



# MATERNAL FETAL MEDICINE ASSOCIATES CARNEGIE IMAGING FOR WOMEN

*... the leading edge in womens' health...*

## DEMOGRAPHIC FORM

**PATIENT'S INFORMATION:**

Patient's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Initial: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Age: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_  
 Social Security: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
 Work Phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Marital Status:  Single  Married  Divorced  Widowed  Other  
 Race:  African American  Hispanic  Multiracial  Asian  Caucasian  Other

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_ Relationship To Patient: \_\_\_\_\_  
 Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

**REFERRAL INFO:**

Referring Physician's Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_  
 Address: \_\_\_\_\_

**INSURANCE INFORMATION:**

Primary Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Claims Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
 Patient's Relationship To Insured: \_\_\_\_\_ Policy Holder's Name (If Other Than Patient): \_\_\_\_\_  
 Subscriber's Social Security #: \_\_\_\_\_ Gender:  Male  Female Date Of Birth: \_\_\_\_\_  
 Secondary Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Claims Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
 Patient's Relationship To Insured: \_\_\_\_\_ Policy Holder's Name (If Other Than Patient): \_\_\_\_\_  
 Subscriber's Social Security #: \_\_\_\_\_ Gender:  Male  Female Date Of Birth: \_\_\_\_\_

**ASSIGNMENT AND 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 or Carnegie Imaging For Women, PLLC. I understand I am financially responsible for all non-covered services as well as obtaining insurance pre-authorization when necessary. 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 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 and MFM Associates Welcome Letter to new patients.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

