The Perinatal Center

PATIENT INFORMATION

PLEASE READ ENTIRE FORM

We want to welcome you to The Perinatal Center.
Below is some helpful information about your appointment.

PLEASE BRING ALL MEDICATIONS

Please be on time for your scheduled appointment. If you are more than 15 minutes late to your appointment you may be asked to reschedule. Please be sure and call our office if you think you are going to be late.

EMERGENCIES- Please note that we are not a typical OB/GYN office. We do have occasional emergencies which require our immediate attention. We will always do our best to keep you informed, but please understand if your appointment is delayed that we try to provide the optimal care to all our patients. We apologize for any delays you may experience. We understand that your time is valuable but we do ask that you allow TWO hours for your appointment.

You do not need to drink large quantities of water before your exam.

We do NOT allow the ultrasounds to be video taped or recorded by patients or family members.

Access our website at www.perinatalcenter.com for patient information and New Patient paperwork.

THE PERINATAL CENTER, PLLC

PATIENT INFORMATION

Name:_____Date:_____

Address:_____City_____ZIP_____

Home Ph:_____Work Ph:_____Cell Ph:_____

Date of birth:_____Age: _____SS#:_____

Employer:_____

Email Address _____

IN CASE OF APPOINTMENT CHANGE OR EMERGENCY, NOTIFY:

Name: _____Ph:_____Relation:_____

Fill in the information of the policy holder even if we have made a copy of your card.
This is info that cannot be obtained from the card.

Insurance #1 Name:	Insurance #2 Name:
Name of Policy Holder:	Name of Policy Holder:
SS#	SS#
DOB: Relationship to Patient:	DOB: Relationship to Patient:
Employer:	Employer:

Referring Physician:_____Ph:_____

Referring Pharmacy:_____Ph:_____

(PLEASE SIGN ALL THREE LINES)

I authorize medical treatment for myself or my family member. I understand that I am responsible for all charges incurred, regardless of insurance status. I agree to pay for services as they are provided and pay promptly upon receipt of a statement.

X _____ _____

SIGNATURE OF PATIENT Date

I authorize my insurance company to pay these providers for services filed on my behalf. This assignment will remain in effect until revoked by me in writing. I authorize release of information necessary to secure payment from my insurance.

X _____ _____

SIGNATURE OF PATIENT Date

I acknowledge I have been provided with a PATIENT PRIVACY NOTICE that provides a description of information uses and disclosures.

X _____ _____

Signature of PATIENT or legal representative Date

THE PERINATAL CENTER

Name:_____Date of Visit:_____Date of Birth:_____

Race:_____ Your age when you deliver:_____ Age of the father of baby:_____

Reason for visit / Current Problem:_____

LIST ALL PRIOR PREGNANCIES BELOW ALONG WITH ANY COMPLICATIONS OR PROBLEMS

Year	Circle *D*elivery *M*iscarriage or *A*bortion	Circle delivery type	Weeks at delivery	Gender	Birth weight	Complications
	D M A	Vag C/S		M F		
	D M A	Vag C/S		M F		
	D M A	Vag C/S		M F		
	D M A	Vag C/S		M F		
	D M A	Vag C/S		M F		

Total number of living children _____

Pregnancy/Gynecological History (please circle answer, if yes please explain on line)

Date of last menstrual cycle: _____ Regular periods: Y N _____ Due Date:_____
In vitro Fertilization: Y N – Transfer date: _____

Have you ever been told you have a uterine abnormality: Y N _____
Have you ever been diagnosed with an STD: Y N _____
Have you ever had abnormal PAP smear : Y N _____
Have you ever had a cervical procedure: Y N _____

Have you had an Ultrasound with this pregnancy: Y N At how many weeks?_____

Have you had screening for Down Syndrome, Spina Bifida and Trisomy 18: Y N
When and do you know the results?_____

Have you had any complications with your **current** pregnancy: Y N
Please explain:_____

