EvergreenHealth OBSTETRIX Eastside Maternal-Fetal Medicine

PATIENT INFORMATION

First Name:_____ Mid. Initial:_____ Last Name:_____

Date of Birth: _____ Social Security Number:_____ Marital Status:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone (OK to leave message☐) :_____Cell Phone (OK to leave message ☐): _____

Email:_____

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:_____ Mid. Initial:_____ Last Name:_____

Date of Birth: _____ Social Security Number:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone(OK to contact ☐): _____Cell Phone (OK to contact ☐):_____

SPOUSE/PARTNER EMPLOYMENT

Employer:_____ Occupation:_____

Address:_____ City:_____ State:_____ Zip:_____

Employer Phone:_____ Ext:_____

REFERRING PHYSICIAN INFORMATION

Referring Obstetrician:_____ Phone Number:_____

Primary Care Physician:_____ Phone Number:_____

PRIMARY INSURANCE INFORMATION

Ins. Name & Address:_____ Phone:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Relationship to Patient:_____ ID Number: _____Group Number:_____

Please provide complete Subscriber information and a copy of your current insurance card.

SECONDARY INSURANCE INFORMATION

Ins. Name & Address:_____ Phone:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Relationship to Patient:_____ ID Number: _____Group Number:_____

Please provide complete Subscriber information and a copy of your current insurance card

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____Phone:_____

Relationship to Patient:_____