ self-employed □ retired □ active military duty			
Address				
City	**State**	**Zip**	**Occupation**	
Work Phone Number	□ **OK** to leave message with detailed information □ Leave message with call-back number only			

Student Status □ **Full-time** □ **Part-time** □ **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** □ full-time □ part-time □ not-employed □ self-employed □ retired □ active military duty			
Address				
City	**State**	**Zip**	**Occupation**	**Work Phone Number**

Insurance Information

Primary Insurance Carrier			Plan Type □ HMO □ PPO □ POS □ medicare □ 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 □ HMO □ PPO □ POS □ medicare □ 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 and/or Beth Dickens,RN,CNM on _____ (date) for examination and treatment. The reason for the visit is:_____.
I, _____ (parent/guardian) give Guy Van Dell, MD and/or Beth Dickens, RN,CNM 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 (HIPPA) 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 and/or Beth Dickens, RN ,CNM 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 and/or Beth Dickens, RN,CNM 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 and/or Beth Dickens, RN,CNM 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