Austin Maternal-Fetal Medicine

Name _____ Date of Birth _____

Pregnancy History **Current Pregnancy**: IMP _____ EDD _____

Total # of Pregnancies	# of Term Births (>37 wks)	If of Premature Births (<37 wks)	# of Abortions	# of Miscarriages	# of Ectopic Pregnancies	# of Multiple Births (twins etc.)	# of Living

#	Month / Year	Weeks Pregnant	Birth Weight	Sex M/F	Delivery Type (Vaginal, C-Section, Vacuum, VBAC, D&C)	Place of Delivery	Comments/Complications (Diabetes. Hypertension, Preeclampsia, Pre-term labor/delivery etc.)
1							
2							
3							
4							
5							
6							

* Please continue on back side if previous pregnancies >6

Medical History

	Y/N	For Yes, please Include dates, treatment and treating Physician		Y/N	For Yes, please Include dates, treatment and treating Physician
Diabetes			Drug or Latex Allergies/Reactions		
Hypertension			Gastrointestinal Disorders		
Heart Disease/Murmur			Anemia/Blood transfusion		
Stroke/blood clots Pulmonary embolism			Hepatitis/liver Disease		
Kidney Disease/UTI			Depression/Anxiety or Psychiatric d/o		
Autoimmune Disorder			History of Abnormal Pap		
Neurologic/seizures (migraines)			Breast		
Pulmonary (TB, Asthma)			Uterine Abnormalities		
Thyroid dysfunction			Infertility/ fertility treatments		
For any relevant family history, please list illness and relationship:					

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Surgical History

General Surgery	Yes	No	Comments	Gynecological Surgery	Yes	No	Comments
Tonsillectomy				LEEP			
Cholecystectomy				Cold Knife Conization			
Appendectomy				Myomectomy			
Back Surgery				Hysteroscopy			
Gastrointestinal Surg.				Oophorectomy/Cystectomy			
Thyroidectomy				Salpingectomy			

Current Medications/Preferred Pharmacy

(Include vitamins/supplements)

	Medication Name	Dosage & Frequency		Medication Name	Dosage & Frequency
1			4		
2			5		
3			6		
Preferred Pharmacy Name/Phone Number:					

* if >6 medications please use back of form

Social History

	Amt/Day PrePreg	Amt/Day Preg	44 years use
Tobacco use			
Alcohol use			
Illicit/recreational drug use			

1. Are you on a special diet, if so list _____
2. Have you been or are you in an abusive relationship? _____
3. Will you accept blood products In an emergency? _____
4. Have you been exposed to any infectious disease or recently had a rash or fever? _____

Genetic History

Personal or Family History	Yes	No		Personal or Family History	Yes	No	
Patients age 235 Years at Estimated Date of Delivery	☐	☐		Hemophilia or other blood disorders	☐	☐	
Thalassernia (Italian, Greek Mediterranean or Asian Background) MCV <80	☐	☐		Muscular Dystrophy/Neuromuscular Disease	☐	☐	
Neural Tube Defect (Spina Bifida, Anencephaly or Meningomyelocele)	☐	☐		Cystic Fibrosis	☐	☐	
Congenital Heart Defect	☐	☐		Huntington's Chorea	☐	☐	
Down Syndrome	☐	☐		Mental Retardation or Autism (If yes, were they tested for Fragile X? Yes No)	☐	☐	
Tay Sachs (Jewish, Cajun, French Canadian)	☐	☐		Cleft lip/cleft palate	☐	☐	
Canavan Disease	☐	☐		Consanguinity (related)	☐	☐	
Sickle Cell Disease or Trait (African)	☐	☐		Other Inherited Chromosomal Disorder Not Listed	☐	☐	

Genetic Screening

Have you or your partner had carrier testing or have you had any of the following tests? Please circle

Cystic Fibrosis	You	Partner	First Trimester Screen	Yes	No	
Spinal Muscular Atrophy (SMA)	You	Partner	Cell Free DNA (Harmony, Panorama etc.)	Yes	No	
Fragile X	You	Partner	Chorionic VIM Sampling (CVS)	Yes	No	
Other genetic disorders	You	Partner	Amniocentesis (Amnia)	Yes	No	

Would you like any of the above testing or other testing not listed? Please list tests _____

_____

Is there anything else you would like us to know that will impact your medical care? _____

_____

Austin Maternal Fetal Medicine

☐ Dr. ☐ Miss ☐ Mrs. ☐ Ms.

