PATIENT INFORMATION – FETAL APPOINTMENT

Today's Date ______________

Name of Patient: ____

Pregnancy # of weeks ________

Birthdate: ____

# of other children ________

Address: ____

City ____________________ State ______________ Zip ________________

Home Phone: (__________)________________________ Cell phone: (   )____________

Baby's Father's Name: ______________________________ D.O.B. ______________

OB/GYN: ______________________________________ Phone:(______)__________

Referring Physician: _______________________________ Phone:(______)__________

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Primary Insured's Name: ______________________________________ SS#: ______________

Address:(if other than above) ____

City: ________________ State ____________ Zip ________ Phone(_______)__________

Insurance Company: ____

Group#: ____________________ ID# __________________ Birthdate: ____________

Employer' Name: ____

Address: ____

City: ________________ State ____________ Zip ________ Phone(_______)__________

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Secondary Insured's Name: ______________________________________ SS#: ______________

Address:(if other than above) ____

City: ________________ State ____________ Zip ________ Phone(_______)__________

Insurance Company: ____

Group#: ____________________ ID# __________________ Birthdate: ____________

Employer' Name: ____

Address: ____

City: ________________ State ____________ Zip ________ Phone(_______)__________

Does patient have any allergies to medications:

____ Yes Is so, please list: _____

_____

____ No _____

_____

_____

I authorize the release of any medical or other information necessary to process this claim. I authorize the release of medical records to any physicians regarding the treatment of this patient and to anyone listed below. I also authorize payment of medical benefits to:

ALPERT, ZALES AND CASTRO PEDIATRIC CARDIOLOGY, P. A.
MITCHEL B. ALPERT, M. D.
VINCENT R. ZALES, M. D.
ELSA I. CASTRO, M. D.

_____

_____

_____

_____
Signature

_____
Print Name