Indiana University Health

Prenatal Diagnosis Clinic

Patient Label

AMBULATORY REGISTRATION FORM

Welcome to the IU Prenatal Diagnosis Clinic and thank you for allowing us to participate in your health care needs. Please take a moment to provide the following information.

PATIENT DEMOGRAPHIC INFORMATION:

Legal Name: _____ Birthdate: _____/_____/_____

SS#: _____-_____-_____ Race: _____ Gender:_____ Marital Status: _____

Address: _____ City: _____ State: _____Zip: _____

County of Residence: _____ Country: _____ Primary Language: _____

Primary Phone: (_____) _____-_____ Alternate Phone: (_____) _____-_____

Primary Care Doctor: _____ Referring Doctor: _____

Employment Status: (circle one) Full-time Part-time Disabled Retired Not Employed Self Employed On Active Duty

Employer Name: _____ Employer Phone: (_____) _____-_____

NEXT OF KIN: ***(Emergency Contact Person Information)***

Patient Relationship to NOK: _____ Birthdate: _____/_____/_____

Last Name: _____ First Name: _____ MI: _____

Phone: (____) _____-_____ Work: (_____) _____-_____ Alternate: (_____) _____-_____

ALTERNATIVE CONTACT INFORMATION:

Patient Relationship to Contact Person: _____ Birthdate: _____/_____/_____

Last Name: _____ First Name: _____ MI: _____

Phone: (_____) _____-_____ Work: (_____) _____-_____ Alternate: (_____) _____-_____

PLEASE BE SURE TO BRING ALL INSURANCE CARDS AND A PHOTO ID WITH YOU FOR YOUR APPOINTMENT