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name _____

Address: _____

City, State _____ ZIP_____ Pharmacy _____ Pharmacy Phone: _____

Home Phone: _____ Cell:_____ Work Phone: _____

Primary Care Provider _____ Referring Provider_____

Date of Birth MM_____ /DD_____ /YYYY _____ Sex ☐ Female ☐ Male ☐ Transgender

Race ☐ American India/ Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language : ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other: _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number: _____-____-_____ Employer Name: _____

Employment Status ☐ 1-Full Time ☐ 2-Part Time ☐ 3-Not Employed ☐ 4-Self Employed ☐ 5-Retired ☐ 6-Active Military

Student Status ☐ F-Full Time Student ☐ P-Part Time Student ☐ N-Not a Student

Emergency Contact Last Name: _____ First Name: _____

Emergency Contact Phone Number _____ Do you have a living will? ☐ Yes ☐ No

Relationship to Patient _____ ☐ Guardian

Emergency Contact Address _____

City, State _____ Zip_____ Home Phone: _____ Work Phone: _____

RESPONSIBLE PARTY INFORMATION (Information used for patient balance statements)

Responsible Party ☐ Self ☐ Guarantor ☐ Other: _____ Relationship: _____ ☐ Info is the same as patient

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Date of Birth MM_____ /DD_____ /YYYY_____ Social Security Number: _____ ☐ Male ☐ Female

Address _____

City, State _____ Zip _____ Phone _____

Employer _____ Employer Phone _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company _____ Phone _____

Name of Insured _____ DOB of Insured MM _____/DD_____/YYYY_____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company _____ Phone _____

Name of Insured _____ DOB of Insured MM _____/DD_____/YYYY_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient/Responsible Party Signature_____ **Date** _____

_____ (patient initials) **Financial Responsibility:**

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Austin Maternal Fetal Medicine, PLLC (may be referred to as "The Practice") and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify Austin Maternal Fetal Medicine of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Austin Maternal Fetal Medicine and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

_____ (patient initials) **Assignment of Benefits:**

I authorize direct remittance of payment of all insurance benefits, including Medicare if I am a Medicare beneficiary, to Austin Maternal Fetal Medicine for all covered medical services and supplies provided to me during all courses of treatment and care provided by the Practice and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Austin Maternal Fetal Medicine, and will constitute a continuing authorization, maintained on file with the Practice, which will authorize and allow for direct payment to Austin Maternal Fetal Medicine of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by the practice.

_____ (patient initials) **Notice of Privacy Practices:**

acknowledge that I have been given the Austin Maternal Fetal Medicine Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.

_____ (patient initials) **Insurance Coverage Waiver:**

I acknowledge that Austin Maternal Fetal Medicine does not accept all insurance plans. I understand that I am financially responsible for all services and/or supplies received in the event my insurance is not accepted by the Practice. I understand my insurance may not be confirmed at this time; however I wish to receive service and care from Austin Maternal Fetal Medicine. I understand the below list of insurance plans not accepted by Austin Maternal Fetal Medicine is not a complete list and it is my responsibility to ensure my insurance plan is accepted by the Practice.

Austin Maternal Fetal Medicine does NOT accept the following insurance plans:

- **Seton Medicaid**
- **Seton EPN**
- **Covenant Management Systems by Seton Health Plan**
- **Scott and White Insurance**
- **Scott and White Right Care**

Patient Signature _____ Date _____

Austin Maternal Fetal Medicine

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to he informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo am' suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing_ and treatment. By signing below, you are indicating that (I) you intend that this consent is continuing *in* nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, 1 will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	Date
Printed Name of Patient or Personal Representative	Relationship to Patient
Printed Name of Witness	Employee Job Title
Signature of Witness	Date