FORT WORTH PERINATAL ASSOCIATES, P.A.

P.O. Box 961094, File 916211
Fort Worth, Texas 76161-1094

PATIENT REGISTRATION INFORMATION

Social Security #: _____ Driver's License #: _____ State: _____

Name: _____ _____ _____ _____ _____ _____ ☐ S ☐ M ☐ D ☐ W
Last First M.I Sex Date of Birth Age Marital Status

Address: _____ _____ _____ _____ _____ _____
Street or P.O Box Apt City State Zip Preferred Phone (Daytime)

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed ☐ Student _____
Alternate Phone (Evening)

Employer's or School Name: _____ _____ _____
Work Phone Ext

Employer's Address: _____ _____ _____ _____
Street or P.O Box City State Zip

Occupation: _____

Emergency Contact:(Please indicate a friend or relative not living at the same address)

_____ _____ _____
Name Phone Relationship

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient is responsible party, however if the patient is a minor the guardian's information should be listed in this section.

Patient Relationship to Responsible Party: Child: _____ Other (Specify): _____

Social Security #: _____ Driver's License #: _____ State: _____

Name: _____ (Last) _____ (First) _____ (M.I) _____ (Sex) _____ (Date of Birth) _____ (Age) ☐ S ☐ M ☐ D ☐ W (Marital Status)

Address: _____ (Street (no P.O Box please)) _____ (Apt) _____ (City) _____ (State) _____ (Zip) _____ (Home Phone)

Employment Status (Please check one): ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed ☐ Student Occupation: _____

Employer's or School Name: _____ _____ (Work Phone) _____ (Ext)

Employer's Address: _____ (Street or P.O Box) _____ (City) _____ (State) _____ (Zip)

SPOUSE'S INFORMATION

Spouse Name: _____ DOB: _____ SS #: _____

Spouse's Wk Phone: _____ Occupation: _____

PRIMARY INSURANCE

Insurance Company: _____ Address: _____
Street or P.O Box

Ins. Phone: _____ _____ _____ _____
City State Zip

Policy Holder: _____ _____ _____ _____ _____
Last First Sex Date of Birth SS#

Patinet Relationship to Insured Party: ☐ Self ☐ Spouse ☐ Child ☐ Other Specify: _____

Employer's Name: _____ _____ _____
Insured ID Group Number

Address: _____ _____ _____ _____
Street or P.O Box City State Zip

SECONDARY INSURANCE

Insurance Company: _____ Address: _____
Street or P.O Box

Ins. Phone: _____ _____ _____ _____
City State Zip

Policy Holder: _____ _____ _____ _____ _____
Last First Sex Date of Birth SS#

Patinet Relationship to Insured Party: ☐ Self ☐ Spouse ☐ Child ☐ Other Specify: _____

Employer's Name: _____ _____ _____

Insured ID Group Number

Address: _____ _____ _____ _____

Street or P.O Box City State Zip

REFERRAL INFORMATION

Obstetrician: _____ Phone: _____

I fully understand and acknowledge that Fort Worth Perinatal Associates, P.A. is a specialty practice for which I have been referred on a consultation basis only. My Obstetrician will continue to care for me during my pregnancy and will be delivering me as planned. I also understand that it is vital for me to continue going to my obstetrician for regularly scheduled appointments, even if l have an appointment with Fort Worth Perinatal Associates, P.A.

PATIENT SIGNATURE: _____ DATE: _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRWACY PRACTICES APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ:

I authorize qualified staff to perform upon me, rehabilitation, therapy and/or any other care including treatment necessary to improve my well-being. I acknowledge that no guarantees can be made to me as to the outcome of treatment. I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

PATIENT SIGNATURE: _____ DATE: _____

I authorize my insurance benefits to be paid directly to Fort Worth Perinatal Associates, PA realizing I am responsible to pay non-covered and/or denied services. In the event that my insurance carrier denies payment for any reason, I acknowledge that I am responsible for payment of services provided to me.

PATIENT SIGNATURE: _____ DATE: _____

I authorize the release of information to my insurance carrier named above concerning my medical condition and for the purpose of claims processing. I also authorize the release of medical information to my referring physician and any physician I am recommended to see for continuation of care. I understand that the release of information will only consist of medical records belonging to Fort Worth Perinatal Associates, P A.

PATIENT SIGNATURE: _____ DATE: _____