PATIENT INFORMATION

Please complete all blanks

PATIENT

NAME LAST	FIRST	MI	AGE	DATE OF BIRTH	RACE	ARE YOU PREGNANT?

ADDRESS	CITY	STATE	ZIP	PHONE	CELL/PAGER

SOCIAL SECURITY NUMBER	MARITAL STATUS □ MARRIED □ DIVORCED □ SINGLE □ WIDOWED	HAVE YOU BEEN TREATED BY THESE PHYSICIANS BEFORE? □ YES □ NO	UNDER WHAT NAME	DATE

OCCUPATION	NAME OF EMPLOYER OR SCHOOL

EMPLOYER'S ADDRESS	CITY	STATE	ZIP	PHONE

WHO REFERRED YOU TO OUR OFFICE? NAME	ADDRESS

PREFERRED PHARMACY NAME	PHONE NUMBER

WHO IS YOUR PRIMARY CARE PHYSICIAN? NAME	ADDRESS	PHONE

IN CASE OF EMERGENCY NOTIFY:	NAME	ADDRESS, CITY, STATE, ZIP	PHONE

HUSBAND OR RESPONSIBLE PARTY

NAME	ADDRESS, CITY, STATE, ZIP	PHONE

SOCIAL SECURITY NUMBER	OCCUPATION	NAME OF EMPLOYER	DATE OF BIRTH

EMPLOYER'S ADDRESS	CITY	STATE	ZIP	PHONE

INSURANCE

PRIMARY INSURANCE	MAIL TO: STREET ADDRESS	CITY	STATE	ZIP	PHONE

POLICY HOLDER (IF GROUP, EMPLOYER)	INSURED'S NAME	□ GROUP □ PRIVATE	POLICY OR I.D. #	GROUP OR OTHER #

SECONDARY INSURANCE	MAIL TO: STREET ADDRESS	CITY	STATE	ZIP	PHONE

POLICY HOLDER (IF GROUP, EMPLOYER)	INSURED'S NAME	□ GROUP □ PRIVATE	POLICY OR I.D. #	GROUP OR OTHER #

PLEASE READ AND SIGN

In order to control our costs of billing, we request that office visits be paid at the time service is rendered. We would rather control our billing costs than be forced to raise our fees. A billing fee may be assessed after 60 days.

_____ **PLEASE NOTE: You will receive a separate bill from the lab for any lab services performed in this office.**
(INITIAL)

_____ **PLEASE NOTE: There will be a $35.00 charge for returned checks to be electronically debited from your checking account.**
(INITIAL)

AUTHORIZATION

I hereby authorize Mid-South Maternal Fetal Medicine, P.C. to release any information concerning my treatment and hereby irrevocably assign to them all insurance benefits for my treatment I understand that I am financially responsible for payment of all charges at the time they are rendered including any charges in excess of my insurance reasonable and customary, whether or not covered by Medicare or other insurance. I understand that I am responsible for verifying my insurance coverage & pre-certifying my benefits with my insurance company, I also understand that I am responsible for reasonable collection costs and / or attorney fees incurred in the collection of this account. A photocopy of this statement is considered to be as valid as an original.

I acknowledge receipt of the Notice of Privacy Practices that was given to me by this Practice.

My signature below acknowledges consent to treat

Signed: _____ **Date:** _____

MID-SOUTH MATERNAL FETAL MEDICINE, P.C.

Summary and Signature Page

I hereby acknowledge that I have been provided a Privacy Notice for Mid-South Maternal Fetal Medicine, P.C. and understand my rights as a patient.

I understand that my protected health information (PHI) can be used for my treatment, payment and health care operations.

I understand that I have certain rights to restrict the use and disclosure of my PHI, to obtain a copy of the Notice of Privacy Practices and Protected Health Information, to amend in order to correct incomplete or incorrect information in my records, to receive an accounting of disclosures of my PHI, and to request that communication of my PHI be made by alternative means or at an alternative location. '"

I understand that I can request additional information by contacting Lydia Bors-Koefoed at 901-682-2595.

I understand that I can file a complaint by contacting Lydia Bors-Koefoed and that I may also file a complaint by contacting the Secretary of Health and Human Services at 200 Independence Avenue SW, Room 615F, Washington, D.C. 20201.

I understand that I may be contacted by your office for appointment reminders, alternative treatment information, and with information about other health-related benefits and services.

