metro OBGYN

OB INFORMATION FORM

DOWNTOWN_____ WOODBURY_____

MAPLEWOOD_____ APPLE VALLEY_____

PATIENT NAME:_____

DOB:_____

ACCOUNT NUMBER:_____

METRO OB/GYN PHYSICIAN NAME:_____

DATE OF LAST MENSTRUAL PERIOD:_____

DUE DATE:_____

NUMBER OF PREGNANCIES(INCLUDING THIS ONE):_____

PREVIOUS C-SECTION YES_____ NO_____

INSURANCE COMPANY:_____

REFERRING PHYSICIAN:_____

PRIMARY CARE CLINIC:_____

WHAT HOSPITAL WILL YOU DELIVER AT?

UNITED_____ST JOHNS_____WOODWINDS_____RIVER FALLS_____

PLEASE ROUTE TO THE CODING DEPARTMENT.

FOR BILLING USE ONLY

HOSP ADM DATE:_____ DELIVERY DATE:_____ D/C DATE:_____

HOSPITAL: UHI—NE—WW—RF PHYSICIAN: _____ DELIVERING PHYSICIAN:_____

CPT:_____ DIAGNOSIS: _____

_____ _____

_____ _____

_____ BMI @ FIRST OB_____ _____

Updated 6/7/2018