EvergreenHealth

Patient Sticker

Eastside MATERNAL FETAL MEDICINE

The following questions will help your provider complete a risk assessment and determine if certain tests are appropriate. If you are unsure about your family history, please speak with family members.

RACE/ETHNICITY: Please circle and check all that apply

	Patient	Partner
Chinese, Taiwanese, Asian Indian, Pakistani, Filipino, Pacific Islander or Southeast Asian	☐	☐
Japanese or Korean	☐	☐
Italian, Greek, Middle Eastern, Spanish or Portuguese	☐	☐
Jewish, French Canadian or Cajun	☐	☐
African American, African descent, Black, Puerto Rican, Caribbean or Central American	☐	☐
Hispanic or Mexican	☐	☐
Caucasian	☐	☐
Other (specify) _____	☐	☐

FAMILY HISTORY: Have you, your partner or anyone in your families ever had the following conditions?

	Yes	No
Down syndrome	☐	☐
other chromosome condition	☐	☐
mental retardation, autism, developmental delay	☐	☐
spina bifida (open spine) or anencephaly (open head/brain)	☐	☐
cystic fibrosis (a lung disease)	☐	☐
muscular dystrophy or neuromuscular disease	☐	☐
skeletal disorder, like dwarfism	☐	☐
polycystic kidney disease	☐	☐

	Yes	No
heart defect	☐	☐
cleft lip/cleft palate	☐	☐
blindness / deafness	☐	☐
blood disorder, such as hemophilia or sickle cell	☐	☐
stroke or blood clot at age less than 50	☐	☐
any other birth defect/genetic/inherited condition	☐	☐
please list_____		
any other serious medical condition or surgery	☐	☐
please list_____		

	Yes	No
Are you and your partner related to each other - other than by marriage?	☐	☐
Is there a history of infertility in either you and/or your partner?	☐	☐
Please specify the cause of infertility, if known. _____		
Have you ever had a miscarriage.	☐	☐
If yes, how many times?_____ How far along was/were the pregnancy(s)?_____		
Have you or your partner (with a previous partner) ever had a still birth.	☐	☐
Have you or your partner (with a previous partner) ever had an infant death.	☐	☐
Have you ever had a baby born small for its age, or that the doctors delivered early because it was small?	☐	☐

PERSONAL HISTORY: Please complete the following patient information:

	Yes	No
Was this pregnancy achieved with IVF?	☐	☐
If yes, did you use:		
donor egg (age of donor____) or donor sperm?	☐	☐
preimplantation genetic diagnosis/screening (PGD/PGS)	☐	☐
Do you have diabetes (type 1 or type 2)?	☐	☐
Do you have lupus or Sjogren's syndrome?	☐	☐
Do you have PKU or Marfan Syndrome?	☐	☐

	Yes	No
Since you have been pregnant:		
have you taken any medication?	☐	☐
Please list:_____		
had any alcoholic drinks?	☐	☐
smoked any cigarettes?	☐	☐
used any recreational drugs?	☐	☐
had any rashes, infections, fevers?	☐	☐
had exposure to any x-rays (other than dental)?	☐	☐

I have answered these questions to the best of my knowledge. _____ Patient's signature _____ Date

MD/GC

Eastside Maternal Fetal Medicine
An affiliate of Obstetrix Medical Group

Thank you for visiting Eastside Maternal Fetal Medicine. Our practice includes a team of professionals dedicated to patient care:

- Seven Maternal-Fetal Medicine Specialists (Perinatologists)
- A Radiologist with advanced training in Obstetrical Ultrasound
- Registered Nurses and an Advanced Registered Nurse Practitioner (ARNP)
- Certified Diabetic Educators
- Ultra Sonographers & Medical Assistants
- Board Certified Genetic Counselor
- Patient Service Associates & Billing Associates

Our goal is to provide you with high-quality care by combining cutting-edge technology, compassionate care for you and your family and ultrasound education. Our doctors are experts in obstetrical ultrasound and we perform the most complete and detailed ultrasounds available. Your provider has sent you here for a level two, high-resolution, or targeted ultrasound. This means that we will be using state-of-the-art equipment to examine all the organs of the baby(ies) and some of the internal organs of the mother. We will also assess the size and health of the baby, where the placenta is and how it is functioning, and how much fluid there is in the sac.

There is no evidence that ultrasound will harm you or your baby. Sound waves (far outside the range humans can hear) are sent from the ultrasound probe and these waves bounce off your uterus and baby creating echoes. A computer translates these echoes into images.

If your baby is in an adequate position, images will be provided to you so that you may share them with your family and friends. Therefore, cellular phones and/or recording devices are not allowed to be used during your appointment.

If your ultrasound is not as clear as possible we may want you to return for another ultrasound to obtain a better view. However, even under the best of circumstances, with the most experienced of doctors, not all birth defects will be seen during an ultrasound. For example, most cases of spina bifida (an opening in the spine) can be diagnosed before a baby is born, but about a third of heart defects will ***not*** be found until ***after*** birth. Ultrasound is not generally used to identify functional problems such as mental retardation. (A baby's brain may look normal by ultrasound but not work properly).

Please feel free to ask questions during your ultrasound. We will share all available information about your baby with you before you leave our office.

We respectfully request that you think carefully before deciding to bring small children to your appointment. Your complete focus is important to providing the best care for you and your baby. If you do bring small children, please have a responsible adult attend to supervise them for the duration of your appointment.

Thank you in advance for your cooperation.

Please sign below to show that you have read and understand the information on this page.

_____ _____

Patient Signature Date

_____ _____

Printed Name Date of Birth

OBSTETRIX MEDICAL GROUP
an affiliate of MEDNAX

EASTSIDE MATERNAL FETAL MEDICINE

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.

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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 regulation requires 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 (e-mail) to 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