OBSTETRIX MEDICAL GROUP
an affiliate of MEDNAX

**MRN:**___________________

Today's Date: _______________

**Patient Information:**

Name: ____________________________________________ Date of Birth: ______________________

SSN#: XXX-XX-________ Marital Status: ☐ S ☐ M ☐ D ☐ W

Address: ____________________________________________________________________________

City: ________________________________State: __________ Zip: _________

Home Phone: ______________________________ Cell Phone: ___________________________________

Emergency Contact: ________________________Phone: _________________Relationship: ____________

Patient Employer: _____________________________________________Phone: ______________________

Address: ____________________________________City: ________________State: ____ Zip: _________

Referring Physician: ___________________________________LMP: __________ Due Date: ___________

Primary language? ________________________________

How well do you speak English? ☐ Well ☐ Fair ☐ Poor

**Email:** ________________________________________________________

**Spouse's Information:**

Spouse's Name: ______________________________________________Date of Birth: ____________________

SSN#: __________________________ Phone #: ____________________________________

Employer: ________________________________ Phone #: ____________________________________

**Insurance Information:**

Primary Insurance: _______________________Group #: ______________ ID#: _______________________

Insured's Name: ____________________________________________Date of Birth: _____________________

SSN#: __________________Relationship to patient: ________________☐ HMO ☐ PPO ☐ POS ☐ EPO

Insurance Co. Address: __________________________City: ________________ State: ____Zip: ________

Phone #: ____________________________

Secondary Insurance: _____________________Group #: _______________ ID#: _____________________

Insured's Name: ____________________________________________Date of Birth: _____________________

SSN#: _________________ Relationship to patient: ________________ ☐ HMO ☐ PPO ☐ POS ☐ EPO

Insurance Co. Address: _________________________City: _______________State: ___Zip: ________

Phone #: ____________________________

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

I authorize the practice to discuss appointment dates, times, location, medical history, diagnosis, treatment, lab results performed by Integrated Genetics/LabCop, 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.______________________________ 3.______________________________

2. ______________________________ 4. ______________________________

___ **Yes** ___**No** The practice staff has 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 message concerning treatment (e.g. Lab Results) on my:**

| ○ **Home Phone Number:** ______________________ | ○ **Cell 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).

______________________________ ______________________
Signature of Patient or Authorized Representative* Date

______________________________
Printed name

Authorized Representative's authority* to act on the Patient's behalf:
**Evidence of authority must be provided and on file with the practice.*

- o Parent/legal guardian
- o Power of Attorney

**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** 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

________________________________
Printed name

**OUR FINANCIAL POLICY**

Our physicians and staff are concerned about the cost of your health care and have taken considerable effort in setting our fees. We assure you that our charges reflect the skill and expertise required for the evaluation and management of your condition. We participate in numerous managed healthcare plans, however if you have questions regarding our participation in your specific plan do not hesitate to ask, or contact your insurance provider for clarification. If you have any questions regarding our financial policy or our fees, please feel free to discuss them with our billing office at 888.822.2855. In accordance with SB1731, upon request, you will be given an itemized statement of charges including an explanation of said charges within ten (10) business days. Medicaid or HMO participants understand that it is your responsibility to provide all necessary coverage information, as well as obtaining prior authorization from your primary care physician.

Please note: Failure to provide this information will result in you being financially responsible for all charges incurred.

**AUTHORIZATION TO RELEASE RECORDS**

I hereby authorize Obstetrix Medical Group of Dallas to release any medical information including, but not limited to, information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), laboratory test results, medical history, progress notes, or any other such related information to: 1.) Representatives of local, state or federal agencies in accordance with the law. 2.) My insurance carrier or its designated representatives. 3.) Person(s) financially responsible for my care or treatment in order to obtain payment for expenses incurred.