Do you have any questions or concerns you would like to discuss with the physician today: Y N
Please explain:_____

Personal Medical History (please circle answer, if yes please explain on line)

1. Heart/Cardiac.....Y/N_____
2. Diabetes.....Y/N_____
3. Seizures/Epilepsy.....Y/N_____
4. High Blood Pressure .....Y/N_____
5. Asthma.....Y/N_____
6. Depression.....Y/N_____
7. Tuberculosis.....Y/N_____
8. Hepatitis.....Y/N_____
9. Thyroid Dysfunction.....Y/N_____
10. Blood Transfusion / Disorders Y/N_____
11. Autoimmune Disorders....Y/N_____
12. Alcohol, Tobacco, or Illegal Drug use...Y/N_____

Type: Current or Past: Amount daily:

_____
_____

13. Allergies (medicine or latex) _____
14. Surgeries (list type and year)_____
15. Other significant medical _____
16. Current Medications (prescribed, over the counter, herbal supplements, and vitamins)

Medication: Dosage: Frequency:

Patient Name: _____

THE PERINATAL CENTER

GENETIC HISTORY:

Have you or any member of either family ever had:	Patient's Family	Father of Baby
A child with mental retardation?	☐ Yes ☐ No	☐ Yes ☐ No
A child with Down Syndrome?	☐ Yes ☐ No	☐ Yes ☐ No
A child with a chromosomal problem?	☐ Yes ☐ No	☐ Yes ☐ No
Learning problems or developmental delay?	☐ Yes ☐ No	☐ Yes ☐ No
Cleft lip and / or palate?	☐ Yes ☐ No	☐ Yes ☐ No
Heart defect?	☐ Yes ☐ No	☐ Yes ☐ No
Spina Bifida, Skull Defect or Anencephaly?	☐ Yes ☐ No	☐ Yes ☐ No
Cystic Fibrosis?	☐ Yes ☐ No	☐ Yes ☐ No
Have you been screened for Cystic Fibrosis w/ this pregnancy?	☐ Yes ☐ No	☐ Yes ☐ No
Muscle or Neuromuscular disease?	☐ Yes ☐ No	☐ Yes ☐ No
Hemophilia?	☐ Yes ☐ No	☐ Yes ☐ No
Sickle cell anemia, Thalassemia or other blood disorder?	☐ Yes ☐ No	☐ Yes ☐ No
Kidney Disorder?	☐ Yes ☐ No	☐ Yes ☐ No
Huntington's Disease?	☐ Yes ☐ No	☐ Yes ☐ No
Tay Sach's, Canavan disease, or Familial Dysautonomia?	☐ Yes ☐ No	☐ Yes ☐ No
Any birth defects or genetic diseases not listed above?	☐ Yes ☐ No	☐ Yes ☐ No

Are you and the father of the baby related by blood ? ☐ Yes ☐ No

If you answered "yes" to any of the above questions, Please state how the affected individual is related to you and any known details about their condition._____

_____

_____

THE PERINATAL CENTER
MATERNAL-FETAL MEDICINE

IMAGE EMAIL CONSENT

This disclaimer and authorization agreement sets forth terms and conditions under which you, the undersigned patient authorize The Perinatal Center to transmit your ultrasound images to an email address of your choice. This agreement will become effective on the date of your signature and will terminate after all the images throughout your current pregnancy are sent to you. The Perinatal Center is not responsible for the security of the ultrasound images once the email recipients you have designated download the images. By directing The Perinatal Center to transmit the images to an email address that you specify, you authorize The Perinatal Center to provide images to the person who owns or uses the email address and any persons who may have access to the email address.

☐ I want my ultrasound images delivered digitally as an email attachment.

Email address: _____

☐ I authorize the send of images during my pregnancy.

☐ I have read, understand and agree to this disclaimer.

Name: _____ Date: _____

Signature: _____