

Obstetrix Medical Group of Houston



**Patient Registration Form**

**PATIENT INFORMATION**

How well do you speak English? \_\_\_ Very Well \_\_\_ Well \_\_\_ Not Well \_\_\_ Not At All

Name (First, M/I., Last) \_\_\_\_\_ DOB \_\_\_\_\_

Mailing Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Cell Number \_\_\_\_\_ Email \_\_\_\_\_

Social Security # \_\_\_\_\_ Marital Status \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed

Patient Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

**SPOUSE/GUARDIAN INFORMATION**

Name \_\_\_\_\_ DOB \_\_\_\_\_

Social Security \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

**EMERGENCY INFORMATION**

Name \_\_\_\_\_ Number \_\_\_\_\_

**PATIENT RESPONSIBILITY**

I authorize the release of any medical records or other information necessary to process my insurance claims on my behalf. I authorize Obstetrix Medical Group of Houston to appeal all insurance claims as appropriate on my behalf. I agree to be fully responsible for all lawful debits incurred by myself for services whether or not covered by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION  
TO FAMILY AND FRIENDS**

I authorize the practice to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial, insurance and billing information with those listed below. I understand that my or my child's healthcare provider will use his/her judgment in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed HIPAA-compliant authorization. This permission will be considered on-going until I indicate otherwise in writing.

**PHI may be released to the following individuals:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Yes**    **No**   The practice staff have my permission to share my or my child's personal health information with family members or others who are in the room with me/us during the appointment.

**The practice staff have my permission to leave messages concerning treatment (i.e., Lab Results) on my: (Please check all that apply)**

- Home Voice Mail or Answering Machine   Home Phone number: \_\_\_\_\_
- Cell phone   Cell phone number: \_\_\_\_\_
- Work Voice Mail   Work phone number: \_\_\_\_\_

**NO INFORMATION:** I do not authorize the release of any verbal information (other than appointment reminders to the number(s) that I have provided).

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
\*Print Name of Authorized Representative

\_\_\_\_\_  
Patient/Authorized Representative Signature

\_\_\_\_\_  
Date Signed

Authorized Representative's authority\* to act on the Patient's behalf:

- Parent/legal guardian                       Power of Attorney

\*Evidence of authority must be provided and on file with the practice.



## **Obstetrix Medical Group of Houston**

### Policy on Children

Our practice is committed to family-centered care and welcomes family members at routine clinic visits. To ensure that our staff members can devote their undivided attention to each patient, if you will be bringing a child under the age of 10 to your appointment, please also bring another adult to provide supervision during your examination, procedures or critical discussions.

Viral and infectious diseases, common in children, can be harmful to the fetus in early pregnancy. To protect our patients and their unborn babies, please refrain from bringing a child to your appointment who is exhibiting any signs of illness, including coughs, cold symptoms or fever.

Please sign below to acknowledge that you have read and understand our policy.

Signature \_\_\_\_\_

Date \_\_\_\_\_

## ASSIGNMENT OF BENEFITS

This Assignment of Benefits allows Pediatrix Medical Group to be paid directly by my health insurance carrier for medical services rendered by its providers. By signing this I assign and transfer to Pediatrix Medical Group all rights, title and interest in all benefits payable for the services rendered, which are provided in any and all insurance policies and health benefit plans from which my dependents or I are entitled to recover.

I hereby designate Pediatrix Medical Group to act as my representative during insurance or plan benefits appeal in the event of a coverage limitation or denial. I understand that Pediatrix Medical Group has the right to decline or accept this designation at the time a limitation or denial is received. The outcome of any appeal is not guaranteed and I understand that I may be responsible for any charges that remain unpaid by the insurance or benefit plan regardless of the outcome of any appeal. I have read this assignment of benefits, and I have signed this document freely and without inducement.