**I UNDERSTAND THAT MY MEDICAL INFORMATION MAY BE NECESSARY FOR MY INSURANCE COMPANY TO PROCESS A CLAIM. I FURTHER UNDERSTAND THAT BY NOT SIGNING THIS RELEASE I ACCEPT FULL FINANCIAL RESPONSIBILITY AND WILL PAY ALL CHARGES AT THE TIME SERVICES ARE RENDERED.**

**ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY**

Although we are happy to assist you in submitting and appealing your claim, please understand that your insurance policy is an agreement between you and your insurance carrier. You are responsible for all lawfully incurred expenses whether or not covered by insurance.
At the time services are rendered your deductibles, co-payment or percentage portion is required.
We accept MasterCard, Visa, Discover, and American Express, checks, cash or money orders.

I hereby authorize transfer of any benefits to or for my benefit under hospitalization, sickness, accident, or any other insurance coverage for payment of services rendered to Obstetrix Medical Group of Dallas. I understand that should this account become delinquent, I will be financially responsible for collection and /or attorney's fees.

I agree to fulfill all policy provisions required by my insurance company.

My signature, or that of my representative, confirms my understanding of the above.

_______________________________ _____________________

Signature of Patient or Authorized Representative* Date

_______________________________

Printed name

## 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 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 that evolve over time, appearing normal at the time of the ultrasound exam but becomes 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. 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.

________________________________ ______________________
Signature of Patient or Authorized Representative* Date

________________________________
Printed name

OBSTETRIX MEDICAL GROUP
an affiliate of MEDNAX

**Today's Date** *Fecha de hoy*: ___________

**Patient Name** *Nombre* ____________________________ **Date of Birth** *Fecha de Nacimiento* _____________

**Social Security Number** *Numero de Seguro Social*: XXX-XX-________________

**Are you currently Pregnant?** □ **Yes**/Si □ No
*Esta embarazada*

**What is your height?** ___________________
*Su estatura*

**What was the first day of your last menstrual period?:**__________________
*Cuando fue el primer dia de su ultima regla*

**What is your due date?:**______________________ **What is your blood type?:**______________
*Cual es la fecha supuesta de parto* *Tipo de sangre*

**Have you had a sonogram / ultrasound during the current pregnancy?** □ **Yes**/Si □ **No**
*Ha tenido un sonograma / ultrasonido durante este emarazo*

**Do you wish to know the sex of the baby?** □ **Yes**/Si □ **No**
*Desea saber el sexo del bebe´*

**Is this an IVF pregnancy?** *Embarazo in vitro fertilization* □ **Yes**/Si □ **No**

**Are there any problems with your current pregnancy?:**__________________________________________________
*Tiene problems con este embarazo? Si la respuesta es si, describelos abajo*

**Prior Pregnancies**: *Embarazos anteriores:*

____ **Number of total pregnancies** / *Numero de embarazos*
____ **Number of pregnancies carried to full term** / *Numero de embarazos continuado a termino entregados prematuramente*
____ **Number of pregnancies delivered prematurely** / *Numero de embarazos*
____ **Number of miscarriages** / *Aborto espontaneos (aborto natural)*
____ **Number of tubal / ectopic pregnancies** / *Numero de embarazos de trompa / ectopicos*
____ **Number of abortions** / *Numero de abortos*
____ **Number of multiple births** / *Numero de embarazos multiples (gemelos, trillizos)*
____ **Number of living children** / *Numero de hijos viv*

**Complete the table below for each pregnancy (living or deceased) start with your first pregnancy**

*Llena la informacion en el cuadro abajo para cada embarazo, empezando con el primero*

| **Year** *Ano* | **Weeks (full term = 40 wks)** *Semanas* | **Labor Length** *Duracion de parto* | **Birth Weight** *Peso de nacimiento* | **Sex** *Sexo* | **Type of Delivery** (Vaginal / C-section) *Tipo de parto (vaginal o cesarean)* | **Type of Anesthesia** *Anestesia* | **Place of Birth** *Lugar de Nacimiento* |
|---|---|---|---|---|---|---|---|
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**How would you describe your ancestry (check all that apply):**

