Letter from the Doctor

Tara A. Dullye, M.D., F.A.C.O.G.

Obstetrics, Gynecology, & Infertility

Margot Perot Women's and Children's Hospital
8160 Walnut Hill Lane, Suite 219
Dallas, TX 75231

Phone: (214) 369-2400

Email: dullyeforms@obgyndallas.com

Dear New Patient,

It is important to me that I give the best possible care to my patients. Part of that care depends upon my having as much information as possible about your medical history and current problems.

The following new-patient information form is a necessary part of the evaluation. By completing the form and also an on-line medical history questionnaire in your own home or other convenient location, you will have time to obtain the required information that might be hard to accurately recall otherwise.

Also, if I am able to reflect upon your information and history in an unhurried manner before your appointment, our discussion in my office may better focus on the areas of concern to you. For these reasons, please complete and return the needed forms as soon as possible prior to scheduling your appointment.

As soon as we receive your completed information, we will contact you to schedule an appointment.

Please provide the following **new-patient information** to us in one of several ways:

1. Download the new-patient information PDF form and either complete it on your computer (preferable) or print it and complete it by hand, or you may call our office at (214) 369-2400 and ask for a blank form to fill out. We can email or mail it to you.

2. Once you have completed it, you can:

   - scan and/or email the form to dullyeforms@obgyndallas.com; or
   - mail or deliver the printed information form to us at 8160 Walnut Hill Lane, Suite 219, Dallas, TX 75231.

Once we have received the completed new-patient information form, we will contact you by phone to provide instructions to you on how to complete your **on-line medical history questionnaire**. We require the completed information from you prior to making your first appointment.

Thank you for taking the time to complete the information form and on-line health history questionnaire and returning the forms to me. I look forward to meeting you.

Sincerely,

Tara A. Dullye, M.D.

To be able to fill in items on this form, you need to open it using Adobe Reader. Click here to install Adobe Reader.

Patient Information

Last Name:

First Name:

Date of Birth:

Address:

City:

State:

Zip Code:

Cell Phone:

Home Phone:

Work Phone:

Email Address:

Preferred Contact Method: ☐ Email ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Postal Mail

Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Social Security No:

Patient's Primary Language:

Patient's Race/Ethnicity:

Patient's Occupation:

Referred by:

Student Patient's School Name:

School Location:

and Grade Level:

Reason for Visit: ☐ Routine Exam – No Problems

☐ Problem Visit - Reason below, in detail including length of time

Problem(s):

Your Primary Care Doctor:

Other Doctors Providing You Care (or None):

Patient's Employer:

Employer's Phone No:

Spouse/Significant Other Information:

Last Name:

First Name:

Date of Birth:

Social Security No:

Cell Phone No:

Employer:

Occupation:

Emergency Notification Information (Other than spouse/significant other):

Name:

Relationship:

Address:

City:

State:

Zip Code:

Phone No:

Insurance Information (If self-pay, enter None in required blanks):

Insurance Co. Name:

Claims Address:

Claims City:

Claims State:

Claims Zip Code:

Claims Phone No.:

Policy or Member ID No.:

Group No.:

Guarantor Name:

Guarantor: ☐ Patient

☐ Spouse/Significant Other

☐ Other (Complete following, if "Other")

"Other" Guarantor Date of Birth: Click here to enter a date.

"Other" Guarantor Social Security No.:

"Other" Guarantor Address:

"Other" Guarantor City:

"Other" Guarantor State:

"Other" Guarantor Zip Code:

"Other" Guarantor Phone No.:

Patient's Relation-ship to "Other" Guarantor:

NOTE: After you fill in the above items, do a "File Save" to ensure your entries are saved.

Once you have filled out this form completely and accurately, please fax, email, or mail to our office. Check to be sure all the information in the "Reason for Visit" and "Other Doctors" boxes is included in your completed form. If you do not receive a call from us within two business days of our receiving the document, please call us at 214-369-2400. Thank you.

Note: On your initial visit to our office, you will be asked to sign a form authorizing Dr. Dullye to release medical information that may be necessary to request reimbursement from insurance companies to whom you have submitted a claim. You also will be asked to sign your understanding that it is YOUR RESPONSIBILITY to determine if Dr. Dullye is or is not in network with your insurance company plan. If Dr. Dullye is NOT in network with your insurance plan, you will be responsible for a higher deductible or coinsurance payment than if you see a physician who is in network with your plan. You also will be asked to sign your agreement to pay any charges incurred at this visit and will assign all medical and/or surgical benefits, to include major medical benefits to which you are entitled, to Dr. Dullye.