OBSTETRIX MEDICAL GROUP

PATIENT REGISTRATION FORM

PATIENT INFORMATION

How well do you speak English? ☐Very Well ☐Well ☐Not Well ☐Not at All

What is your race? _____ Your nationality? _____ Your native language? _____

Name (First, M.I., Last): _____DOB:_____

Mailing Address: _____Apt #: _____ Cell #: ( ) _____

City, State, Zip Code: _____Phone #: ( ) _____

Social Security #: _____/_____/_____ Marital Status (Please circle): Single Married Divorced Widowed

Patient's Employer: _____Work #: ( ) _____

E-mail Address: _____ None Declined

You may receive a survey by email asking you about your visit. Please complete the survey. We will use your feedback to make improvements. Thanks!

SPOUSE/GUARDIAN INFORMATION

Name (First, M.I., Last): _____DOB:_____

Mailing Address: _____Apt #: _____

City, State, Zip Code: _____Phone #: ( ) _____

Relationship to Patient: _____

REFERRING PHYSICIAN INFORMATION

Dr.'s Name (First): _____ (Last): _____ Specialty (i.e. Ob/Gyn/PCP): _____

Street Address: _____

City, State, Zip Code: _____

Phone #: ( ) _____ Fax #: ( ) _____

SIGNATURE: _____ DATE: _____

OBSTETRIX MEDICAL GROUP

OBSTETRIC HISTORY QUESTIONNAIRE

Patient Name: _____ DOB: _____

Social Security #: _____/_____/_____ Today's Date: _____

Are you currently pregnant? ☐ Yes ☐ No

If yes, what is your due date?: _____

What was the first day of your last menstrual period?: _____

Have you had any problems in the current pregnancy? ☐ Yes ☐ No

If yes, please specify: _____

_____

_____

Prior pregnancies

_____ Number of pregnancies (not including this one)

_____ Number of full term deliveries

_____ Number of preterm deliveries

_____ Number of pregnancies carried past 4 ½ months [20 weeks]

_____ Number of miscarriages [spontaneous]

_____ Number of voluntary abortions

_____ Number of ectopic [tubal] pregnancies

_____ Number of multiple births

_____ Number of living children

Please fill in the table below for all pregnancies, starting with the first, and include all pregnancies, living or deceased.

Year	**Weeks** Full term=40w ks	**Length of Labor**	**Weight lbs oz**	**Sex** (circle one)	**Anesthesia**	**Type of delivery (i.e. vaginal or C/S)**	**Hospital**
		hrs	lbs oz	M F			
		hrs	lbs oz	M F			
		hrs	lbs oz	M F			
		hrs	lbs oz	M F			
		hrs	lbs oz	M F			
		hrs	lbs oz	M F			
		hrs	lbs oz	M F			
		hrs	lbs oz	M F			
		hrs	lbs oz	M F			

What medications do you take currently (including prenatal vitamins)?			
Name	**Dose**	**How many times a day?**	**For how long?**

Were you taking any other medications when you became pregnant? ☐ Yes ☐ No

If yes, please list:

Medication	Strength	Dose

Do you drink alcohol? ☐ Yes ☐ No

If yes, how often during the pregnancy _____

How often before pregnancy _____

Do you use illicit drugs ("street drugs")?

