PAUL W. DAUM, M.D.
Mansfield Miracles
Obstetrics-Gynecology-Infertility
2800 E. Broad St. Suite 412 Mansfield, Tx 76063
Ph. 817-477-0200 Fax 817-225-0920
www.mansfieldmiracles.com

PATIENT ENROLLMENT

CONTACT INFORMATION

NAME _____
Last Name First Name Middle Initial

DATE OF BIRTH _____/ _____ /_____ SOCIAL SECURITY # _____/ _____/_____

HOME PHONE (_____)_____ CELL PHONE (_____)_____

ADDRESS _____

CITY/STATE _____ ZIP_____

EMAIL _____

REFFERED BY: _____

EMPLOYMENT INFORMATION

EMPLOYER _____

OCCUPATION _____

WORK PHONE (_____)_____ EXT _____

EMPLOYER ADDRESS _____

MARITAL STATUS: (Check One)

Single_____ Married _____ Divorced _____ Widow _____ Separated _____

SPOUSE'S NAME _____
Last Name First Name Middle Initial

SOCIAL SECURITY # _____/ _____/ _____ DATE OF BIRTH _____/ _____/ _____

CELL PHONE (_____) _____

SPOUSE'S EMPLOYER _____

OCCUPATION _____WORK PHONE (_____)_____ EXT_____

PAUL W. DAUM, M.D.
Mansfield Miracle
Obstetrics-Gynecology-Infertility
2800 E. Broad St. Suite 412 Mansfield, Tx 76063
Ph. 817-477-0200 Fax 817-225-0920
www.mansfieldmiracles.com

PRIMARY CARE PHYSICIAN INFORMATION

NAME OF FAMILY PHYSICIAN_____

PHONE NUMBER (_____)_____ EXT_____

ADDRESS : _____

_____

PHARMACY INFORMATION

PHARMACY # (_____)_____

ADDRESS_____

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY _____ RELATIONSHIP_____
Last Name First Name

HOME PHONE (_____)_____ CELL PHONE (_____)_____

WORK PHONE (_____)_____ EXT _____

ADDRESS _____

_____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT_____
Last Name First Name

HOME PHONE (_____)_____ CELL PHONE (_____)_____

WORK PHONE (_____)_____ EXT_____

ADDRESS _____

_____

PAUL W. DAUM, M.D.
Mansfield Miracle
Obstetrics-Gynecology-Infertility
2800 E. Broad St. Suite 412 Mansfield, Tx 76063
Ph. 817-477-0200 Fax 817-225-0920
www.mansfieldmiracles.com

INSURANCE INFORMATION

PRIMARY INSURANCE:

NAME OF INSURANCE COMPANY _____

NAME OF INSURED _____

SS# OF INSURED _____/ _____/ _____ RELATIONSHIP TO PATIENT_____

EMPLOYER OF INSURED_____

DATE OF BIRTH OF INSURED _____/ _____/ _____

SECONDARY INSURANE:

NAMES OF INSURANCE _____

NAME OF INSURED _____

SS# OF INSURED _____ RELATIONSHIP TO PATIENT _____

EMPLOYER OF INSURED _____

DATE OF BIRTH OF INSURED _____/ _____/ _____

*******WE WILL COLLECT PAYMENT AT THE TIME OF YOUR VISIT. THIS INCLUDES ANY COPAYS, DEDUCTIBLES AND/OR COINSURANCE AMOUNTS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR MY ACCOUNT IN THE EVENT MY INSURANCE DOES NOT PAY******

I authorize treatment by Paul Daum, M.D. and give permission for him to release (via fax, electronic copy, mail, or by phone) information for prescription certification, referrals to other physicians, psychologists, family counselors, or to my employer for disability or family leave. A copy of this authorization is valid as the original.

_____ _____
Patient or Guardian Signature Date