APPOINTMENT BY:_____ ACCOUNT #_____

APPT. DATE_____/_____/_____
APPT TYPE NP

PATIENT REGISTRATION

LAST NAME_____ FIRST _____ M.I. _____

STREET ADDRESS_____CITY_____ ST____TX__ ZIP__77_____

MAILING ADDRESS (IF DIFFERENT FROM ABOVE)_____

HOME PHONE (_____) _____ - _____ MARITAL STATUS (CIRCLE ONE) M S DATE OFBIRTH_____/_____/_____

SOCIAL SECURITY #_____/_____/_____DRIVER'S LICENSE #_____ (PLEASE LET US MAKE A COPY)

WHO MAY WE THANK FOR REFERRING YOU TO HOUSTON PERINATAL ASSOCIATES? DR._____
PHONE _____

KA, BK, JH, AR, PP, MM

PATIENT'S EMPLOYER_____EMPLOYER ADDRESS_____

BUSINESS PHONE (_____) _____ - _____ CITY_____ ST _____ ZIP_____

SPOUSE'S NAME_____ SOCIAL SECURITY #_____/_____/_____

SPOUSE'S EMPLOYER_____ BUS PHONE (_____) _____ - _____

NEAREST RELATIVE_____ PHONE _____RELATIONSHIP_____
NOT LIVING WITH YOU

INSURANCE INFORMATION

INSURANCE CARRIER _____ ADDRESS _____

PHONE (_____) _____ - _____ CITY_____ ST_____ ZIP_____

POLICYHOLDER'S FULL NAME _____ DOB _____/_____/_____
RELATIONSHIP TO PATIENT _____

POLICY/CERTIFICATE #_____GROUP #_____ MEMBER #_____

SECONDARY INS. CARRIER _____ADDRESS_____

PHONE (_____) _____ - _____ CITY_____ ST_____ ZIP _____

POLICYHOLDER'S FULL NAME_____ DOB_____/_____/_____
RELATIONSHIP TO PATIENT _____

POLICY/CERTIFICATE #_____GROUP #_____ MEMBER #_____

Authorization to pay benefits to Physician

I hereby authorize payment directly to the physician of the surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay any and all non-recovered services.

Signature_____ Date_____

Authorization to Release Information

I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process any insurance claims.

Signature_____ Date_____

AGE_____ LMP_____EDC_____BLOOD TYPE_____DIAGNOSIS_____

In this pregnancy, have you had an ultrasound? □Yes □No How many?_____