___ I used drugs in the past. ___ I used drugs before pregnancy. ___I am still using drugs.

Drug	How often

Do you have any medical problems? ☐ Yes ☐ No **If yes, please list below.**

_____

_____

_____

_____

Patient Name: _____ **DOB:** _____

OBSTETRIX MEDICAL GROUP

MEDICAL HISTORY

Do YOU have, or have you had, any of the following conditions:			
☐ Yes	☐ No	☐ Unsure	Unexplained Fever
☐ Yes	☐ No	☐ Unsure	Vision Problems
☐ Yes	☐ No	☐ Unsure	Hearing Loss
☐ Yes	☐ No	☐ Unsure	Ear Infections (other than childhood)
☐ Yes	☐ No	☐ Unsure	Sinus Problems
☐ Yes	☐ No	☐ Unsure	Repeated Nosebleeds
☐ Yes	☐ No	☐ Unsure	Long Term Sore Throat
☐ Yes	☐ No	☐ Unsure	Pneumonia
☐ Yes	☐ No	☐ Unsure	Asthma
☐ Yes	☐ No	☐ Unsure	Close Contact With Persons(s) With Tuberculosis
☐ Yes	☐ No	☐ Unsure	Tuberculosis Vaccine (BCG)
☐ Yes	☐ No	☐ Unsure	Positive Tuberculosis Skin Test
☐ Yes	☐ No	☐ Unsure	Unexplained Cough
☐ Yes	☐ No	☐ Unsure	Unexplained Shortness Of Breath
☐ Yes	☐ No	☐ Unsure	Other Lung Problems
☐ Yes	☐ No	☐ Unsure	Heart Murmur
☐ Yes	☐ No	☐ Unsure	Mitral Valve Prolapse
☐ Yes	☐ No	☐ Unsure	Other Heart Valve Problems
☐ Yes	☐ No	☐ Unsure	Heart Attack
☐ Yes	☐ No	☐ Unsure	Heart Disease
☐ Yes	☐ No	☐ Unsure	Unexplained Chest Pains
☐ Yes	☐ No	☐ Unsure	Unexplained Fainting
☐ Yes	☐ No	☐ Unsure	Irregular Heart Beat
☐ Yes	☐ No	☐ Unsure	Other Heart Problems
☐ Yes	☐ No	☐ Unsure	High Blood Pressure in Pregnancy
☐ Yes	☐ No	☐ Unsure	High Blood Pressure, Other
☐ Yes	☐ No	☐ Unsure	Raynaud's Disease, Raynaud's Phenomenon
☐ Yes	☐ No	☐ Unsure	Poor Blood Circulation
☐ Yes	☐ No	☐ Unsure	Severe Nausea and Vomiting in Pregnancy
☐ Yes	☐ No	☐ Unsure	Severe Nausea and Vomiting Before Pregnancy
☐ Yes	☐ No	☐ Unsure	Intestinal Problems (Irritable Colon, Crohn's Disease, Etc.)
☐ Yes	☐ No	☐ Unsure	Dietary Restriction
☐ Yes	☐ No	☐ Unsure	Unexplained Recurring Diarrhea
☐ Yes	☐ No	☐ Unsure	Constipation Problem
☐ Yes	☐ No	☐ Unsure	Heartburn, Reflux
☐ Yes	☐ No	☐ Unsure	Hepatitis, Yellow Jaundice
☐ Yes	☐ No	☐ Unsure	Liver Problems
☐ Yes	☐ No	☐ Unsure	Bladder or Kidney infections
☐ Yes	☐ No	☐ Unsure	Kidney Stones
☐ Yes	☐ No	☐ Unsure	Problems With Urine
☐ Yes	☐ No	☐ Unsure	Menstrual Problems
☐ Yes	☐ No	☐ Unsure	Infertility, Difficulty Getting Pregnant
☐ Yes	☐ No	☐ Unsure	Vaginal Infections

Patient Name: _____ **DOB:** _____

OBSTETRIX MEDICAL GROUP

(cont.) **Do YOU have, or have you had, any of the following conditions:**			
☐ Yes	☐ No	☐ Unsure	Herpes or a Partner with Herpes
☐ Yes	☐ No	☐ Unsure	Sexually Transmitted Disease
☐ Yes	☐ No	☐ Unsure	Pelvic Inflammatory Disease
☐ Yes	☐ No	☐ Unsure	Gonorrhea
☐ Yes	☐ No	☐ Unsure	Chlamydia
☐ Yes	☐ No	☐ Unsure	Syphilis
☐ Yes	☐ No	☐ Unsure	Genital Warts
☐ Yes	☐ No	☐ Unsure	HIV Infection, AIDS, or a Partner with HIV/AIDS
☐ Yes	☐ No	☐ Unsure	Abnormal PAP Smear(s)
☐ Yes	☐ No	☐ Unsure	Diabetes (High Blood Sugar)
☐ Yes	☐ No	☐ Unsure	Thyroid Problems
☐ Yes	☐ No	☐ Unsure	Other Hormone Problem
☐ Yes	☐ No	☐ Unsure	Epilepsy, Seizure Disorder
☐ Yes	☐ No	☐ Unsure	Unexplained Drowsiness
☐ Yes	☐ No	☐ Unsure	Migraine/Cluster Headaches
☐ Yes	☐ No	☐ Unsure	Other Recurring headaches
☐ Yes	☐ No	☐ Unsure	Depression
☐ Yes	☐ No	☐ Unsure	Panic Attack Disorder
☐ Yes	☐ No	☐ Unsure	Psychiatric/Mental/Emotional/Problems
☐ Yes	☐ No	☐ Unsure	Skin Problems
☐ Yes	☐ No	☐ Unsure	Unexplained Hair Loss
☐ Yes	☐ No	☐ Unsure	Arthritis/Joint Pains
☐ Yes	☐ No	☐ Unsure	Lupus
☐ Yes	☐ No	☐ Unsure	Rheumatic fever
☐ Yes	☐ No	☐ Unsure	Blood Transfusions If Yes, Date _____ Reason _____
☐ Yes	☐ No	☐ Unsure	Bleeding Tendency
☐ Yes	☐ No	☐ Unsure	Blood Clots, Thrombophlebitis
☐ Yes	☐ No	☐ Unsure	Rh Sensitized
			Do you currently smoke? _____I have never smoked. ___ I smoke every day. Number of packs per day? _____ For how many years? _____ ___ I smoke but not every day. How often do you smoke? _____ ___ I smoked in the past but not currently. When did you quit? _____

