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Santa Fe, NM 87505
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PATIENT INFORMATION

Patient Name _____ DOB _____ Date _____
Social Security No. _____ Driver's License No _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Referring Physician _____
Employer _____ Phone _____
Occupation _____ Length of Employment _____
Father of Baby _____ DOB _____
Address _____ Social Security Number _____
City _____ State _____ Zip _____
Employer _____ Phone _____
Occupation _____ Length of Employment _____

INSURANCE

Primary Insurance _____ Secondary Insurance _____
Name of Insured _____ Name of Insured _____
Relationship _____ Relationship _____
Insurance address _____ Insurance address _____
City _____ State _____ Zip _____
City _____ State _____ Zip _____
Certificate No. _____ Certificate No. _____
Group No. _____ Group No. _____

IN CASE OF AN EMERGENCY

Person to contact in case of emergency _____ Phone _____
Address _____ Relationship _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to PERINATAL ASSOCIATES OF NEW MEXICO, LTD. of the surgical and/or medical benefits, if any, otherwise payable to me for their services. this assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.
RELEASE OF INFORMATION. I hereby authorize said assignee to release all information necessary to secure payment.

Signature _____ Date _____