Texas Children's Hospital® | Pavilion for Women

**International and Destination Medicine**
**Telephone: 832-824-1138**
**Fax: 832-825-2545**

## PATIENT INFORMATION

| Last Name First Name Middle Initial | Date of Birth: | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | Religion: |
|---|---|---|---|

| Patient Language: | Home Phone: | Cell Phone: | Additional Phone: | Fax: |
|---|---|---|---|---|
| Interpreter Needed: ☐ Yes ☐ No | | | | |

| Street Address: City Country | Employment Status: ☐ unemployed ☐ full time ☐ part time ☐ full time student ☐ part time student |
|---|---|

| Occupation: | Employer: | Email Address: |
|---|---|---|

| Employer's Address: City Country | Work Phone: |
|---|---|

## EMERGENCY CONTACT

| Name: | Relationship to Patient: |
|---|---|
| Emergency Contact Number: | Preferred Language: |

## INSURANCE INFORMATION

Please Check Appropriate Box, is Patient: ☐ Self Pay ☐ Insured ☐ Government Funded — ***If insured, please complete the insurance section below***

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other *Specify:*

| Subscriber's Name: | Subscriber's DOB: | Name of Primary Insurance: | |
|---|---|---|---|
| Policy/ Member Number: | Group Number: | Claims Address: | Member Services Phone Number: |
| Provider Services Number: | Occupation: | Employer: | Work Phone: |

**Which insurance/policy will newborn baby be added to?**

## CLINICAL INFORMATION

| Visit related to: ☐ C-Section ☐ Vaginal Delivery ☐ Surgery ☐ Other | Date of Last Menstrual Cycle: | Expected Due Date: |
|---|---|---|
| Diagnosis: | Goal of Care: | Preferred Appointment Date: |
| Current Ob/ Gyn Physician and Address: | Current Physician Phone Number/ Email Address: | Do you have preference for a male or female provider? ☐ Male ☐ Female |

## LOCAL CONTACT INFORMATION IN THE UNITED STATES (IF APPLICABLE)

| Name: | Relationship to Patient: | Preferred Language: |
|---|---|---|
| Local Address: | Local Phone: | E-mail: |

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