Austin Perinatal Associates
6500 N MoPac Epwy. Building 1, Ste 1205, Austin, TX 78731
(512)206-0101

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 #:** _____

CLAIMS MAILING ADDRESS: _____

POLICY #: _____ **GROUP #:** _____

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

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

POLICY HOLDER'S SS#: _____ **RELATIONSHIP TO PATIENT:** _____

REFERRING PHYSICAIN: _____ **REASON FOR APPOINTMENT:** _____

OTHER CONDITIONS/COMPLICATIONS: _____

_____

_

DATE OF LMP: ____/____/_____ **LIST ANY DRUG ALLERGIES:** _____

_____

EXPECTED DUE DATE: ____/____/_____ **TOTAL # OF PREGNANCIES (INCLUDING THIS ONE):** _____
NUMBER OF LIVING CHILDREN: _____

I authorize David L. Berry, M.D. 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 regarding the outcome of treatment and/or my pregnancy.

PATIENT SIGNATURE: _____ **DATE:** _____

I understand the under the Health Insurance Portability and Accountability Act of 1996 I have certain rights to privacy in regards to my private health information. I have read, received a copy (if requested) and understand the Notice of Privacy Practices presented by *Austin Perinatal Associates*. I acknowledge this practice reserves the right to modify this policy as governed by law and I can request a copy of the policy at any time.

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 *Austin Perinatal Associates*.

PATIENT SIGNATURE: _____ **DATE:** _____