Orsel S. McGhee MD
Patient Information Sheet

DATE: _____

PATIENT'S NAME: _____ BIRTHDATE: _____ AGE: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ BIRTHPLACE: _____

EMAIL: _____ RELIGION: _____

MARITAL STATUS: _____ MAIDEN NAME: _____ SOC.SECURITY #: _____

OCCUPATION: _____ EMPLOYER: _____

BUS. ADDRESS: _____ CITY: _____ ZIP: _____

BUS. PHONE: _____ HOW LONG: _____ DRIVER'S LICENSE NO: _____

SPOUSE'S NAME: _____ SOC. SECURITY #: _____ BIRTHDATE: _____ AGE: _____

(If patient is a minor, name of responsible parent or guardian)

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ BIRTHPLACE: _____ RELIGION: _____

OCCUPATION: _____ EMPLOYER: _____

BUS. ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

BUS. PHONE: _____ HOW LONG: _____ DRIVER'S LICENSE: _____

IN CASE OF EMERGENCY, NOTIFY (OTHER THAN SPOUSE)

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

PATIENT REFERRED BY: _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____ POLICYHOLDER: _____

CERTIFICATE NO: _____ GROUP NO: _____

INSURANCE ADDRESS: _____ PHONE: _____

SECONDARY INSURANCE: _____ POLICYHOLDER: _____

CERTIFICATE NO: _____ GROUP NO: _____

INSURANCE ADDRESS: _____ PHONE: _____

ASSIGNMENT OF BENEFITS

I authorize_____to pay for surgical and/or medical benefits directly to Orsel S. McGhee 617 West Moore Avenue Suite B Terrell, TX 75160 I understand that I am financially responsible for any charges not covered by this assignment. A photostatic copy of this assignment is as valid as the original.

Signed_____ Date_____

Orsel S. McGhee MD

PRENATAL SCREENING

NAME: _____ DATE _____

	Please check YES	NO
1. Will you be 35 years or older when the baby is due ?		
2. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders ? ◯ Down's Syndrome (mongolism) ◯ Other chromosomal abnormality ◯ Neural tube defect (spina bifida, anencephaly, etc.) ◯ Hemophilia ◯ Muscular Dystrophy ◯ Cystic Fibrosis		
3. Do you or the baby's father have a birth defect ? If yes, who has the defect and what is it ? _____		
4. In any previous marriages, have you or the baby's father had a child, born dead or alive with a birth defect not listed in Question 2 above. If yes, what is it ? _____		
5. Do you or the baby's father have any close relatives with mental retardation ?		
6. Have you or the baby's father had a stillborn child or three or more first trimester pregnancy losses ?		
7. If you, or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease ? If yes, indicate who and the results _____		
8. If you or the baby's father are black, have either of you been screened for sickle cell trait ? If yes, indicate who and the results _____		
9. If you or the baby's father are of Italian, Greek, or Mediterranean background, have either of you been tested for beta-thalassemia ?		
10. Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period ? (Include over-the-counter drugs) If yes, give name of medication and time taken during pregnancy: _____		

Patient's signature _____ Date _____