



PATIENT INFORMATION

Name (*First, M.I., Last*): _____ Social Security # _____

Date of Birth: _____ Age: _____ Marital Status: S M D W

Physical Address: _____

Street

Apt #

City/Zip

Phone: Evening _____ Mobile: _____ Day: _____

Employer: _____ Referring Physician: _____

Spouse/Guardian: _____ Relationship: _____

Address: (if different) _____

Street

Apt #

City, State Zip

Phone: Home _____ Work: _____ Cell: _____

Employer: _____ Social Security # _____

Other Emergency Contact: _____

INSURANCE INFORMATION

Insurance Co: _____ Phone #: _____

Insurance Address: _____

Group #: _____ Certificate or ID#: _____

Insured's Name: _____ Relationship to Patient: _____

Insured's Employer: _____ Phone #: _____

Employer's Address: _____

Insured's Social Security #: _____ Date of Birth: _____

I hereby assign over to Hill Country Maternal Fetal Medicine and/or Celeste Sheppard, MD all of my rights and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Acknowledgement of "Notice of Privacy Practices"

Initial: _____

Patient's Signature

Date