Insurance Policy Holder Name \_\_\_\_\_

Insurance Policy Holder Signature \_\_\_\_\_

Signature Date \_\_\_\_\_

## CESIÓN DE BENEFICIOS

La presente Cesión de Beneficios permite que Pediatrix Medical Group sea pagado directamente por mi asegurador médico por los servicios médicos provistos por sus proveedores. Con mi firma en el presente documento, cedo y transfiero a Pediatrix Medical Group todos los derechos, título e interés en todos los beneficios pagaderos por los servicios provistos, que sean dispuestos en todas y cualesquier pólizas de seguro y planes de beneficios médicos de los cuales mis dependientes o yo tengamos derecho a recuperar.

Por este medio designo a Pediatrix Medical Group para que actúe como mi representante durante apelaciones de seguro o planes de beneficios en caso de una limitación o rechazo de cobertura. Entiendo que Pediatrix Medical Group tiene el derecho de rechazar o aceptar esta designación en el momento del recibo de una limitación o rechazo. No se garantiza el resultado de cualquier apelación y entiendo que podré ser responsable de cualesquier cargos que quedasen sin pagar por el plan de seguro o beneficios, sin importar el resultado de cualquier apelación. He leído la presente cesión de beneficios y he firmado el presente documento voluntariamente y sin aliciente alguno.

Nombre de titular de la póliza de seguro \_\_\_\_\_

Firma del titular de la póliza de seguro \_\_\_\_\_

Fecha de la firma \_\_\_\_\_



**NOTICE OF PRIVACY PRACTICES  
PATIENT ACKNOWLEDGMENT 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 about our patients.

Federal regulations require that we give our patients or their authorized representatives our Notice before signing this acknowledgment.

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

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

By signing this form, you are only acknowledging that you have been provided our Notice.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient/Authorized Representative

## IMPORTANT INFORMATION REGARDING ULTRASOUND EXAMINATION

### 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 the uterus, placenta and baby, making echoes which a computer converts into detailed images. In essence, an ultrasound exam 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 diagnostic power and frequency 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 examination can detect many abnormalities, but some abnormalities are not detectable by ultrasound. The exam gives information about the size and shape of the baby 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 be detected by ultrasound. Additionally, there are many conditions that evolve over time, appearing normal at the time of the 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 or those abnormalities that can appear later in the 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. The only way to assess the baby's chromosomes with certainty is to actually obtain a sample of the baby's cells by amniocentesis or chorionic villus 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 a normal chromosome count.

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.

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Patient/Guardian signature

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Date

## Genetic/Family History Questionnaire

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Date:** \_\_\_\_\_

How would you describe your ancestry? Please check all that apply.

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> White            | <input type="checkbox"/> French Canadian | <input type="checkbox"/> Samoan            | <input type="checkbox"/> Vietnamese               |
| <input type="checkbox"/> African (Black)  | <input type="checkbox"/> Native American | <input type="checkbox"/> Chinese           | <input type="checkbox"/> Laos                     |
| <input type="checkbox"/> Hispanic         | <input type="checkbox"/> Greek           | <input type="checkbox"/> Cambodian         | <input type="checkbox"/> Taiwanese                |
| <input type="checkbox"/> Ashkenazi Jewish | <input type="checkbox"/> Italian         | <input type="checkbox"/> Filipino          | <input type="checkbox"/> Korean                   |
| <input type="checkbox"/> Cajun            | <input type="checkbox"/> Middle Eastern  | <input type="checkbox"/> Japanese          | <input type="checkbox"/> Other Southeastern Asian |
| <input type="checkbox"/> Guamanian        | <input type="checkbox"/> Hawaiian        | <input type="checkbox"/> Asian-East Indian | <input type="checkbox"/> Unknown Race             |
| <input type="checkbox"/> Other: _____     | <input type="checkbox"/> Other: _____    |  |   |

Are you and the father of this baby a blood relative (i.e. cousins)? \_\_\_\_\_ No \_\_\_\_\_ Yes

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):

