Welcome to ROC!

Our patients are very important to us. Please understand that each patient scheduled at our office is potentially being seen for a different reason.

Due to the nature of our specialty, office delays can be caused by patients with unexpected medical complications. Unfortunately, this can cause the office to run behind schedule. We will do our best to accommodate your appointment time. Our goal is to provide each patient with the time and care that they require.

Please be patient with any delays and thank you for your understanding.

REGIONAL OBSTETRIC CONSULTANTS

Ramon A. Castillo, M.D. Gerardo O. Del Valle, M.D. Francisco L Gaudier, M.D.
Kathryn S. Villano, M.D. Joann G Acuna, M.D. Edgard E. Ramos-Santos, M.D.
Jill G. Mauldin, M.D. Maggie Davis, ARNP

PATIENT INFORMATION MEMO

Name: ______________________________ Birthdate: __________ Age: ______
Last First M. Initial

Address: ______________ Apt#: ____ City: __________ State: ____ Zip: ______
Race/Primary Language/Ethnicity: ______________________________
Cell Phone: ______________________ Home Phone: ______________________
Email Address: ______________________________
SS#: ______________________ Marital Status: ☐ S ☐ M ☐ D ☐ W
Patient's Employer: ______________________________
Business Address: ________________ City: __________ State: ____ Zip: ______
Business Phone: ________________ Occupation: ______________________

Name of Spouse: ________________ Birthdate: __________ SS#: __________
Business Address: ________________ City: __________ State: ____ Zip: ______
Business Phone: ________________ Occupation: ______________________

Name, Address and Phone Number of two relatives not at your address:

____

List of known allergies: ______________________________

I will pay today by: ☐ Cash ☐ Check ☐ MasterCard/Visa Insurance Authorization/Referral #

____

Health Insurance Information:

(Primary)	(Secondary)
Company: ______________	Company: ______________
Policy #: ______________	Policy #: ______________
Group #: ______________	Group #: ______________
Policy Holder ______________	Policy Holder ______________
Address to send insurance form: ______________	Address to send insurance form: ______________

Delivering Physician: ______________________________
Is this your first ultrasound for this pregnancy? ______________________
First day of last menstrual period? ________ / ________ / ________ Due Date: __________
How many full term infants? _____ Living? _____ Preterm? _____ Miscarriages or Abortions? _____

These physicians participate in the Florida Birth-Related Neurological Injury Compensation Associations (NICA)

PARTICIPATING INSURANCE – I hereby give consent to Regional Obstetric Consultants to provide whatever treatment they may deem necessary to the above patient. I hereby request payment of authorized benefits and/or any insurance benefits to be paid directly to Regional Obstetric Consultants for any services rendered to the patient by Regional Obstetrics Consultants. I authorize Regional Obstetric Consultants and staff to release my insurance carrier and its agents any information concerning healthcare, advice, and treatment provided to the patient, needed to to determine these benefits or the benefits payable for related services. I understand 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 guardian Date

REGIONAL OBSTETRIC CONSULTANTS

Financial Agreement

I hereby authorize Regional Obstetric Consultants to render services for my medical care. I understand that I am directly responsible for any fees that are not covered by my insurance company and it is my responsibility to arrange payment with Regional Obstetric Consultants for any bills incurred. I understand that I will be considered a self-pay patient and payment will be expected at the time of service, if I do not have insurance coverage.

I understand that it is my responsibility to provide Regional Obstetric Consultants with a copy of my **current** insurance card and to obtain a referral from my primary obstetrician (if required by my insurance). I will notify Regional Obstetric Consultants to release any information acquired and/or obtained during my services to my insurance company that may be necessary in the review of claims for reimbursement.

I have read and fully acknowledge, authorize and understand all the contents of the above information.

Signature: ______________________________________ Date: ___________

Printed Name: ___________________________________

Joann G. Acuna, M.D.
Ramon A. Castillo, M.D.
Maggie Davis, ARNP
Gerardo O. Del Valle, M.D.
Francisco L. Gaudier, M.D.
Jill G. Mauldin, M.D.
Edgard E. Ramos-Santos, M.D.
Kathryn S. Villano, M.D.

Medical History

Name: ☐Ms. ☐Mrs. ______________________________ **Name of OB** ______________________ **Date** ____________

Age _______ **Date of birth** _______________ **Race/Ethnicity** ______________________ **Due Date** ______________

Height _______ **ft** _______ **in** **Current weight** _________ **Prepregnancy weight** __________ **Blood Type** __________

PREGNANCY HISTORY (live births, miscarriages, abortions)

MM/YY	Sex	Weight	Vaginal or C-Section	Weeks at Delivery	Preterm Labor	Gestational Diabetes	High blood pressure	Birth Defects	Complications
					Y / N	Y / N	Y / N		
					Y / N	Y / N	Y / N		
					Y / N	Y / N	Y / N		
					Y / N	Y / N	Y / N		
					Y / N	Y / N	Y / N		
					Y / N	Y / N	Y / N		
	☐ Miscarriage ☐ Missed Abortion ☐ Elective abortion ☐ Ectopic _______ wks pregnant ☐ with D&C ☐ without D&C								
	☐ Miscarriage ☐ Missed Abortion ☐ Elective abortion ☐ Ectopic _______ wks pregnant ☐ with D&C ☐ without D&C								
	☐ Miscarriage ☐ Missed Abortion ☐ Elective abortion ☐ Ectopic _______ wks pregnant ☐ with D&C ☐ without D&C								