Any Previous Surgeries? (include minor or outpatient surgeries such as wisdom tooth removal, D&C, etc.)

Year	Procedure	Hospital

Any allergies to medications? ☐ Yes ☐ No

Medication	Reaction

Any other Problems	

Reviewed by_____ _____ _____

Provider signature **Patient signature** **DOB**

OBSTETRIX MEDICAL GROUP

GENETIC/FAMILY HISTORY

How would you describe your ancestry (check all that apply):

☐ Caucasian (white)	☐ French Canadian	☐ Samoan	☐Vietnamese
☐ African (black)	☐ Native American	☐ Chinese	☐ Laos
☐ Hispanic	☐ Greek	☐ Cambodian	☐ Taiwanese
☐ Ashkenazi Jewish	☐ Italian	☐ Filipino	☐ Korean
☐ Cajun	☐ Middle Eastern	☐ Japanese	☐ Other Southeast Asian
☐ Guamanian	☐ Hawaiian	☐ Asian – East Indian	☐ Unknown Race
☐ Other		☐ Other 2	

Are you and the father of this baby blood relative (example: cousins)? ☐Yes ☐No

What is your occupation? _____

What is the name of the father of this baby? _____

What is the occupation of the father of this baby? _____

What is the age of the father of this baby? _____

How would you describe the ancestry of the father of this baby (check all that apply):

☐ Caucasian (white)	☐ French Canadian	☐ Samoan	☐Vietnamese
☐ African (black)	☐ Native American	☐ Chinese	☐ Laos
☐ Hispanic	☐ Greek	☐ Cambodian	☐ Taiwanese
☐ Ashkenazi Jewish	☐ Italian	☐ Filipino	☐ Korean
☐ Cajun	☐ Middle Eastern	☐ Japanese	☐ Other Southeast Asian
☐Guamanian	☐ Hawaiian	☐ Asian – East Indian	☐ Unknown Race
☐Other		☐ Other 2	

Is the father of this baby your partner? ☐ Yes ☐ No

Comments: _____

_____

_____

Patient Name: _____ **DOB:** _____

OBSTETRIX MEDICAL GROUP

Does the father of the baby, or any close relative of yours or the father, have any of the following (if yes, please note who):

Disease/Condition	Yes	No	Relation
1. Thalassemia MCV<80			
2. Neural Tube Defect (Spina Bifida, or Anencephaly)			
3. Congenital Heart Defect			
4. Down Syndrome			
5. Tay-Sachs			
6. Sickle Cell Disease or Trait			
7. Hemophilia or bleeding Problems (Type:)			
8. Muscular Dystrophy			
9. Cystic Fibrosis			
10. Canavan Disease			
11. Mental Retardation/Autism/Learning disorder			
If Yes, Tested for Fragile X			
12. Huntington Chorea			
13. Other inherited genetic or chromosomal disorder			
14. Maternal Metabolic Disorder (i.e. Insulin-Dependent Diabetes, PKU)			
15. Patient or baby's father had a child with birth defects not listed above			
16. Recurrent pregnancy loss, or stillbirth			
17. Blindness or deafness			
18. Bone or skeletal disorder			
19. Breast, ovarian or colon cancer			
20. Kidney disorder			
21. Do any of your parents, siblings, or children have diabetes			
22. Blood clots/stroke			
23. Anything else that seems to run in the family			

Reviewed by_____ _____

Provider signature Patient signature

Patient Name: _____ **DOB:** _____

What is Ultrasound?

