PATIENT INFORMATION
Please complete all blanks

PATIENT

NAME LAST FIRST MI			AGE	DATE OF BIRTH	RACE	ARE YOU PREGNANT?
ADDRESS	CITY	STATE	ZIP		PHONE	CELL/PAGER
SOCIAL SECURITY NUMBER	MARITAL STATUS □ MARRIED □ DIVORCED □ SINGLE □ WIDOWED	HAVE YOU BEEN TREATED BY THESE PHYSICIANS BEFORE? □ YES □ NO	UNDER WHAT NAME		DATE	
OCCUPATION			NAME OF EMPLOYER OR SCHOOL			
EMPLOYER'S ADDRESS			CITY	STATE	ZIP	PHONE
WHO REFERRED YOU TO OUR OFFICE? NAME ADDRESS						
PREFERRED PHARMACY NAME PHONE NUMBER						
WHO IS YOUR PRIMARY CARE PHYSICIAN? NAME ADDRESS						PHONE
IN CASE OF EMERGENCY NOTIFY:	NAME	ADDRESS, CITY, STATE, ZIP				PHONE

HUSBAND OR RESPONSIBLE PARTY

NAME	ADDRESS, CITY, STATE, ZIP				PHONE
SOCIAL SECURITY NUMBER	OCCUPATION	NAME OF EMPLOYER			DATE OF BIRTH
EMPLOYER'S ADDRESS		CITY	STATE	ZIP	PHONE

INSURANCE

PRIMARY INSURANCE MAIL TO: STREET ADDRESS CITY STATE ZIP				PHONE
POLICY HOLDER (IF GROUP, EMPLOYER)	INSURED'S NAME	□ GROUP □ PRIVATE	POLICY OR I.D. #	GROUP OR OTHER #
SECONDARY INSURANCE MAIL TO: STREET ADDRESS CITY STATE ZIP				PHONE
POLICY HOLDER (IF GROUP, EMPLOYER)	INSURED'S NAME	□ GROUP □ PRIVATE	POLICY OR I.D. #	GROUP OR OTHER #

PLEASE READ AND SIGN

In order to control our costs of billing, we request that office visits be paid at the time service is rendered. We would rather control our billing costs than be forced to raise our fees. A billing fee may be assessed after 60 days.

________ **PLEASE NOTE: You will receive a separate bill from the lab for any lab services performed in this office.**
(INITIAL)

________ **PLEASE NOTE: There will be a $35.00 charge for returned checks to be electronically debited from your checking account.**
(INITIAL)

AUTHORIZATION

I hereby authorize Mid-South Maternal Fetal Medicine, P.C. to release any information concerning my treatment and hereby irrevocably assign to them all insurance benefits for my treatment I understand that I am financially responsible for payment of all charges at the time they are rendered including any charges in excess of my insurance reasonable and customary, whether or not covered by Medicare or other insurance. I understand that I am responsible for verifying my insurance coverage & pre-certifying my benefits with my insurance company, I also understand that I am responsible for reasonable collection costs and / or attorney fees incurred in the collection of this account. A photocopy of this statement is considered to be as valid as an original.

I acknowledge receipt of the Notice of Privacy Practices that was given to me by this Practice.

My signature below acknowledges consent to treat

Signed: ______________________________ **Date:** ______________

FPS#33940