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Thank you for choosing our practice. The staff of Maryland Perinatal Associates would like to make your experience with our office a pleasant one. Please take a few moments to read about our office policies regarding your account, and sign this page to acknowledge receipt and approval.

Our office hours are from 8:00 am to 4:30 pm, Monday through Friday. Our offices accept personal checks, cash, Visa and MasterCard for all co-payments and balances, which are to be paid prior to your visit with a physician. If you have any questions regarding your account, our internal billing department can be reached at 1-866-866-8542.

We participate with a wide variety of insurance companies, a list of which can be found on our website. If we do not participate with your insurance, we will file a claim on your behalf. However, once your insurance carrier pays the claim, you will be responsible for any unpaid balance.

Finally, we ask that in the event you that you need to cancel or reschedule your appointment, we ask that you please give our office at least 24 hours notice. If you have any questions or concerns regarding our office policies, we invite you to contact our Rockville office at 301.251.8611. Again, we thank you for selecting our practice.

Sincerely,

Maryland Perinatal Associates

8926 Woodyard Rd, Suite 601, Clinton, MD 27035 • 301.856.3062 • Fax: 301.856.3113
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## Maryland Perinatal Associates
## New Patient Information (please print and complete in full)

**Patient name:**

**Last** **First** **Middle**

**Street:** **Apt#**

**City:** **State:** **Zip:**

**Home #:** **Work #:**

**Cell #:** **Email:**

**Social security number:** - -

**Date of birth:** / / **Age:**

**Marital status: (please select the appropriate box)**

❒ Single ❒ Married ❒ Divorced

❒ Separated ❒ Widowed ❒ Engaged

**Your race:** **Religion:**

**<u>Do we have your permission to:</u>**

**Leave a message on your answering machine at home?** Yes / No **On your cell phone?** Yes / No

**Leave a message on your answering machine at work?** Yes / No

**Discuss your medical condition with any member of your household?** Yes / No

**If yes, whom?:** **Relationship:**

**Your last menstrual date:** **Your occupation:**

**Your employer:** **Employer's phone number:**

**Employer's address:**

**City:** **State:** **Zip:**

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**Spouse or partner's name:**

**Your employer:** **Employer's phone number:**

**Employer's address:**

**City:** **State:** **Zip:**

**Date of birth:** / / **Social security number:** - -

**Referring physician:** **Office location:**

**In case of emergency:**

**Name:** **Phone number:**

**Primary Insurance Information (Please complete in full)**

**Insurance company:**

**Policy Id#:** **Group #:**

**Claims mailing address:**

**City:** **State:** **Zip:**

**Policy holder's name:**

**Policy holder's date of birth:** / / **Social security number:** - -

**Relationship to patient:**

**Please Note:** If your insurance company requires that you bring a referral, you as the patient are responsible for contacting your primary care physician (Not your Obstetrician) prior to your visit to obtain a referral. If you do not obtain your referral prior to your appointment, we may need to reschedule your appointment. It is the patient's responsibility, solely, to understand their individual benefits.

**Patient Signature** **Date**

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## Maryland Perinatal Associates
## Release and Assignment

I, ______________________________, hereby authorize **Maryland Perinatal Associates** to release my insurance carrier ___________________________________, all information concerning my illness and treatment and hereby assign **Maryland Perinatal Associates** all payments for medical services rendered to myself and/or my dependents. I understand that I am fully responsible for any amount NOT covered by my insurance carrier.

_________________________________ _________________________________

Patient Signature Date

## Authorization to Release Medical Records

I, ________________________, hereby authorize **Maryland Perinatal Associates** to release any and all information related to my past and present medical history, diagnoses, and treatments to my referring physician (OB/GYN) and other PCP, or specialist, that will be treating me during my illness and treatment. I understand that any records not related to my illness and treatment will not be released.

_________________________________ _________________________________

Patient Signature Date

## Receipt of Notice of Privacy Practice
## Written Acknowledgement Form

I,_________________________, have received a copy of **Maryland Perinatal Associates** notice of privacy practices.

_________________________________ _________________________________

Patient Signature Date

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# Maryland Perinatal Associates Family History

**Name:** **Partner's name:**

**Your birthdate:** **Partner's birthdate:**

**Race:** **Partner's race:**

Ethnic Background (Italian, Irish, Asian, German, Polynesian, African, etc.):

**Yours:** **Your partner's:**

Have you or your partner ever had genetic screening?______________________________

**Family History:** Do you, your partner, your children or any other members of your family have any of the following conditions?

| | Yes | No | Whom/Explain |
|---|---|---|---|
| Blindness | | | |
| Blood Clotting Disorders (i.e., Pulmonary Embolism / DVT / MTHFR / Protein C or S Deficiency) | | | |
| Bone disorders or short stature | | | |
| Cancer of early onset (under 45 years of age) | | | |
| Chromosome abnormality | | | |
| Cleft lip and/or palate | | | |
| Cystic fibrosis | | | |
| Deafness | | | |
| Down syndrome | | | |
| Epilepsy/seizure disorder | | | |
| Genital abnormality | | | |
| Heart defect (as a child) | | | |
| Hemophilia/bleeding disorder | | | |
| Huntington's disease | | | |
| Hydrocephaly (fluid or water on the brain) | | | |