Ultrasound uses the same principle as sonar. Sound waves from the ultrasound probe (far beyond the range of human hearing) bounce off of the uterus, placenta, and baby making echoes which a computer converts into detailed images. In essence, an ultrasound is a series of pictures of the baby and organs in the mother's pelvis.

Is Ultrasound safe?

There has been extensive evaluation of the safety of diagnostic ultrasound. There is no documented evidence that diagnostic ultrasound causes harm to either the mother or the baby when ordinary power is used. Ultrasound exams done in our facility are done using the lowest power level that can reasonably achieve a meaningful image.

Does a normal Ultrasound prove that my baby will have no abnormalities?

Ultrasound examinations can detect many abnormalities, but some abnormalities are not detectable by ultrasound. The exam gives information about the size and shape of the bay and the baby's organs, but does not give complete information about the function of the baby's organs or tell us that the baby is completely "healthy". Abnormalities of brain function such as mental retardation cannot b e detected by ultrasound exam but become apparent later in the pregnancy.

You should realize that even with a complete ultrasound exam, we may be unable to find existing fetal abnormalities that can appear later in pregnancy or after birth. Thus, although ultrasound examination is a very helpful diagnostic tool, it should not be considered absolute proof that the baby is normal.

Can Ultrasound determine if there are chromosomal abnormalities?

Findings on an ultrasound exam can be an indicator of potential chromosomal abnormalities but are not definitive. Currently the only way to assess the baby's chromosomes with certainty is to actually obtain a sample of the baby's cells by amniocentesis, chorionic villus sampling or fetal blood sampling. Some pregnancies are at increased risk for fetal chromosome abnormalities either because of the mother's age, because of results of blood screening test, or because of findings on the ultrasound exam. It is important to realize that an ultrasound exam cannot tell for certain whether the baby's chromosome count is normal or abnormal. A normal ultrasound examination does not guarantee that the chromosomes are normal.

If you have any questions concerning ultrasound, please do not hesitate to ask the ultrasound technologist, perinatologist, or your doctor. You are requested to sign this document before your ultrasound examination to acknowledge that you have read and understood the information on this form and have had the opportunity to ask questions.

Patient/Guardian Signature	**Date**
Printed Name	**Date of Birth**

OBSTETRIX MEDICAL GROUP

PEDIATRIX-OBSTETRIX MEDICAL GROUP AND AFFILIATES
PATIENT ACKNOWLEDGEMENT FORM

Our notice of Privacy Practices ("Notice") provides information about: 1.) the privacy rights of our patients; and 2.) how we may use and disclose protected health information ("PHI") about our patients.

Federal regulation requires that we give our patients or their authorized representatives ("You") the opportunity to review our Notice before signing this acknowledgement. An on-page summary of our Notice is displayed in our offices and in the hospitals we serve. A copy of our Notice will be made available to you and you may also view our Notice by visiting our internet web site, www.pediatrix.com/HIPAA Privacy/Notice of Privacy Practices.

If you have any questions about your rights or our privacy practices, please send an electronic message (e-mail) to **privacy_officer@pediatrix.com** or letter to:

Privacy Officer
Pediatrix Medical Group, Inc.
1301 Concord Terrace
Sunrise, FL 33323

We will respond to you within five (5) business days.

By signing this form, you acknowledge only that we have provided you with immediate access to our Notice of Privacy Practices.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Print Name of Patient Print Name of Authorized Representative

Patient Name: _____ **DOB:** _____

OBSTETRIX MEDICAL GROUP

AUTHORIZATION FOR VERBAL RELEASE OF PROTECTED HEALTH INFORMATION

__ **STANDARD DISCLOSURE**

I authorize Obstetrix Medical Group of Georgia dba Atlanta Maternal-Fetal Medicine to discuss my medical history, diagnosis, treatment and prognosis with those listed below. I understand this may include information regarding testing, examination and treatment for HIV, AIDS related illness, mental health and drug, alcohol or chemical abuse, as well as confirmation of any appointments for me to be seen in the office, hospital, or at another physician's office.

