Melinda B. McFarland, MD
Ashley N. Parker, MD
John T. Hardy, MD

Ometeotl M. Acosta, MD
Tania Roman, MD
Gian E. Diaz Rodriguez, MD
Veronica M. Gonzalez Brown, MD

NEW PATIENT FORM

Patient Information

Name: ______________________ DOB: ____/____/________

Phone #: ______________________ SS Number: ______________

Address: ____

Services Requested (Please check all that apply)

- ☐ Preconception Consultation
- ☐ Ultrasound with Consultation
- ☐ Diabetic Management
- ☐ First Trimester Screening

Patient EDD: ____/____/________

Patient Diagnosis: ____

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____

Referring Physician: ______________________ Phone #: ______________

Contact Name: ______________________ Fax #: ______________

Insurance

Insurance Information (Please fill out all of insurance info or send legible copy of Patient Insurance Card/Demo Page)
*** ALL HMO PLANS REQUIRE AUTHORIZATION FROM INSURANCE BEFORE SCHEDULING APPOINTMENT***

Primary Insurance:

Patient's Insurance Name: ____

Insurance ID #: ______________ Insurance Group #: ______________

Policy Holder Name (if not patient): ____

Policy Holder DOB: ____/____/________ Relationship to Patient: ______________

Secondary Insurance:

Patient's Insurance Name: ____

Insurance ID #: ______________ Insurance Group #: ______________

Policy Holder Name (if not patient): ____

Policy Holder DOB: ____/____/________ Relationship to Patient: ______________

PERINATAL ASSOCIATES STAFF ONLY

Date Received Referral: ______________________ Employee Name: ______________

☐ New Patient: ______________________ Appointment Date: ______________

☐ Established Patient: ______________________ Appointment Time: ______________

Notes: ____

____

____

New Patient Paperwork: ☐ Mailed ☐ Emailed: ______________

502 Madison Oak, Suite 210
San Antonio, TX 78258
P: 210-481-3000
F: 210-496-0042

7707 Ewing Halsell, Suite 234
San Antonio, TX 78229
P: 210-614-3000
F: 210-614-3001

www.perinatalassociatessa.com