

**J. MICHAEL PUTMAN, M.D. & ASSOCIATES**  
REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY  
ADVANCED GYNECOLOGIC ENDOSCOPY

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(214) 887-8244 FAX

*Please print clearly. Please complete **all** information so that your claim can be processed quickly and efficiently. Thank you!*

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**PATIENT INFORMATION**

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Name (First, M.I., Last): \_\_\_\_\_ Date: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male / Female Marital Status: S M W D

Address (Street) \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

Phone #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Religious Preference: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referred By: \_\_\_\_\_ Address: \_\_\_\_\_

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**Responsible Party Information**

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Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone #: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Employer: \_\_\_\_\_ Work #: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Friend or Relative Not Living with You: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_