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.
PATIENT INFORMATION MEMO

Name: _______________________________ Birthdate: _______________ Age: __________

Last Name  First Name  M. Initial

Address: ____________________________ Apt#: _______ City: _______________ State: _____ Zip: ______

Race/Primary Language/Ethnicity: ________________________________

Cell Phone: ___________________________ Home Phone: ___________________________

Email Address: ________________________________________________

SS#: __________________________________________________________

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 Obstetrics 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 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: _______________________________
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)

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<thead>
<tr>
<th>MM/YY</th>
<th>Sex</th>
<th>Weight</th>
<th>Vaginal or C-Section</th>
<th>Weeks at Delivery</th>
<th>Preterm Labor</th>
<th>Gestational Diabetes</th>
<th>High blood pressure</th>
<th>Birth Defects</th>
<th>Complications</th>
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<td>Y / N</td>
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</tbody>
</table>

- □ 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 ____________

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

Infertility  □ Yes □ No  HPV □ Yes □ No

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

Hypertension  □ Yes □ No  Ulcer  □ Yes □ No  Seizure  □ Yes □ No
Diabetes  □ Yes □ No  Colitis  □ Yes □ No  Migraines  □ Yes □ No
Heart Murmur  □ Yes □ No  Hepatitis  □ Yes □ No  Blood clots  □ Yes □ No
Heart Problems  □ Yes □ No  Arthritis  □ Yes □ No  Pulmonary embolus  □ Yes □ No
Palpitations  □ Yes □ No  Urinary tract problems  □ Yes □ No  Transfusions  □ Yes □ No
Tuberculosis  □ Yes □ No  Kidney problems  □ Yes □ No  Cancer(s)  □ Yes □ No
Asthma  □ Yes □ No  Thyroid problems  □ Yes □ No

Explain Positives: ____________

SURGICAL HISTORY

Year: _______ Type of surgery: ________________________  Year: _______ Type of surgery: ________________________
**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. ____________________

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**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:

<table>
<thead>
<tr>
<th>Tobacco</th>
<th>Yes ☐ No ☐</th>
<th>Current ☐ Past ☐</th>
<th>How long quit ________</th>
<th>How much/often: ____________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Yes ☐ No ☐</td>
<td>Current ☐ Past ☐</td>
<td>How long quit ________</td>
<td>How much/often: ____________________</td>
</tr>
<tr>
<td>Street drugs</td>
<td>Yes ☐ No ☐</td>
<td>Name/Type(s) (list all): Current ☐ Past ☐</td>
<td>How long quit ________</td>
<td>How much/often: ____________________</td>
</tr>
</tbody>
</table>

Other: Yes ☐ No ☐

Name/Type(s) (list all): Current ☐ Past ☐

How long quit ________  How much/often: ____________________

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**FAMILY AND GENETIC HISTORY**

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

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

<table>
<thead>
<tr>
<th>Diabetes</th>
<th>Yes ☐ No ☐</th>
<th>Who &amp; Explain: Mental retardation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>Yes ☐ No ☐</td>
<td>Who &amp; Explain: Down syndrome</td>
</tr>
<tr>
<td>Cancer(s)</td>
<td>Yes ☐ No ☐</td>
<td>Who &amp; Explain: Muscular dystrophy</td>
</tr>
<tr>
<td>Lupus</td>
<td>Yes ☐ No ☐</td>
<td>Who &amp; Explain: Birth Defects</td>
</tr>
<tr>
<td>More than 3 miscarriages</td>
<td>Yes ☐ No ☐</td>
<td>Who &amp; Explain: Congenital heart defects</td>
</tr>
<tr>
<td>Clotting/bleeding disorders</td>
<td>Yes ☐ No ☐</td>
<td>Who &amp; Explain: Canvan disease (Jewish)</td>
</tr>
<tr>
<td>Thalassemia</td>
<td>Yes ☐ No ☐</td>
<td>Who &amp; Explain: Familial Dysautonomia (Jewish)</td>
</tr>
<tr>
<td>Sickle Cell trait/disease</td>
<td>Yes ☐ No ☐</td>
<td>Who &amp; Explain: Tay Sachs disease (Jewish)</td>
</tr>
<tr>
<td>Deafness</td>
<td>Yes ☐ No ☐</td>
<td>Who &amp; Explain: Huntington’s Chorea</td>
</tr>
<tr>
<td>Neural Tube defects (Spina bifida, Meningomyelocoele or Anencephaly)</td>
<td>Yes ☐ No ☐</td>
<td>Who &amp; Explain: Fragile X</td>
</tr>
<tr>
<td>Cystic Fibrosis</td>
<td>Yes ☐ No ☐</td>
<td>Who &amp; Explain: Cystic Fibrosis</td>
</tr>
</tbody>
</table>

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