Texas Perinatal Group
911 W. 38th Street, Suite #201
Austin, Texas 78705
(512) 459-1131

Please Complete All Sections. If Not Applicable, Please Indicate as "NA"

PATIENT INFORMATION

THE DOCTOR WHO DIRECTED YOU HERE TODAY _____

Name (Last, First, MI) _____

Address _____Apt#_____City _____State _____ Zip _____

Employer/School Name _____Occupation _____

Home/Cell #: _____ Work #: _____ Email address: _____

Sex _____ Birthdate _____ Age _____ SS# _____

Ethnicity: _____ Non-Hispanic _____ Hispanic

How well do you speak English? _____ Very Well _____Well _____ Not well ____ Not at All

Language: ____ Arabic _____ Chinese _____ Creole ____ Hindi _____Spanish _____ Vietnamese

Other: _____

Marital Status **S M W D** Drivers License # / State _____

Spouse's Name _____ Employer _____ Work #: _____

Emergency contact, other than spouse _____ Phone #: _____

OBSTETRICAL HISTORY

Total number of ultrasounds for this pregnancy? _____

1st Day of Last Menstrual Period _____ Due Date _____ By: Sono or LMP (circle one)

# of Previous Pregnancies _____ Full Term _____ Premature (less than 37 weeks) _____

Miscarriages _____ Ectopic _____ Elective Terminations ___ Living Children _____

Any smoking, alcohol, or recreational drug use during pregnancy? Y N If yes, how much per day _____

Any further explanation _____

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Primary Insurance Company _____

Ins. Phone _____ ID# _____ Group # _____

Ins. Address _____City _____ State _____ Zip _____

Policy Holder (if different from patient) _____Relationship to patient _____

Home Address _____ City _____State _____Zip _____

Birthdate _____ Age ____ Sex _____ SS# _____

Employer _____ City _____ State _____ Zip _____

Home Phone _____ Bus. Phone _____ Cell/Pager # _____

Secondary Insurance Company _____

Ins. Phone _____ ID# _____ Group # _____

Ins. Address _____ City _____ State _____ Zip _____

Policy Holder (if different from patient) _____Relationship to Patient _____

Home Address _____ City _____ State _____ Zip _____

Birthdate _____ Age _____ Sex _____ SS# _____

Employer _____ City _____ State _____ Zip _____

Home Phone _____ Bus. Phone _____ Cell/Pager # _____

AUTHORIZATION

I hereby assign to this Practice, my physician or other healthcare professionals involved in my care, all rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs that I identify for which benefits may be available, to pay for all services provided to me. I agree to cooperate and provide information as needed to establish my eligibility for such benefits. I understand that I am responsible for all charges (hospital and/or physician) until the bills are paid in full and for the balance of charges not covered by insurance.

PATIENT SIGNATURE _____ **DATE** _____

www.texasperinatalgroup.com