

Appointment Request Form



SEEBABY

550 PEACHTREE ST NE * STE 1165 * ATLANTA, GA 30308

phone: (404) 223-9306 * web: seebaby.org

Fax form and all other scheduling correspondence to (404) 223-9307. If you require immediate assistance, please call us at (404) 223-9306.

Date: _____

Nature of Visit: Routine (1 - 2 weeks) Priority (Within 1 week) ASAP (Within 24 hours) Stat (Today as work-in)

If ASAP or Stat, please explain: _____

Preferred Appointment Date: _____ Preferred Appointment Time: _____ AM PM

Please select requested service: OB US w/ Consult if needed BPP/NST Consult only

Patient Name: (PLEASE PRINT) _____

Address: _____ City: _____ State: _____ Zip Code: _____

SS #: _____ DOB: _____ Home/Mobile #: _____

Name of Insurance: _____ Type of Plan: HMO PPO POS Other _____

Policy #: _____ Member Services phone #: _____ Group #: _____

Referring Physician: _____ Phone #: _____ Fax #: _____

Office Location: _____ Contact Person: _____

HISTORY & PHYSICAL (REQUIRED BY SOME INSURANCE CARRIERS)

LMP: _____ EDD: _____ Blood Type: _____

Please select the appropriate diagnosis: (PLEASE FAX ALL LABS NEEDED FOR THE STATED DIAGNOSIS)

- | | | |
|--|--|--|
| <input type="checkbox"/> AMA 1st pregnancy 659.53 | <input type="checkbox"/> Hypertension 642.33 | <input type="checkbox"/> Post term; 40-42 wks 645.13 |
| <input type="checkbox"/> Anatomy V28.3 | <input type="checkbox"/> Hypertension (chronic) 642.03 | <input type="checkbox"/> Pre-eclampsia (mild) 642.43 |
| <input type="checkbox"/> Asthma 648.93,493.90 | <input type="checkbox"/> Incompetent cervix 654.5 | <input type="checkbox"/> Premature Labor 644.03 |
| <input type="checkbox"/> Breech; other malpresentation 652.23 | <input type="checkbox"/> Large for dates 656.63 | <input type="checkbox"/> PROM 658.13 |
| <input type="checkbox"/> Decreased fetal movement 655.73 | <input type="checkbox"/> Late prenatal care (LPC) V23.7 | <input type="checkbox"/> Pyelectasis 655.83 |
| <input type="checkbox"/> Diabetes (gestational) 648.83 | <input type="checkbox"/> Low MSAFP (abn AFP) 655.13 | <input type="checkbox"/> Small for dates 656.53 |
| <input type="checkbox"/> Diabetes (pregestational) 648.03 | <input type="checkbox"/> Lupus 648.93,710.0 | <input type="checkbox"/> Teen pregnancy under 16yrs @ DOD 659.83 |
| <input type="checkbox"/> Elevated MSAFP; susp spinal defect 655.03 | <input type="checkbox"/> Maternal sickle cell trait 648.23,282.5 | <input type="checkbox"/> Thyroid dysfunction 648.13 |
| <input type="checkbox"/> Fetal arrhythmia 659.73 | <input type="checkbox"/> Obesity 649.13,278.00 | <input type="checkbox"/> Twin pregnancy 651.03 |
| <input type="checkbox"/> Habitual aborter 646.33 | <input type="checkbox"/> Oligohydramnios 658.03 | <input type="checkbox"/> Uterine fibroids 654.13 |
| <input type="checkbox"/> HIV V23.89,V08 | <input type="checkbox"/> Pelvic pain 648.73,719.45 | <input type="checkbox"/> Uterine size date discrepancy 649.63 |
| <input type="checkbox"/> h/o intrauterine fetal demise V23.5 | <input type="checkbox"/> Placenta previa w/ hemorrhage 641.13 | <input type="checkbox"/> Vaginal bleeding 640.93 |
| <input type="checkbox"/> Hx PTL/ Pre term delivery V23.41 | <input type="checkbox"/> Polyhydramnios 657.03 | |

Other: _____

Scheduled Appointment Date and Time: (FOR OFFICE USE ONLY) _____