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| | Yes | No | Whom/Explain |
|---|---|---|---|
| Infertility/multiple miscarriages (more than 2) | | | |
| Kidney defects | | | |
| Limb defects | | | |
| Mental illness | | | |
| Mental retardation | | | |
| Muscular dystrophy | | | |
| Neurofibromatosis | | | |
| Sickle cell disease/thalassemia | | | |
| Spina bifida/anencephaly | | | |
| Tay Sachs disease | | | |
| Other medical conditions | | | |
| Multiple family members with the same trait | | | |
| Multiple family members with the same trait | | | |

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## Maryland Perinatal Associates Pregnancy History

**Name:** ______________________ **Date of birth:** ______________________

**Obstetrician:** ______________________ **Preferred pharmacy:** ______________________

**Pharmacy phone #:** ______________________

Do you have any complaints presently? Yes_____ No___

If yes, please describe______________________

Last menstrual period: ______________________Number of prior pregnancies:______________________

| Live birth | Date | Weight | Full term? | M/F | Vaginal/CS | Complications |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Miscarriage(s): Date(s) and week(s):

Termination(s): Date(s) and week(s):

Blood type (circle): A B AB O Rh positive/negative

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## Maryland Perinatal Associates Medical History

| Have you ever had: | **Yes** | **No** | **Whom/Explain** |
|---|---|---|---|
| Anemia | | | |
| Arthritis | | | |
| Asthma | | | |
| Back problems | | | |
| Blood clots | | | |
| Blood transfusion | | | |
| Cancer | | | |
| Cervical Surgery (i.e., LEEP / CONE) | | | |
| Depression | | | |
| Diabetes | | | |
| Heart problems/murmurs | | | |
| Hepatitis | | | |
| High blood pressure | | | |
| Lupus/autoimmune disorders | | | |
| Migraines/seizures | | | |
| Sexually transmitted disease | | | |
| Surgery | | | |
| Thyroid disease | | | |
| Other medical problems | | | |

Do you smoke cigarettes? Yes ________________No _______________ How many?
Do you drink alcohol? Yes _______________No ______________ How many?
Do you use any drugs? Yes_____No_____ How much?___________________________________

Are you taking any medications? (prescription and over the counter, during this pregnancy)
______________Dose______________Dose______________
______________Dose______________Dose______________
Are you allergic to any medications? (list): __________________________________

Date: ______________________________Reviewed:_______________________________

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# Maryland Perinatal Associates Ultrasound Safety Information

## Prudent use and Clinical Safety

Approved March 19, 2007

Diagnostic ultrasound has been in use since the late 1950's. Given its known benefits and recognized efficacy for medical diagnosis, including human pregnancy, The American Institute of Ultrasound in Medicine herein addresses the clinical safety of such use:

No independently confirmed adverse effects caused by exposure from present diagnostic ultrasound instruments have been reported in human patients in the absence of contrast agents. Biological effects have been reported in mammalian systems at diagnostically relevant exposures, but the clinical significance of such effects is not yet known. Ultrasound should be used by qualified health professionals to provide medical benefit to the patient.

## Prudent use in Obstetrics

Approved March 19, 2007

The American Institute of Ultrasound in Medicine advocates the responsible use of diagnostic ultrasound and strongly discourages the non-medical use of ultrasound for entertainment purposes. The use of ultrasound without a medical indication to view the fetus, obtain a picture of the fetus or determine the fetal gender is inappropriate and contrary to responsible medical practice. Ultrasound should be used by qualified health professionals to provide medical benefit to the patient.

## Informed Consent for Ultrasound

Your physician has requested that you undergo a diagnostic procedure known as an ultrasound. Simply stated, this procedure involves the transmission of sound waves reflected off your womb and fetus, which will be monitored and recorded on a videotape or film to obtain information concerning your pregnancy. This test is believed to carry with it very little risk to you or your fetus.

The standard ultrasound exam takes approximately 10-30 minutes to perform and may provide information concerning placenta location, fetal position, multiple gestation, approximate gestational age, and the possible presence of gross fetal malformations. This test, however, is not definitive for the absence of fetal malformations, and despite a normal interpretation of the test, some babies are born with anomalies not identified by the examiner during the ultrasound study. Thus, although ultrasonography is a helpful diagnostic tool, it does not absolutely determine the absence of fetal defects. This type of exam is also done prior to performing genetic amniocentesis.

Should you have any questions concerning ultrasonography, please discuss them with your referring physician before undergoing the procedure. You are requested to sign this document prior to the performance of this exam, thereby acknowledging that **you have read and have understood the information contained herein, and have given an informed consent to this procedure, and are aware of the risks involved.**

________________________ ________________________

Patient Signature Date

________________________ ________________________

Patient's name Witness Date

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