GYNECOLOGICAL HISTORY

Age menstrual period started ____________ Regular cycles ☐ Irregular cycles ☐ 1st Day of Last Period ______________

Length of menstrual period ______________ Days between menstrual periods ________________

	Yes	No			Yes	No
Abnormal PAP smear(s)	☐	☐	Date(s): ____________	HIV	☐	☐
Colposcopy	☐	☐	Date(s): ____________	Chlamydia	☐	☐
LEEP	☐	☐	Date(s): ____________	Gonorrhea	☐	☐
Cone biopsy	☐	☐	Date(s): ____________	Syphilis	☐	☐
Cryotherapy	☐	☐	Date(s): ____________	Herpes - If yes,	☐	☐
Infertility	☐	☐	HPV **Yes** ☐ **No** ☐	date of last outbreak: ______________		

Explain positives and treatment(s): ____

Use of fertility treatment this pregnancy? Yes ☐ No ☐ If yes, please indicate below:

☐ Clomid ☐ IUI (intrauterine insemination) or Ovulation induction

☐ IVF (in-vitro fertilization) ☐ ICSI (Intracytoplasmic sperm injection)

MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No
Hypertension	☐	☐	Ulcer	☐	☐	Seizure	☐	☐
Diabetes	☐	☐	Colitis	☐	☐	Migraines	☐	☐
Heart Murmur	☐	☐	Hepatitis	☐	☐	Blood clots	☐	☐
Heart Problems	☐	☐	Arthritis	☐	☐	Pulmonary embolus	☐	☐
Palpitations	☐	☐	Urinary tract problems	☐	☐	Transfusions	☐	☐
Tuberculosis	☐	☐	Kidney problems	☐	☐	Cancer(s)	☐	☐
Asthma	☐	☐	Thyroid problems	☐	☐	*If yes type(s):* ____________		

Explain Positives: ____

SURGICAL HISTORY

Year: ________ Type of surgery: ______________________ Year: ________ Type of surgery: ______________________

Year: ________ Type of surgery: ______________________ Year: ________ Type of surgery: ______________________

Explain any surgical complications: ____

MEDICATIONS/DRUG/ALLERGIES

Are you taking any medications (prescriptions, vitamins, herbs, alternative medications, over the counter)? Yes ☐ No ☐

If so, please list all and their dosage: ____

ALLERGY TO LATEX Yes ☐ No ☐
ALLERGY TO IODINE Yes ☐ No ☐

Do you have any medication allergies? Yes ☐ No ☐ If so please list below:

1. ________________ **2.** ________________ **3.** ________________ **4.** ________________

SOCIAL HISTORY

Married Yes ☐ No ☐ **Name of your partner/father of baby:** ______________________

Partner's age: ____________ **Partner's Race/Ethnic background:** ______________________

Do you (patient) **work outside the home?** Yes ☐ No ☐ **If so, what is your occupation?** ______________

Please indicate Yes or No for the following:

	Yes	No				Describe
Tobacco	☐	☐	Current ☐ Past ☐	How long quit ________	How much/often:	________
Alcohol	☐	☐	Current ☐ Past ☐	How long quit ________	How much/often:	________
Street drugs	☐	☐	**Name/Type(s) (list all):** ________			
			Current ☐ Past ☐	How long quit ________	How much/often:	________
Other:	☐	☐	**Name/Type(s) (list all):** ________			
			Current ☐ Past ☐	How long quit ________	How much/often:	________

FAMILY AND GENETIC HISTORY

	Yes	No		
Is your mother living?	☐	☐	**Age:** ______	**Medical problems:** ________
If deceased, age/cause of death? ________				
Is your father living?	☐	☐	**Age:** ______	**Medical problems:** ________
If deceased, age/cause of death? ________				
Do you have any brothers?	☐	☐	**How many/age(s)?** ________	
If deceased, age/cause of death? ________				
Do you have any sisters?	☐	☐	**How many/age(s)?** ________	
If deceased, age/cause of death? ________				

Do you, your partner, or your relatives have any of the following, if yes please explain:

	Yes	No	Who & Explain		Yes	No	Who & Explain
Diabetes	☐	☐	________	Mental retardation	☐	☐	________
Hypertension	☐	☐	________	Down syndrome	☐	☐	________
Cancer(s)	☐	☐	________	Muscular dystrophy	☐	☐	________
Lupus	☐	☐	________	Birth Defects	☐	☐	________
More than 3 miscarriages	☐	☐	________	Congenital heart defects	☐	☐	________
Clotting/bleeding disorders	☐	☐	________	Canvan disease (Jewish)	☐	☐	________
Thalassemia	☐	☐	________	Familial Dysautonomia (Jewish)	☐	☐	________
Sickle Cell trait/disease	☐	☐	________	Tay Sachs disease (Jewish)	☐	☐	________
Deafness	☐	☐	________	Huntington's Chorea	☐	☐	________
Neural Tube defects **(Spina bifida, Meningomyelocele or Anencephaly)**	☐	☐	________	Fragile X	☐	☐	________
				Cystic Fibrosis	☐	☐	________

Any other condition not listed above: ____

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 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. 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

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 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

____
Print Name of Patient/Authorized Representative