Melissa Aerts, MD
Javier Castillo, MD
Lissa Magloire, MD
Deirdre McCullough, MD
Theresa Stewart, MD

OBSTETRIX MEDICAL GROUP

ALLERGIES:

_____

_____

Please Complete ALL sections in Blue or Black Ink.

____**Medical Center** ____**Westover Hills** ____**New Braunfels** ____**SW General** ____**Metropolitan**

Name of Referring OBGYN Doctor:_____

PATIENT INFORMATION

Last Name:_____First Name:_____MI:_____

Street Address_____Apt #_____Zip:_____

City:_____State:_____Date of Birth:___/___/___ Age:_____Social Security #:_____-_____-_____

Home Phone: (___) _____Work Phone: (___) _____Cell/Pager: (___) _____

Marital Status: (S M D W) Student: (Y / N) Driver License # - State_____E-Mail:_____

Employer / School Name:_____Occupation:_____

Employer Address:_____City:_____State:_____Zip:_____

Spouse / Guardian Name:_____Employer:_____ Wk Ph:(___) _____

In case of Emergency, Notify:_____Relation:_____Phone: (___) _____

(other than spouse)

OBSTETRICAL HISTORY

1st Day of Last Menstrual Period_____Due Date:_____By Sono or Last Period?(circle one)

# of Pregnancies_____Full Term____Premature____Miscarriages____Ectopic____Elective_____Living Children_____

(less than 37 weeks) Terminations

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:_____Insurance Phone:_____Policy ID:_____

Group#: _____Claims Address_____City:_____State:_____Zip:_____

Subscriber's Name:_____DOB:_____SSN:_____Relationship to Patient:_____

Employer:_____Occupation:_____City:_____State:_____Zip:_____

SECONDARY INSURANCE NAME:_____Insurance Phone:_____Policy ID:_____

Group#: _____Claims Address_____City:_____State:_____Zip:_____

Subscriber's Name:_____DOB:_____SSN:_____Relationship to Patient:_____

Employer:_____Occupation:_____City:_____State:_____Zip:_____

OBSTETRIX MEDICAL GROUP

MEDICAID RECIPIENTS

MEDICAID PLAN NAME_____**MEDICAID ID NUMBER**_____

AUTHORIZATION

FINANCIAL RESPONSIBILITY. ASSIGNMENT OF BENEFITS, AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician to release information in connection with my treatment to my insurance company, employer, their representatives, or referring physicians, at such time as information is requested. I authorize assignment of benefits to physician. I understand that, if I have not obtained the REQUIRED PRIOR AUTHORIZATION or REFERRAL from my primary care physician or insurance carrier, or the required approval cannot be verified, the services I receive will be my RESPONSIBILITY.

CONSENT FOR TREATMENT: I do hereby consent to necessary examination procedures and /or treatment by my physician, his/her assistants, designees as is necessary in his/her judgment.

Patient Signature_____Date_____

TEXASPERINATAL-SA.COM

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