*Como describirias tu ascendencia (marca todos los aplicables)*

□ **White** *Blanco*
□ **French Canadian** *Canadiense Frances*
□ **Samoan** *Samoano*
□ **Vietnamese** *Vietnames*
□ **Asian-East Indian** *Asiatico – Indias* Orientales

□ **African** *Africano*
□ **Native American** *Americano Nativo*
□ **Chinese** *Chino*
□ **Laos**
□ **Hawaiian** *Hawaiano*

□ **Hispanic** *Hispano*
□ **Greek** *Griego*
□ **Cambodian** *Camboyano*
□ **Taiwanese** *Taiwanes*
□ **Guamanian** *Guamaniano*

□ **Ashkenazi Jewish** *Judio Askenazi*
□ **Italian** *Italiano*
□ **Filipino**
□ **Korean** *Coreano*
□ **Middle Eastern** *Medio Oriental*

□ **Japanese** Japones
□ **Other Southeast Asian**
□ **Unknown Race** ***Raza desconocida***
□ **Other** ______________

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

*Como describirias tu ascendencia del padre este bebe (marca todos los aplicables)*

□ **White** *Blanco*
□ **French Canadian** *Canadiense Frances*
□ **Samoan** *Samoano*
□ **Vietnamese** *Vietnames*
□ **Asian-East Indian** *Asiatico – Indias Orientales*

□ **African** *Africano*
□ **Native American** *Americano Nativo*
□ **Chinese** *Chino*
□ **Laos**
□ **Hawaiian** *Hawaiano*

□ **Hispanic** *Hispano*
□ **Greek** *Griego*
□ **Cambodian** *Camboyano*
□ **Taiwanese** *Taiwanes*
□ **Guamanian** *Guamaniano*

□ **Ashkenazi Jewish** *Judio Askenazi*
□ **Italian** *Italiano*
□ **Filipino**
□ **Korean** *Coreano*
□ **Middle Eastern** *Medio Oriental*

□ **Japanese Japones**
□ **Other Southeast Asian**
□ **Unknown Race Raza desconocida**
□ **Other** ______________

- **Are you and the father of this baby blood relatives (ex: cousins)?** □ **Yes/Si** □ **No**
  *Son parientes de sangre tu y el padre de este bebe? (por ejemplo, primos)*

- **What is your occupation? /***Cual es su ocupacion* ________________________________________

- **What is the name of the father of this baby?** ________________________________________
  *Cual es nombre del padre de este bebe*

- **What is the occupation of the father of this baby?**________________________________________
  *Cual es la ocupacion del padre de este bebe*

- **What is the age of the father of this baby?** *Cual es la edad del padre de este bebe* ____________________

- **Is the father of this baby your partner?** *Es el padre de este bebe tu pareja* □ **Yes/Si** □ **No**

- **Have you had exposure to:** *Ha tenido exposicion a***:**

| | | |
|---|---|---|
| ○ **Cat litter /** *Arena higienica de gato* | ○ **X-Rays**/ *Rayos X* | ○ **Chemicals/** *Quimicos* |
| ○ **Fever/** *Fiebre* | ○ **Infections/** *Infeccion* | ○ **Rashes/** *Erupcion* |

- **Do you or have you taken any medications in the last year?** □ **Yes/Si** □ **No**
  *Tomas actualmente o has tomado medicamentos durante el ultimo ano*

| **Medications taken /** *Medicamentos tomados* | **Date taken** / *Fecha que se tomaron* |
|---|---|
| | |
| | |
| | |
| | |

- **Have you taken any medications other than Prenatal vitamins since becoming Pregnant?** □ **Yes/Si** □ **No**
  *Has tomado algun medicamento aprte de las vitaminas prenatales desde qu quedaste embarazada*
  **If yes what type /** *que tipo***:**________________________________________

