OBSTETRIX MEDICAL GROUP OF WASHINGTON
ISSAQUAH MATERNAL-FETAL MEDICINE

PATIENT INFORMATION

First Name:_____Last Name:_____
Date of Birth:_____Social Security Number:_____Marital Status:____
Address:_____City:_____State:_____
Zip:_____Home Phone:_____ Cell Phone:_____
First day of last menstrual period:_____Estimated due date:_____

PATIENT EMPLOYMENT

Employer:_____Occupation:_____
Employer Address:_____City:_____State:_____Zip:_____
Employer Phone:_____Ext:_____ May we leave a message? _____

SPOUSE/PARTNER INFORMATION

First Name:_____Last Name:_____
Date of Birth:_____Social Security Number:_____
Address:_____City:_____State:_____Zip:_____
Work/Cell Phone:_____ May we leave a message? _____

SPOUSE/PARTNER EMPLOYMENT

Employer:_____Occupation:_____
Address:_____City:_____State:_____Zip:_____
Employer Phone:_____Ext:_____ May we leave a message?_____

REFERRING PHYSICIAN INFORMATION

Primary Obstetrician's name:_____Phone # _____
Primary Care Physician's name_____Phone #_____

INSURANCE INFORMATION

Name and Address of Insurance:_____Telephone:_____
Name of Subscriber:_____Subscriber's Birthdate:_____
Relationship to patient:_____ ID Number:_____Group Number:_____
Please provide complete Subscriber information and a copy of your current insurance card.

SECONDARY INSURANCE INFORMATION

Name and Address of Insurance:_____Telephone:_____
Name of Subscriber:_____Subscriber's Birthdate:_____
Relationship to patient:_____ ID Number:_____Group Number:_____
Please provide complete Subscriber information and a copy of your current insurance card.

EMERGENCY CONTACT INFORMATION *Someone not living with you.*

Name of emergency contact:_____Phone:_____
Relationship to patient:_____ ***Please turn page over, read and sign. Thank you.***

I hereby authorize direct payment of surgical/medical benefits to OBSTETRIX MEDICAL GROUP OF WASHINGTON, INC. P.S. dba Eastside Maternal Fetal Medicine and permit them to release any medical or incidental information that may be necessary for either medical care of processing medical claims. I permit a copy of this authorization to be used in place of the original. I hereby request payment for services provided by OBSTETRIX MEDICAL GROUP OF WASHINGTON, dba Eastside Maternal-Fetal Medicine be submitted directly to OBSTETRIX MEDICAL GROUP OF WASHINGTON. I understand that I am ultimately responsible for charges incurred.

Patient Signature:_____ **Date:**_____