

SOUTHWEST MIDWIVES PATIENT INFORMATION
(PLEASE PRINT & FILL OUT COMPLETELY)

Today's Date: _____

Patient Name: _____

Address—Physical: _____
Last First Middle P.O. Box: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Employer: _____ Work Phone: (_____) _____

May we leave a message at home/cell/work? _____ E-mail Address: _____

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

Who is responsible for this account? (Fill out if different from above) _____

SSN: _____ DOB: _____ Relationship to patient: _____

Mailing Address: _____ City: _____ State: _____

Zip: _____ Home/Cell/Work phone: _____

Emergency Contact: _____ Relationship to patient: _____

Home/Cell/Work phone: _____

Primary Care Physician: _____ Who told you about us? _____

- Authorization to Consult with Four Corners OB-GYN:** I hereby authorize Southwest Midwives to release my medical information to Four Corners OB-GYN in the event my care requires a physician consultation.
- Third Party Payor Authorization/Release:** I hereby authorize direct payment to Southwest Midwives of any third party payor benefits (insurance company, government agency, etc.). I hereby authorized Southwest Midwives to release medical records to any third party payor.
I understand I am financially responsible for charges not covered by a third party payor.

Signature (Patient or Guardian): _____

INSURANCE INFORMATION (We need a copy of your most *current* card):

Insurance Company: _____

Member ID #: _____ Group ID #: _____

Claims Address: _____ City: _____ State: _____

Zip: _____ Customer Service Phone #:(_____) _____

****Please be sure to let us know if any of your information changes so we can keep our records current. Thank you!****