DONNA DURAN, M.D., P. A.
OBSTETRICS / GYNECOLOGY
11803 S. Freeway, Suite 215
Fort Worth, TX 76115

DATE ______________

PATIENT LAST NAME ______________________ FIRST ________________ MIDDLE INITIAL ______
ADDRESS ____ APT# __________
CITY ______________________ STATE _________ ZIP CODE ___________
DOB __________ MALE ☐ FEMALE ☐ MARITAL STATUS: M ☐ D ☐ S ☐ W ☐
PHONE# ( ) __________ SOCIAL SECURITY # ______________ DRIVER'S LICENSE # __________

PATIENT EMPLOYER NAME __________________________
ADDRESS ____ STE# __________
CITY ______________________ STATE _________ ZIP CODE ___________
WORK PHONE# ( ) ____________ EXT# _____ CAN YOU BE CONTACTED AT WORK? YES ☐ NO ☐

RETIRED: YES ☐ NO ☐ RETIREMENT DATE ___/___/___

WHAT BRINGS YOU TO THE DOCTOR'S OFFICE? ____

GUARANTOR/RESPONSIBLE PARTY: *(If you are over 18 years old you will be responsible for the services today.)*
(If you are signing in a minor you will be billed for today's services. Please fill in the following:)

LAST NAME ______________________ FIRST ________________ MIDDLE INITIAL ______
ADDRESS ____ APT# __________
CITY ______________________ STATE _________ ZIP CODE ___________
DOB __________ MALE ☐ FEMALE ☐ MARITAL STATUS: M ☐ D ☐ S ☐ W ☐
PHONE# ( ) __________ SOCIAL SECURITY # ______________ DRIVER'S LICENSE # __________

ARE PARENTS DIVORCED? ______ IF YES, WHO HAS CUSTODY? ______________________________

GUARANTOR:
EMPLOYER NAME __________________________
ADDRESS ____ STE# __________
CITY ______________________ STATE _________ ZIP CODE ___________
WORK PHONE# ( ) ____________ EXT# __________

NEAREST RELATIVE / EMERGENCY CONTACT:

LAST NAME ______________________ FIRST ________________
ADDRESS ____ APT# __________
CITY ______________________ STATE _________ ZIP CODE ___________
PHONE# ( ) __________

WHO REFERRED YOU TO OUR OFFICE TODAY? DOCTOR ☐ FRIEND ☐ PHONE BOOK ☐ ADVERTISEMENT ☐ HOSPITAL ☐

(To be completed by office staff. This information is necessary for all consultations.)

REFERRING DOCTOR:
NAME __________________________
ADDRESS ____ STE# __________
CITY ______________________ STATE _________ ZIP CODE ___________
PHONE# ( ) __________ FAX# ( ) __________ UPIN# __________

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NEW PATIENT INFORMATION

(PLEASE COMPLETE ALL QUESTIONS AND RETURN TO RECEPTIONIST)

NAME: ____
DATE OF BIRTH: __________________________ AGE: __________
AVERAGE WEIGHT: ________________________ HEIGHT: ________
REASON FOR YOUR VISIT TODAY: ____________________________
____
____

ARE YOU PREGNANT? YES ☐ NO ☐
HAVE YOU SEEN ANOTHER DOCTOR FOR THIS PREGNANCY/CONDITION? YES ☐ NO ☐
IF YES, WHO? ____________________________________
FIRST DAY OF LAST PERIOD? ________________________ (IMPORTANT!)
CURRENT METHOD OF BIRTH CONTROL: NONE
BIRTH CONTROL PILLS ______________ IUD ____________________
DIAPHRAM ______________________ CONDOMS __________________
DEPO PROVERA __________________ NORPLANT _________________
PREVIOUS METHODS OF BIRTH CONTROL (PLEASE LIST DATES USED):
BIRTH CONTROL PILLS ______________ IUD ______________
DEPO PROVERA __________________
NORPLANT ______________________
OTHER _________________________
PLEASE LIST ALL SURGERIES AND DATES OF SURGERIES:
1. ____
2. ____
3. ____
4. ____
PREGNANCIES (INCLUDE CURRENT, IF APPLICABLE):
NUMBER OF LIVING CHILDREN: __________ C/SECTIONS: ____________
ALLERGIES: NONE (CIRCLE)
LIST: ____
DO YOU SMOKE? YES ☐ NO ☐ HOW MANY/DAY? ________ HOW LONG? _____
HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES ☐ NO ☐
PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:
____
____

