Austin Perinatal Associates
6500 N MoPac Epwy. Building 1, Ste 1205, Austin, TX 78731
Phone: (512)206-0101 Fax: (512) 206-0212

PATIENTS NAME: _____
LAST FIRST M

ADDRESS: _____E-MAIL:_____

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 PHYSICIAN: _____REASON FOR APPOINTMENT: _____

ANY OTHER CONDITIONS/COMPLICATIONS/CONCERNS: _____

_____

LIST ALL DRUG ALLERGIES: _____

DATE OF LMP: ____/____/_____

EXPECTED DUE DATE: ____/____/_____

I authorize David L. Berry, M.D. and/or qualified staff to perform upon me, ultrasound and/or any other medical 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: _____