Unless I object, my PHI may be disclosed to assist in notifying a family member, and/or certain other individuals responsible for my care about my location, general condition or my death. My PHI may also be disclosed to assist in disaster relief efforts.

I understand that my PHI may be disclosed as mandated and without my authorization in the following instances:

Controlling Disease	Research
Child Abuse and Neglect	Threat to Health and Safety
Abuse, Neglect, or Domestic Violence	Specialized Government Functions
Judicial/Administrative Procedures	Workers' Compensation

I understand that my PHI may be disclosed as mandated and without my authorization to the following agencies/individuals:

Food and Drug Administration (FDA)	Organ Procurement Organizations
Oversight Agencies	Correctional Institutions
Law Enforcement	Coroners, Medical Examiners, Funeral Dir.

I understand that other uses of my PHI will be made only as otherwise authorized by law or with my written authorization which I may revoke except to the extent information or actions have already been taken.

_____ _____

Signature Date

MID SOUTH MATERNAL FETAL MEDICINE, P.C.
Authorization to release information

Patient's Name: _____

I hereby authorize Mid South Maternal Fetal Medicine to release information regarding my protected health information to include account status, test results and scheduled appointments and information regarding my health care to the persons listed below:

PLEASE PRINT ALL NAMES-YOUR OB DOCTOR WILL RECEIVE ALL RESULTS

Please note any person NOT listed above WILL NOT be able to obtain any information whatsoever; however, you do not need to list other physicians or insurance companies.

_____
_____
_____
_____

When notifying me of lab or test results or matters relating to prescriptions, the practice may call:

Home: Yes____ No____ Home # _____
Can the practice leave you a message on your answering machine? Yes ___ No ___

Work: Yes____ No_____ Work # _____

Cell: Yes____ No____ Cell # _____

THE PATIENT PORTAL IS FOR NON-EMERGENCY USE ONLY. ALL MESSAGES ARE RETURNED WITHIN 3 BUSINESS DAYS.

Please list your Pharmacy and their telephone # you would like medications called in:
_____

Please list any other special instructions we should know about you: _____
_____

_____ _____
Patient Signature Date

Mid-South Maternal Fetal Medicine

Medical History & Review of Systems

In order to provide for your health needs concerning your medical care, we would like you to answer the following questions. This information will become a part of your confidential medical record.

Patient's Name: _____ **Age:** _____ **Today's Date:** _____

Reason for visit: _____

Allergies and reaction: _____ **Latex allergy?** _____

Medications you are taking, please include dosage and frequency: _____
_____

Reproductive History:
Primary OB: _____
Last Menstrual Cycle: _____ Due Date: _____
If pregnancy is result of IVF, what was the implantation date? _____
How many times have you been pregnant (including miscarriages and abortions)? _____
Number of abortions/miscarriages: ____ Number of living children: ____

Year	Vaginal/C-section/Abortion	Boy/Girl	Weight	#Weeks at delivery	Complications of pregnancy	Living?

Any history of clots, HELLP/Toxemia, or small for gestation with previous pregnancies?
_____
When was your last/most recent PAP smear? _____
Any history of abnormal PAP smears? _____ When? _____
Any history of procedures on your ovaries, tubes, uterus, or cervix? ____ When? _____
Age at first menstrual cycle? _____ Are your cycles regular/monthly? _____
Any history of STDs (Gonorrhea, Chlamydia, Trichamonas, Herpes, Syphillis, Genital Warts, HIV)? _____
_____

Personal History:
Personal history of medical/psychiatric illnesses: _____
Past history of surgeries/injuries/hospitalizations: _____

Pre-pregnant Weight: _____ Height: _____

Social:
Marital Status: _____ Employment: _____ Full/Part-time: _____
Do you smoke? _____ Cigarettes or Cigars? _____ #packs/day _____ How many years? _____
If you have quit, when did you quit? _____
Do you use Marijuana? _____ How often? _____ Last used? _____
Do you use illicit(street) drugs? _____ What do you use? _____ How often? _____ Last used? _____
Do you use corticosteroids/NSAIDS? ___ What do you use? _____ How often? _____ Last dose? ___
Do you drink alcohol? _____ What type? _____ How much? _____ How often? _____
Do you use caffeine? _____ How much? _____ How often? _____
Do you have indoor pets? _____ What kind? _____
Do you have any spiritual beliefs/values that may affect your care? _____

