Arlington Perinatal Associates, P.A.
515 W. Mayfield Road, Bldg. A, Suite 304
Arlington, Texas 76014
(817)467-1010

PATIENTS NAME: _____
LAST FIRST M

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **WORK PHONE:** _____ **CELL:** _____

SOCIAL SECURITY #: _____ **DATE OF BIRTH:** _____/_____/_____

EMPLOYER: _____ **DRIVER'S LICENSE #:** _____

SPOUSE'S NAME: _____ **SPOUSE'S EMPLOYER:** _____

SPOUSE'S DATE OF BIRTH: _____/_____/_____ **CONTACT #:** _____

PRIMARY INSURANCE ***IF YOU WOULD LIKE US TO BILL YOUR INSURANCE, YOU MUST COMPLETE EACH BLANK

INSURANCE COMPANY: _____ **PHONE #:** _____

POLICY HOLDER'S EMPLOYER: _____ **POLICY #:** _____ **GROUP #:** _____

CLAIMS MAILING ADDRESS:_____ **RELATIONSHIP TO PATIENT:** _____

POLICY HOLDER'S NAME: _____ **DATE OF BIRTH:** _____ **POLICY HOLDER'S SS#:** _____

SECONDARY INSURANCE ***IF YOU WOULD LIKE US TO BILL YOUR INSURANCE, YOU MUST COMPLETE EACH BLANK

INSURANCE COMPANY: _____ **PHONE #:** _____

POLICY HOLDER'S EMPLOYER: _____ **POLICY #:** _____ **GROUP #:** _____

CLAIMS MAILING ADDRESS:_____ **RELATIONSHIP TO PATIENT:** _____

POLICY HOLDER'S NAME: _____ **DATE OF BIRTH:** _____ **POLICY HOLDER'S SS#:** _____

REFERRING PHYSICIAN: _____ **REASON FOR APPOINTMENT:** _____

LAST MENSTRUAL PERIOD: _____ **DRUG ALLERGIES:** _____

TOTAL NUMBER OF PREGNANCIES: _____ **NUMBER OF LIVING CHILDREN:** _____

OTHER CONDITIONS/COMPLICATIONS: _____

I authorize the physicians and /or qualified staff to perform upon me, ultrasound and/or any other care including treatment necessary for the well being of me and/or my unborn child. I acknowledge that the practice of medicine and/or ultrasound is not an exact science and that no guarantees can be made to me as to the outcome of treatment and/or my pregnancy.

PATIENT SIGNATURE: _____ **DATE:** _____

I authorize my insurance benefits to be paid directly to Arlington 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 Arlington Perinatal Associates, PA.

PATIENT SIGNATURE: _____ **DATE:** _____