MEDICAL HISTORY (YOURSELF ONLY, PLEASE):

HIGH BLOOD PRESSURE	YES ☐	NO ☐
ASTHMA	YES ☐	NO ☐
DIABETES	YES ☐	NO ☐
HEART DISEASE	YES ☐	NO ☐
CANCER	YES ☐	NO ☐
ABNORMAL PAP SMEAR	YES ☐	NO ☐
RH NEGATIVE	YES ☐	NO ☐

WHEN WAS YOUR LAST PAP SMEAR? __________________ DOCTOR? ______________
WHEN WAS YOUR LAST MAMMOGRAM? __________________ WHERE? ______________
WHO REFERRED YOU TO OUR OFFICE? ________________________________
DO YOU HAVE ANY FAMILY MEMBERS WHO COME TO THIS OFFICE? YES NO (LIST):
____

THANKS!!

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DATE ____________

PRIMARY INSURANCE INFORMATION

INSURANCE NAME ________________________
ADDRESS ________________________ APT# ________
CITY ____________ STATE ________ ZIP CODE ________
PHONE# (800) ____________
POLICY NUMBER: ____________ GROUP # ____________
COPAY /COST $ ____________
AUTHORIZATION # ____________ # OF VISITS ______

POLICY HOLDER:
LAST NAME ____________ FIRST ____________ MIDDLE INITIAL ______
ADDRESS ________________________ APT# ________
CITY ____________ STATE ________ ZIP CODE ________
DOB ________ MALE ☐ FEMALE ☐ MARITAL STATUS: M ☐ D ☐ S ☐ W ☐
PHONE# (   ) ________ SOCIAL SECURITY # ____________ RELATIONSHIP TO PATIENT ______
How much is the deductible? ______ How much has been paid? ____________ Max. annual benefit? ________

SECONDARY INSURANCE INFORMATION:

INSURANCE NAME ________________________
ADDRESS ________________________ APT# ________
CITY ____________ STATE ________ ZIP CODE ________
PHONE# (800) ____________
POLICY NUMBER: ____________ GROUP # ____________
COPAY /COST SHARE $ ____________
AUTHORIZATION # ____________ # OF VISITS ______

POLICY HOLDER:
LAST NAME ____________ FIRST ____________ MIDDLE INITIAL ______
ADDRESS ________________________ APT# ________
CITY ____________ STATE ________ ZIP CODE ________
DOB ________ MALE ☐ FEMALE ☐ MARITAL STATUS: M ☐ D ☐ S ☐ W ☐
PHONE# (   ) ________ SOCIAL SECURITY # ____________ RELATIONSHIP TO PATIENT ______

I understand that radiologists, Ultrasound technicians, Pathologists, and the like, are independent contractors and are not employees or agents of Donna Duran, M.D., P. A. **Patient initials**: ____________

I authorize release of any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.
I understand my signature requests that payment be made and authorizes release of medial information necessary to pay the claim if Item 9 of the HCFA 1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown in Medicare/Other Insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/Other Insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Other Insurance company.
I, theundersigned, as patient or on behalf of the patient, whose name appears on this form, do hereby consent and authorize all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of my health care provider being physician or physician assistant on duty.
I permit a copy of this authorization to be used in place of the original.

Patient Signature/Guardian Signature ________________________ Date ____________

INSURANCE NON-COVERAGE RELEASE: To be completed for non-covered services:
I have been notified by my physician that he/she believes that, in my case, the insurance company is likely to deny payment for this service ____________ because ________________________. If the insurance company denies payment, I agree to be personally and fullly responsible for the payment of $ ____________.

Patient Signature/Guardian Signature ________________________ Date ____________

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Phone 817-568-2277
Fax 817-568-2254

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____
Signature of Patient or Personal Representative

____
Date

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority

Staff Will Fill Out This Section If Patient's Signature Not Obtained

Our office made a good faith effort to obtain Acknowledgement of Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reasons:

_____ Patient refused to sign.

_____ Emergency situation kept us from obtaining the patient's signature.

_____ Language barriers kept us from obtaining the patient's signature.

_____ Other ____