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> White            | <input type="checkbox"/> French Canadian | <input type="checkbox"/> Samoan            | <input type="checkbox"/> Vietnamese               |
| <input type="checkbox"/> African (Black)  | <input type="checkbox"/> Native American | <input type="checkbox"/> Chinese           | <input type="checkbox"/> Laos                     |
| <input type="checkbox"/> Hispanic         | <input type="checkbox"/> Greek           | <input type="checkbox"/> Cambodian         | <input type="checkbox"/> Taiwanese                |
| <input type="checkbox"/> Ashkenazi Jewish | <input type="checkbox"/> Italian         | <input type="checkbox"/> Filipino          | <input type="checkbox"/> Korean                   |
| <input type="checkbox"/> Cajun            | <input type="checkbox"/> Middle Eastern  | <input type="checkbox"/> Japanese          | <input type="checkbox"/> Other Southeastern Asian |
| <input type="checkbox"/> Guamanian        | <input type="checkbox"/> Hawaiian        | <input type="checkbox"/> Asian-East Indian | <input type="checkbox"/> Unknown Race             |
| <input type="checkbox"/> Other: _____     | <input type="checkbox"/> Other: _____    |  |   |

Is the father of this baby your partner? \_\_\_\_\_ No \_\_\_\_\_ Yes

Is this pregnancy a Product of IVF? \_\_\_\_\_ No \_\_\_\_\_ Yes If yes:

Was a donor egg used? \_\_\_\_\_ No \_\_\_\_\_ Yes

What is the age of the donor? \_\_\_\_\_

Comments:

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## Genetic/Family History Questionnaire

Do you, the father of this baby, or any close relatives have:

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Thalassemia (Greek, Mediterranean, or Asian Background) MCV < 80          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Neural Tube Defect (Meningomyelocele Spina Bifida or Anencephaly)         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Congenital Heart Defect   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Down Syndrome   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tay-Sachs (Jewish, Cajun, French Canadian)                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sickle Cell Disease or Trait (African)                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hemophilia or Bleeding Problems   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Muscular Dystrophy  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cystic Fibrosis   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Canavan Disease   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mental Retardation/ Autism / Learning Disorder                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If Yes, Tested for Fragile X  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Huntington Chorea   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other Inherited Genetic or Chromosomal Disorder                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Maternal Metabolic Disorder (Insulin Dependent Babies, PKU)               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Patient or Baby's Father had a child with birth defects NOT listed above? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, describe _____  |                              |                             |
| Recurrent Pregnancy Loss or Stillbirth                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blindness or Deafness   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bone or Skeletal Disorder (Dwarfism)                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Breast, Ovarian or Colon Cancer   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney Disorder   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do either you or any of your parents, siblings or children have Diabetes? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood Clots/ Stroke   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anything else that runs in the family? _____                              |                              |                             |
| Other? _____  |                              |                             |

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Reviewed By: \_\_\_\_\_



**Review of Systems Questionnaire**



**Do you or have you taken medication in the last year?:**

Medications Taken	Dose	Frequency	Date Started

**Do you have any known drug allergies?**


**Do you have a past or current history of any Psychiatric Disorders, Depression, or Postpartum Depression?**

No  Yes *If yes, please state the condition/s and when diagnosed.*

Date	Condition

**Do you currently smoke?**  No  Yes

**Have you consumed any alcoholic beverages since becoming pregnant?**  No  Yes *If yes, what type and how often?*

**Have you used any street drugs since becoming pregnant?**  No  Yes *If yes, what type and how often?*

**Past Surgeries: (Examples Appendectomy, Cervical Conization, LEEP, Laparoscopy, Hysteroscopy)**

Surgery	Date

**Do you have any medical problems (for example, diabetes or high blood pressure)?**

Medical Issue	Date

**Previous Pregnancies:**

Year	Outcome (full term, preterm, miscarriage, termination)	Type of delivery (vaginal, cesarean, forceps, vassum)	Weight and Gender	Complications

**Preferred Pharmacy** \_\_\_\_\_ **Phone Number** \_\_\_\_\_