Maternal~Fetal
Associates of Kansas

Phone: 316-962-7188
Fax: 316-962-7199

REFFERING PHYSICIAN INFORMATION:

_____ (____) _____
Physician Name Phone Number

_____ (____) _____
Contact Person Fax Number

PATIENT INFORMATION:

_____ _____/_____/_____ _____
Patient Full Name (Last, First) Date of Birth (mm/dd/yyyy) Patient Social Security Number

_____
Address City State Zip Code

(____)_____ (____)_____ (____)_____ _____
Home/Evening Phone Cell Phone Work/daytime Phone Ext

_____
Insurance Provider (**copy of card must be faxed with this request**)

_____ _____/_____/_____
Subscriber's Name (if not patient) Date of Birth (mm/dd/yyyy)

_____
Subscriber's Social Security Number (if not patient)

MEDICAL INFORMATION: (Fax Pre-natal history, labs & sonos with this form)

LMP: _____ EDC: _____ G/P: _____

Dx: 1. _____ 2. _____
3. _____ 4. _____

APPOINTMENT INFORMATION:

The primary language spoken in the office is English, does the <u>patient</u> need an interpreter? ____ if yes, what language: _____

Appointment/Procedure Requested:
_____
_____
_____

MATERNAL FETAL ASSOCIATES USE ONLY:

Appointment Date and Time(s):_____
_____
_____
_____
_____

PLEASE NOTIFY YOUR PATIENT OF THIS APPOINTMENT. Instruct the patient to arrive at the check-in time. The patient should bring her photo ID, current insurance card and be prepared to pay for any co-pays, co-insurance or services if uninsured. (Late arrivals and patients without photo ID may be asked to reschedule.)