PATIENT INFORMATION FORM

Please print all information in the space provided.
Sign and date at the bottom of each form.

Envision PHYSICIAN SERVICES
DELIVERED BY NORTH TEXAS PERINATAL ASSOCIATES, P.A.

PATIENT INFORMATION

Referring Doctor-Midwife:		Date:
Last Name:	First Name:	M.I.:
Home Address:		Apt:
City:	State:	ZIP Code:
Home Phone:	Work Phone:	Cell:
Email Address:		Appt. Reminders: ❑ Phone ❑ Text ❑ Email
SSN:	DOB:	Age:
Employer:	Employer Address:	
DL Number:	DL State:	
Spouse's-Partner's Name:	SSN:	DOB:
Spouse's-Partner's Employer:		
Spouse's-Partner's Employer Address:		

PRIMARY INSURANCE

Insurance Company:	Phone Number:
Billing Address:	
Name of Insured:	Relationship:
Insured's ID Number:	Group Number:

If patient is under parent or spouse's insurance, please complete the following

Name of Insured:	DOB:	Relationship:
Employer:	Phone Number:	

SECONDARY INSURANCE

Insurance Company:	Phone Number:
Billing Address:	
Name of Insured:	Relationship:
Insured's ID Number:	Group Number:

EMERGENCY CONTACT INFORMATION (Please list someone not living in the same house hold)		
First Name:	Last Name:	Relationship:
Home Phone:	Work Phone:	Cell Phone:

I hereby authorize payment of medical benefits billed to my insurance to North Texas Perinatal Associates. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance. I agree to pay all co-payments, coinsurance, and deductibles at the time the service is rendered.

Date of Signature

Signature of Patient or Guardian