NORTH TEXAS PERINATAL ASSOCIATES, P.A.

Maternal Fetal Medicine

PATIENT INFORMATION

Today's Date: ____________ Referring Doctor/Midwife: ______________________________

Name: ____
(Last) (First) (Middle)

DOB: _________ / _________ / _________ Age: _____ Social Security Number: ___________________

Home: (_____) _______________ Office: (_____) _______________ Cell: (_____) _______________

Home Address: ____ Apt. _______

City: ______________________________________ State: ______ Zip: __________

Driver's License Number: ___________________________ Driver's License State: ___________

Employer: ____

Employer Address: ___________________________ City: __________________ State: _____

Spouse/Partner: ______________________ SS#: _________________ DOB: _____ /_____ /_____

Spouse/Partner's Employer: ____

Spouse/Partner's Employer Address: _______________________________________

City: ______________________________________ State: ______ Zip: __________

EMERGENCY CONTACT INFORMATION

(Person listed should be someone not living with you.)

Name: ______________________________________ Relationship: __________________

Home: (_____) _______________ Office: (_____) _______________ Cell: (_____) _______________

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PATIENT INFORMATION

IF PATIENT IS UNDER PARENT'S INSURANCE, PLEASE COMPLETE THE FOLLOWING:

Father's Name: ______________________ Mother's Name: ______________________

Employer: ______________________ Employer: ______________________

Phone: (______) ______________________ Phone: (______) ______________________

I certify that all information provided is true and correct to the best of my knowledge.

Signature: ______________________________________ Date: ________________

AUTHORIZATION TO DISCUSS PROTECTED INFORMATION

I, ______________________, authorize North Texas Perinatal Associates to release or discuss information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to my insurance carrier and the following persons as listed:

1) ______________________ 3) ______________________

2) ______________________ 4) ______________________

- Please be advised that any person not referred to on this list will not be given any information related to your care, including billing information. You may change, restrict or expand this listing at any time.
- You are not required to list any name(s) is you do not so choose.

Please provide phone numbers at which we can contact you or leave a message regarding the following:

- Lab results
- Appointment reminders
- Changes to scheduled appointments
- Billing information

1) ______________________ 2) ______________________

ADVANCE DIRECTIVE / LIVING WILL

Do you have an advance directive or living will? Yes ______ No ______

If no, are you interested in receiving information pertaining to one? Yes ______ No ______