__ SPOUSE: _____

__ CHILDREN: _____

__ PARENT(S): _____

__ OTHER: _____

__ **NO INFORMATION**

I do not authorize release of any information concerning my treatment. I understand that this includes confirmation of appointment dates, times and locations.

This authorization will expire at the end of my treatment with Obstetrix Medical Group of Georgia dba Atlanta Maternal Fetal Medicine unless I revoke the consent prior to that time.

_____ _____

Signature of Patient Date

_____ _____

Patient's Printed Name DOB

_____ _____

Witness Date

CONSENT FOR TREATMENT

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

PARTICIPATING INSURANCE – I hereby give consent to Obstetrix Medical Group, Inc. dba Atlanta Maternal Fetal Medicine to provide whatever treatment they may deem necessary to me or my dependent, _____. I hereby request payment of authorized benefits and/or any insurance benefits to be paid directly to Obstetrix Medical Group, Inc. dba Atlanta Maternal Fetal Medicine for any service furnished to me by Obstetrix Medical Group, Inc. dba Atlanta Maternal Fetal Medicine. I authorize Obstetrix Medical Group, Inc. dba Atlanta Maternal Fetal Medicine and staff to release to my insurance carrier and its agents, any information concerning healthcare, advice, or treatment provided to me or my dependent _____, that is needed to determine these benefits or the benefits payable for related services. I understand that I am responsible for charges not covered by the insurance policy, and should it become necessary to collect the charges through an attorney or other collection process, I shall be responsible for all costs.

_____ _____

Signature of patient or responsible party, if minor Date

OBSTETRIX MEDICAL GROUP

FINANCIAL POLICY

OUR FINANCIAL POLICY: Our physicians and staff are very concerned about the cost of your health care and want to address some issues related to the cost of medical services in our office. Considerable care has been taken in setting our fees. We want to assure you that the charges accurately reflect the complexity of care rendered and the skill and expertise required for your care.

HMO and PPO MEMBERS: If you are a member of an HMO or PPO in which we participate, your deductible or co-payment is required at the time of service. Sonograms may have a different co-payment than routine visits. You are responsible to see that we have a current referral on file if your insurance carrier requires one. If we do not have this referral at the time of your visit, your insurance company may hold you responsible for all charges. You may also be sent back to see your Primary Care Physician prior to being treated to obtain a current referral.

If you are not sure that our physicians are providers for your PPO, call your insurance carrier for clarification.

NEW INSURANCE/CHANGE OF INSURANCE: Should your insurance change at anytime during your pregnancy it is your responsibility to notify us in writing within 10 working days of this change. We have to have this information in order to file your claim with the correct carrier before the insurance company's filing deadline.

FEE FOR SERVICE: Our policy requires payment of your deductible and/or co-insurance at the time of service.

Our agreement is with you not your insurance company. Although we will assist you in submitting your claim to your insurance carrier, you are ultimately responsible for the service you receive. Payment to our office is neither contingent nor dependent upon your insurance carrier.

We are pleased to accept MasterCard, Visa, Discover, American Express, checks, cash, money orders, or traveler's checks.

MEDICARE: We are participating providers for Medicare. Please present your Medicare card at your visit. Patients are responsible for 20% of the amount that Medicare allows. If you have a supplemental insurance, we will submit a claim for you.

MEDICAID: We are Medicaid Providers. Please present your Medicaid letter of eligibility at each of your visits.

AMNIOCENTESIS, CHORIONIC VILLUS SAMPLING, AND OTHER SPECIALIZED TESTING: Our office will charge you for the services we provide. You will receive a separate bill from the laboratory that processes the test. Our office will be happy to provide you with an approximation of the laboratory charges.

If you have any questions regarding our financial policy or your insurance reimbursement, please feel free to discuss them with our billing office of the practice manager.

I have read and understand my financial responsibilities under this policy of Obstetrix Medical Group of Georgia.

_____ _____

Signature of Patient Date

_____ _____

Patient's Printed Name DOB

OBSTETRIX MEDICAL GROUP

PHARMACY INFORMATION

Name of Pharmacy: _____

Address: _____

City: _____ **State:** _____

Phone Number: _____ **Fax Number:** _____

Patient Name: _____ **DOB:** _____