- **Do you smoke?** *Usted fuma* □ **Yes/Si** □ **No** **If yes, how much? S***i la respuesta es si, cuento* ____________

- **Have you used any street drugs since becoming pregnant** □ **Yes/Si** □ **No**
  *Has usado drogas desde que quedaste embarazada*
  **If yes what type /** *que tipo* ________________________________________

- **Have you consumed any alcoholic beverages since becoming pregnant** □ **Yes/Si** □ **No**
  *Has ingenido bebidas alcoholicas desde que quedaste embarazada*
  **If yes what type /** *que tipo*________________________________________

- **Are you allergic to any drugs or any other known allergies? If so, please specify**____________________
  *Tienes alergias a drogas/medicamento o tipo de alergias?? Si la respuesta es si, anotalos aqui*

- **Any other not mentioned above** / *Cualesquier otras afecciones herencia de familia* □ **Yes/Si** □ **No**
  Comments /Comentarios:________________________________________

**Do you, the father of this baby, or any close relatives have any of the following?**

**If yes, please specifiy which relative:**

*Tienes tu, el padre de este bebe o cualquier familiar inmediato cuualquiera de las siguientes afecciones*

| | | |
|---|---|---|
| • **Thalassemia (Greek, Mediterranean, or Asian Background) MCV <80**<br>*Talasemia (ascendencia griego, mediterranea o asiatico) MCV<80* | □ ***Yes/Si***_______________ | □ ***No*** |
| • ***Neural Tube Defect (Meningomyelocele Spina Bifida, or Anencephaly)***<br>*Defacto tubarico neural (meningomielocele espina bifida or anencefalia)* | □ ***Yes/Si***_______________ | □ ***No*** |
| • **Congenital Heart Defect /** *Defecto cardiac congenito* | □ ***Yes/Si***_______________ | □ ***No*** |
| • ***Down Syndrome*** */ Syndrome de Down* | □ ***Yes/Si***_______________ | □ ***No*** |
| • **Tay-Sachs (Jewish, Cajun, French Canadian)**<br>*(p.ej., Judo, Cajun, Canadiense frances)* | □ ***Yes/Si***_______________ | □ ***No*** |
| • **Sickle Cell Disease or Trait (African)**<br>*Enfirmedad o caracterstica drepanocitica (African)* | □ ***Yes/Si***_______________ | □ ***No*** |
| • **Hemophilia or Bleeding Problems /** *Hemofilia o problemas hemorragicos* | □ ***Yes/Si***_______________ | □ ***No*** |
| • **Muscular Dystrophy /** *Distrofia muscular* | □ ***Yes/Si***_______________ | □ ***No*** |
| • **Cystic Fibrosis /** *Fibrosis quistica* | □ ***Yes/Si***_______________ | □ ***No*** |
| • **Canavan Disease /** Enfermedad de Canavan | □ ***Yes/Si***_______________ | □ ***No*** |
| • **Mental Retardation/Autism/Learning Disorder**<br>*Atraso mental/autismo/trastomo de aprendizaje*<br>**If Yes; Tested for Fragile X? Si la respuesta es si, prueba de X fragil** | □ ***Yes/Si***_______________ | □ ***No*** |
| • **Huntington Chorea /** *Corea de Huntington* | □ ***Yes/Si***_______________ | □ ***No*** |
| • **Other Inherited Genetic or Chromosomal Disorder**<br>*Otro trastomo genetico o chromosomal heredado* | □ ***Yes/Si***_______________ | □ ***No*** |
| • **Maternal Metabolic Disorder ( Insulin dependent diabetic, PKU)**<br>*Trastomo metabolico materno ( p.ej. diabetes dependiente de insulin, PKU)* | □ ***Yes/Si***_______________ | □ ***No*** |
| • **Patient of Baby's Father had a child with Birth Defects not listed.**<br>*Pacienta o padre de este bebe a tenido un hijo con defectos no en esta lista* | □ ***Yes/Si***_______________ | □ ***No*** |
| • **Recurrent Pregnancy Loss or Stillbirth**<br>*Peridídas de embarazo o nacimientos muertos recurrentes* | □ ***Yes/Si***_______________ | □ ***No*** |
| • **Blindness or Deafness /** *Ceguera o sordera* | □ ***Yes/Si***_______________ | □ ***No*** |
| • **Bone or Skeletal Disorder (Dwarfism) /** *Trastomo oseo o esqueletico (enanismo)* | □ ***Yes/Si***_______________ | □ ***No*** |
| • **Breast, Ovarian or Colon Cancer /** *Cancer de mamas, ovarico o de colon* | □ ***Yes/Si***_______________ | □ ***No*** |
| • **Kidney Disorder /** *Trastornoo renal* | □ ***Yes/Si***_______________ | □ ***No*** |
| • **Do either you or any parents, siblings, or children have diabetes?**<br>*Tienes diabetes tu, tupadre/madre, hermanos/hermanas o hijos* | □ ***Yes/Si***_______________ | □ ***No*** |
| • **Blood Clots, Stroke /** *Coagulos sangineos, apoplejia* | □ ***Yes/Si***_______________ | □ ***No*** |

