MATERNAL FETAL MEDICINE ASSOCIATES-VALLEY HOSPITAL
DEMOGRAPHIC FORM

PATIENT INFORMATION

PATIENT LAST NAME	FIRST	INITIAL
STREET ADDRESS		

CITY	STATE	ZIP CODE	DATE OF BIRTH	AGE

SOCIAL SECURITY#	HOME PHONE #	CELL PHONE # BEST TIME TO CALL:

RELIGION:	RACE:	MARITAL STATUS: __ SINGLE __ MARRIED __ DIVORCED __ WIDOWED __ SEPARATED

OCCUPATION:	WORK #	EMPLOYER & ADDRESS:

EMERGENCY CONTACT

NAME:	RELATIONSHIP TO PATIENT
HOME PHONE #	CELL PHONE #

RESPONSIBLE PARTY

NAME:	RELATIONSHIP TO PATIENT
STREET ADDRESS	PHONE #

CITY	STATE	ZIPCODE	

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	POLICY# GROUP #
CLAIMS ADDRESS:	POLICY HOLDERS EMPLOYER (IF OTHER THAN PT)
PATIENT'S RELATIONSHIP TO INSURED	POLICY HOLDERS NAME(IF OTHER THAN PATIENT)
SUBSCRIBER'S SOCIAL SECURITY#	GENDER: ____ MALE ____ FEMALE DATE OF BIRTH:
SECONDARY INSURANCE COMPANY	POLICY#
CLAIMS ADDRESS:	GROUP #
PATIENT'S RELATIONSHIP TO INSURED	POLICY HOLDERS NAME(IF OTHER THAN PATIENT)
SUBSCRIBER'S SOCIAL SECURITY #	GENDER: ____ MALE ____FEMALE DATE OF BIRTH:

REFERRAL INFO

REFERRING PHYSICIAN'S NAME	ADDRESS:
PHONE # _____	

ASSIGNMENT & RELEASE

Please read the following and sign below:

Assignment of Benefits and Release of Information:

I hereby authorize my insurance benefits to be paid directly to Maternal Fetal Medicine Associates, PLLC and Valley Hospital. I understand that I am financially responsible for all non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.

Medicare Patients:

I authorize any holder of medical or other information about me to release to the Centers of Medicare & Medicaid Services and its agents any information needed to determine benefits for this or a related Medicare claim. I request that payment of authorized Medicare benefits be made either to me or the party who accepts assignment.

Notice of Privacy Practices Acknowledgment

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices.

Signature: Date: