Pediatric Heart Center
Fetal Echocardiogram

Do you speak English: ____ Very well ___ Well ____Not Well ____Not at All
Language: ____________

Patient Name: ____
Date of Birth: ___________________ SS#: _____________________
Address: ____ Apt #:______________
City: _____________________________________ State: ______ Zip: __________
Home Phone Number: ____________________ Cell Phone: _______________________
Employer: __________________________ Work Phone Number: __________________
Email: ____
Last Menstrual Period: _________________ Due Date: ____________________

Spouse's Name: ____
Date of Birth: __________________ SS#: ______________
Address: ____ Apt #:_________________
City: ____________________________________ State: ______ Zip: ________
Home Phone Number: __________________ Cell Phone: _________________________
Employer: ___________________________ Work Number: ______________________

Emergency Contact: ________________________ Relationship: ____________________
Phone Number: ___________________ Cell Phone: ______________________________

♥♥
Name of OB/GYN: ____
Phone Number: _________________________
Address: ____ Suite #:______________
City: _________________________ State: ______ Zip: __________

Referring Perinatologist: ____
Phone Number: _________________________
Address: ____ Suite #:______________
City: _________________________ State: _______ Zip: ___________
♥♥
Health Insurance Information:
Primary Insurance Company: ____
Policy #: ______________________________ Group #: ___________________________
Claims Address: ____
Name of Insured: _____________________ D.O.B.: ___________ SS#: _____________

Secondary Insurance Company: ____
Policy #: ______________________________ Group #: ___________________________
Claims Address: ____
Name of Insured: _____________________ D.O.B.: __________ SS#: _____________

CONSENT FOR TREATMENT…AUTHORIZATION FOR ASSIGMENT OF BENEFITS AND INFORMATION RELEASE

PARTICIPATING INSURANCE:- 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.

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Name/Signature of Responsible Party Date

PLEASE FILL IN EVERY LINE