Fetal Diagnostic Center of Pasadena

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REGISTRATION FORM

www.fetal.com

Today's date: / /	Referring (Obstetrician) Physician:

PATIENT INFORMATION

Last Name: (Please PRINT below this line)	First Name: Middle:	Marital Status (Please Check one):
		❑ Sgle ❑ Mar ❑ Div ❑ Sep ❑Wid

How did you hear from us?	Have you had any prior ultrasounds?	Your Birth Date:	Social Security #:	Age:
❑ Physician ❑ Online ❑ Newspaper ❑ Friend	❑ Yes ❑ No	/ /		

Your Home Street Address:	City:	State:	Zip Code:

Your Driver's License#:	Home Phone #:	Cell Phone #:
Occupation:	Employer:	Employer's Phone #:

Employer's Address:	Street Address:	City:	State:	Zip Code:

Method of Payment: Please check appropriate box:	❑ PPO	❑ HMO	❑ Cash	❑ Check
	❑ VISA	❑ MasterCard	❑ Medi-CAL (ID#)	

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home Phone #:

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate **primary** insurance:	❑ PPO	❑ HMO	❑ EPO	❑ Medi-CAL	❑ Other

Subscriber's name:	Subscriber's S.S. #:	Birth date: / /	Group #:	Member or Policy #:	Co-payment: $

Medical Group Name:	Primary Care Physician:	Insurance's Address and Phone #:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Other	

Please indicate **secondary** insurance (if applicable):	❑ PPO	❑ HMO	❑ EPO	❑ Other	

Subscriber's name:	Subscriber's S.S. #:	Birth date: / /	Group #:	Member or Policy #:	Co-payment: $

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship:	Home or Cell Phone#:	Work Phone#:

Consent for examination or treatment, release of information and assignment of benefits.

I hereby consent to and authorize the counseling, examination or treatment which may be necessary. I hereby consent to and authorize any additional testing that may be indicated only upon notification of my physician. I also understand that charges for any additional testing will be billed separately. I hereby authorize payment to **Greggory R. DeVore MD** all medical/insurance benefits otherwise payable tome but not to exceed the regular charges. I hereby authorize the above named to release the information requested by any insurance plan or other agency sponsoring my healthcare bills. I understand it my personal obligation to pay for all charges unless prior arrangements have been made.

Patient/Guardian signature *Date: / /*