**Do you have or have you had any of the following conditions** / *Tienes o has tenido cualquiera de las siguientes afecciones*

| | | | |
|---|---|---|---|
| **Unexplained Fever** / *Fiebre inexplicada* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Ashtma** / *Asma* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Lung Problems** / *Problemas Pulmonares* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Heart Murmur** / *Mumullo Cardiaco* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Heart Disease** / Enfemedad Cardiaca | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Other Heart Problems** / *Otros Problemas Cardiacos* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **High Blood Pressure in Pregnancy** / *Alta Presion Durante el Embarazo* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **High Blood Pressure, Other** / *Alta Presion, otra* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Liver Problems** / Problemas Hepaticos | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Bladder or Kidney Infections** / *Infecciones de la Vejiga o Renales* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Kidney Stones** / *Calculos Renales* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Diabetes (High Blood Sugar)** / *Diabetes (azucar en sangre alto)* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Thyroid Problems** / *Problemas Tiroideos* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Other Hormone Problems** / *Otros Problemas Homonales* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Epilepsy, Seizure Disorder** / *Epilepsia, Trastorno Convulsivo* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Migraine, Cluster Headaches** / *Jaqueca , Cefalea Histaminica* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Other Recurring Headaches** / *Otros Dolores de Cabeza Recurrentes* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Depression** / *Depresion* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Panic Attack Disorder** / *Ataques de Panico, Trastorno de Panico* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Pyschiatric, Mental, Emotional Problems** / *Problemas Psiquiatricos, Mentales, emocionales* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Skin Problems** / *Problemas de la Piel* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Arthritis, Joint Pains** / *Arthritis, Dolor de las Articulaciones* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Lupus** | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Rheumatic Fever** / *Fiebre Reumatica* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Blood Transfusions** / *Tranfusiones de Sangre* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Bleeding Tendency** / *Tendencia Hemorragica* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Blood Clots, Thrombophlebitis** / *Coagulos Sanguineos, Tromboflebitis* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Rh Sensitized** / *Sensibilizacion del Factor Rh* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Any Known Allergies** / *Tiene Alergias Conocidas* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |
| **Any Past Surgeries ( If yes, please list below)** *Intervenciones Quirugicias previas (escribir abajo)* | □ **Yes/Si** | □ **No** | □ **Unsure** *No Segura* |

**Past Surgeries** / *Interveniones Quirugicas Previas*

| **Year** / *Ano* | **Type of Surgery** / *Tipo de Operacion* | **Type of Anesthesia** / *Tipo de Anestesia* | **Hospital/City** *Hospital/ Ciudad* |
|---|---|---|---|
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***Reviewed by:*** ____________________________________

***Providers Name***