

MID-SOUTH
MATERNAL
FETAL
MEDICINE, P.C.

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 <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED		HAVE YOU BEEN TREATED BY THESE PHYSICIANS BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> 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

<u>PRIMARY INSURANCE</u>		MAIL TO: STREET ADDRESS		CITY	STATE	ZIP	PHONE
POLICY HOLDER (IF GROUP, EMPLOYER)		INSURED'S NAME		<input type="checkbox"/> GROUP <input type="checkbox"/> PRIVATE	POLICY OR I.D. #		GROUP OR OTHER #
<u>SECONDARY INSURANCE</u>		MAIL TO: STREET ADDRESS		CITY	STATE	ZIP	PHONE
POLICY HOLDER (IF GROUP, EMPLOYER)		INSURED'S NAME		<input type="checkbox"/> GROUP <input type="checkbox"/> 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.

(INITIAL) **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.**

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: _____



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

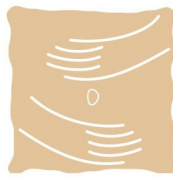
I understand that my PHI may be disclosed as mandated and without my authorization to the following agencies/individuals:

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.

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 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 # _____

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, Trichomonas, Herpes, Syphilis, 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 Blood Sugar (Diabetes)
- ___ High Cholesterol
- ___ Heart trouble
- ___ Stroke
- ___ Cancer, Type: _____
- ___ Asthma
- ___ Arthritis
- ___ Thyroid Problems
- ___ 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/contacts
- ___ 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
- Antithrombin 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:** _____



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