ADDRESSOGRAPH

NORTHSIDE HOSPITAL

Name: ____
(First Name) (MI) (Last Name) (Name Preference)

Address: ______________________ City: __________ St: _____ Zip: _________

Home Phone: __________ Work Phone: ____________ Cell phone: ____________

email: ______________________________ ☐ Single ☐ Married ☐ Other

Please check the preferred contact number for us to call regarding laboratory results or appointments: ☐ Home ☐ Work ☐ Cell

May we leave a voice mail or message at the above number? ☐ Yes ☐ No

☐ I want my ultrasound images delivered digitally (choose one of the following three options)

Email: ______________________________

Text: ______________________________

☐ I prefer to have a printed image of my ultrasound

☐ I authorize the sending of images during my pregnancy

☐ I understand that I will have access to my images for 90 days from my exam date.

It is highly recommended that you download and store your images on your computer or other device since they will be removed from the server at the end of 90 days.

Please list name and phone number of any person (i.e. spouse/parent) authorized by you to speak with our staff on your behalf regarding your medical care, lab results, clinical findings, etc. *as authorized by your signature below.*

____

In the event that it becomes necessary to refer me to another physician/facility, or I am given any portion of my medical record to take with me, my signature below authorizes the release of information by Atlanta Perinatal Consultants for these purposes: __________
(Initials)

______________________________ ______________
(Signature) (Date)

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CENTER FOR PERINATAL MEDICINE
PATIENT INFORMATION SHEET

Not a part of the Permanent Medical Record