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 _____

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

SPOUSE'S ADDRESS _____

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

CELL PHONE (_____)_____

SPOUSE'S EMPLOYER _____

OCCUPATION _____ WORK PHONE (_____)_____ EXT_____

PRIMARY CARE PHYSICIAN INFORMATION

NAME OF FAMILY PHYSICIAN _____

PHONE NUMBER: (_____)_____ EXT _____

ADDRESS: _____

_____

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RESPONSIBLE PARTY INFORMATION

RESPONSIBILE 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 _____

_____

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 INSURANCE:

NAME OF INSURANCE_____

NAME OF INSURED_____

SS# OF INSURED_____ RELATIONSHIP TO PATIENT_____

EMPLOYER OF INSURED_____

DATE OF BIRTH OF INSURED_____/_____/_____

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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.

_____ _____

Signature Date