ALLERGIES:

_____

_____

OBSTETRIX MEDICAL GROUP
an affiliate of MEDNAX

Melissa Aerts, MD Javier Castillo, MD Lissa Magloire, MD Deirdre McCullough, MD Theresa Stewart, MD

Please Complete ALL sections in Blue or Black Ink.

____ St Luke's ____MCH ____Westover Hills ____New Braunfels ____SW General ____Metropolitan

Name of Referring OBGYN Doctor:_____

PATIENT INFORMATION

Last Name:_____First Name:_____MI:_____

Street Address_____Apt #_____Zip:_____

City:_____State:_____Date of Birth:_____/_____/_____ Age:_____Social Security #:_____-_____-_____

Home Phone: (____) _____Work Phone: (____) _____Cell/Pager: (____) _____

Marital Status: (S M D W) Student: (Y / N) Driver License # - State_____E-Mail:_____

Employer / School Name:_____Occupation:_____

Employer Address:_____City:_____State:_____Zip:_____

Spouse / Guardian Name:_____Employer:_____ Wk Ph:(___) _____

In case of Emergency, Notify:_____Relation:_____Phone: (___) _____

(other than spouse)

OBSTETRICAL HISTORY

1st Day of Last Menstrual Period_____Due Date:_____By Sono or Last Period? (circle one)

# of Pregnancies_____ Full Term_____ Premature (less than 37 weeks)_____ Miscarriages_____ Ectopic_____

Elective (Terminations)_____ Living Children_____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:_____Insurance Phone:_____Policy ID:_____

Group#: _____Claims Address_____City:_____State:_____Zip:_____

Subscriber's Name:_____DOB:_____SSN:_____Relationship to Patient:_____

Employer:_____Occupation:_____City:_____State:_____Zip:_____

SECONDARY INSURANCE NAME:_____Insurance Phone:_____Policy ID:_____

Group#: _____Claims Address_____City:_____State:_____Zip:_____

Subscriber's Name:_____DOB:_____SSN:_____Relationship to Patient:_____

Employer:_____Occupation:_____City:_____State:_____Zip:_____

TEXAS PERINATAL GROUP SAN ANTONIO
ST LUKE'S - 7950 Floyd Curl Drive, Suite 904, San Antonio, TX 78229 • 210.944.1738 • Fax: 210.593.0329
MCH - 4330 Medical Drive, Suite 225, San Antonio, TX 78229 • 210.354.2229 • Fax: 210.354.9973
WESTOVER HILLS - 3903 Wiseman Boulevard, Suite 121, San Antonio, TX 78251 • 210.521.1455 • Fax: 210.521.2379
NEW BRAUNFELS - 2115 Stephen's Place, Suite 600, New Braunfels, TX 78130 • 830.312.4509 • Fax: 830.620.8468
SOUTHWEST GENERAL - 7390 Barlite Boulevard, Suite 215, San Antonio, TX 78224 • 210.332.1450 • Fax: 210.332.1460
METROPOLITAN - 1200 Brooklyn Avenue, Suite 350, San Antonio, TX 78212 • 210.614.2209 • Fax: 210.617.6364

OBSTETRIX MEDICAL GROUP
an affiliate of MEDNAX

Melissa Aerts, MD Javier Castillo, MD Lissa Magloire, MD Deirdre McCullough, MD Theresa Stewart, MD

IMPORTANT INFORMATION REGARDING ULTRASOUND EXAMINATION

What is Ultrasound?
Ultrasound uses the same principle as sonar. Sound waves from the ultrasound probe (far beyond the ranges of human hearing) bounce off of 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 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 the 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 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 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. Your 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 Name Today's Date

_____
Printed Name

OBSTETRIX MEDICAL GROUP
an affiliate of MEDNAX

Melissa Aerts, MD Javier Castillo, MD Lissa Magloire, MD Deirdre McCullough, MD Theresa Stewart, MD

PLEASE READ AND SIGN THE FOLLOWING POLICY

We love and care for children, however due to the sensitive nature of our practice we cannot allow children under the age of 10 in the office or waiting room. If you arrive with a child under the age of 10, your appointment will be rescheduled. Thank you for your understanding.

_____ _____

Patient Signature **Date**

OBSTETRIX MEDICAL GROUP
an affiliate of MEDNAX

Melissa Aerts, MD Javier Castillo, MD Lissa Magloire, MD Deirdre McCullough, MD Theresa Stewart, MD

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@mednax.com** or a letter to:

Privacy Officer
MEDNAX Services, 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

OBSTETRIX MEDICAL GROUP
an affiliate of MEDNAX

Melissa Aerts, MD Javier Castillo, MD Lissa Magloire, MD Deirdre McCullough, MD Theresa Stewart, MD

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:

o Parent/legal guardian o Power of Attorney

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