Family: Biological/Blood-related – siblings, parents, grandparents
# of brothers living? _____ # deceased? _____
# of sisters living? _____ # deceased? _____
Mother living, cause of death: _____ Father living, cause of death: _____
Maternal grandmother living, cause of death: _____
Maternal grandfather living, cause of death: _____
Paternal grandmother living, cause of death: _____
Paternal grandfather living, cause of death: _____

Do any of your blood relatives have or have a history of:
____ High Blood Pressure
____ High Cholesterol
____ Stroke
____ Asthma
____ Thyroid Problems
____ High Blood Sugar (Diabetes)
____ Heart trouble
____ Cancer, Type: _____
____ Arthritis
____ Sickle Cell Disease/Trait
____ Genetic disorders (SIDS, Down Syndrome, Cleft lip/palate, Extra digits, etc…)
____ Pre-eclampsia/Toxemia (mother or sister)

Review of Systems: (check all that apply to you)

CONSTITUTIONAL
___ Chills
___ Daytime drowsiness
___ Fatigue
___ Fever
___ Night sweats
___ Weight gain/loss

EYES
___ Wear glasses/contacs
___ Visual Changes
___ Seeing of spots/floaties
Last eye exam _____

EARS/NOSE/THROAT
___ Loss of hearing
___ Ringing in ears
___ Ear aches
___ Drainage from ears
___ Sinus trouble
___ Frequent nose bleeds
___ Sore throat

RESPIRATORY
___ Asthma
___ Recent bronchitis/chest cold
___ Cough
___ Shortness of breath
Last chest X-ray _____

HEART
___ Heart attack
___ High Blood Pressure
___ Heart Murmur
___ Chest pain
___ Heart failure
___ Palpitations, racing, pounding
___ Shortness of breath with activity
___ Stroke, mini stroke, TIA
___ Blood clot in artery or vein
___ Passing out spells
___ Swelling of legs
___ Heart surgery
Last EKG _____

STOMACH
___ Ulcer
___ Frequent heartburn
___ Acid reflux/Hernia
___ Poor appetite
___ Gallbladder attacks
___ Frequent diarrhea
___Chronic constipation
___ Blood in stools
___ Hemorrhoids
___ Nausea/vomiting

ENDOCRINE
___ Thyroid disorder
___ Hair loss
___ Goiter
___ Autoimmune disease
___ Diabetes
Last HgbA1c _____

KIDNEYS
___ Disease or failure
___ Stones/Infection
___ Pain with urination
___ Incontinence
___ Blood in urine

MUSCLE/Bones
___ Arthritis/Joint Disease
___ Chronic Back trouble
___ Bone or joint surgery

ALLERGY
___ Anaphylaxis
___ Food Intolerance
___ Itching
___ Rash
___ Nasal congestion

SKIN
___ Rash, dermatitis
___ History of skin cancer
___ Abnormal mole

Nervous System
___ Headache
___ Depression
___ Seizures/Epilepsy
Date of last seizure ____

PSYCHOLOGICAL
___ Anxiety
___ Loss/change of appetite
___ Behavior/mood change
___ Bipolar disorder
___ Convulsions
___ Depression
___ Insomnia
___ Memory loss

BLOOD
___ Bleeding or bruising
___ History of blood transfusion
___ History of hepatitis

WOMEN
___ Painful periods
___ Excessive flow
___ Irregular cycles
___ Vaginal burning
___ Vaginal itching
___ Vaginal discharge

AUTOIMMUNE/CLOTTING DISORDERS
___ Lupus – Systemic or Discoid
___ Antiphospholipid Antibody
___ Antithromibin III Deficiency
___ Anticardiolipin Antibody
___ Protein S Deficiency
___ Protein C Deficiency
___ MTHFR
___ Factor V Leiden
___ Homocysteine

Please sign below after you have completed this form to the best of your ability and knowledge.

Signature: _____ **Date:** _____

MID-SOUTH
MATERNAL
FETAL
MEDICINE, P.C.

NOTICE

Medical Related Forms

Please note that effective August 1, 2005, there will be a $20.00 fee to complete all forms and/or to copy your medical records. We ask that this fee be paid at the time of the request.

In order to comply with your requests in a professional and efficient manner, we ask that you allow 2-3 working days for the forms to be completed. If you are going to pick the forms back up at our office, please call to ensure forms are ready.

If you like for the forms to be mailed to you or forwarded elsewhere, please supply us with an addressed envelope with the correct address.

We appreciate your consideration and patience along with the ability to better serve you.

_____ _____

Patient Signature Date