Patient Information Form

Name_____ Sex: M____ F____ Email_____
Social Security #_____ Birthdate_____ Age_____ Marital Status: S__ M__ W__ D__
Home Phone #_____ Cell Phone #_____ Work # _____
Can we text your cell phone with appointment reminders?(circle) YES NO Can we contact you via email?(circle) YES NO
Street Address_____ Apt #_____
City _____ State_____ Zip_____
Employer/School_____ Title:_____ Phone #_____
Street Address_____ City_____ St._____ Zip_____
Spouse_____ Birthdate_____Age _____
Translator Needed? ___Yes ___No Primary Language _____ Referred By_____

Authorization to Disclose Protected Health Information

I, _____, authorize Perinatal Centers of Florida to release or discuss information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to the following named persons**: _____
_____

PRIMARY Insurance Information

Insurance Co_____
I.D. #_____
Insured's full name_____
Insured's social sec. #_____
Insured D.O.B. _____

SECONDARY Insurance Information

Insurance Co_____
I.D. #_____
Insured's full name_____
Insured's social sec. #_____
Insured D.O.B. _____

Pharmacy Information

Name _____
Phone # _____
Address _____
City _____

Emergency Contact

Name _____
Phone # _____
Relationship _____
Address _____
City _____
State and Zip _____

Consent for treatment

By signing this consent, I am authorizing my physician(s) to perform and/or order another person to perform all exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Perinatal Center of Florida unless revoked by me in writing.

Guarantee of Payment

I fully understand that I am directly responsible for payment to the Physicians in this office for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay all collection costs including reasonable attorney's fees and costs in the event it becomes necessary to file suit to effect payment. I authorize payments to be made directly to my doctor.

Assignment of Insurance Benefits

If insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any benefits to the Physicians in this office for medical or surgical treatment received by me. In this circumstance, I understand that I am financially responsible for any charges not covered by insurance. I permit a copy of the authorization to be used in place of the original.

Signature_____ Date_____
(Patient's Parent, if minor)

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have reviewed the Notice of Privacy Practices for the company and its subsidiaries and affiliates. I understand that copies of the Notice of Privacy Practices are available on the company's website and paper copies are out and available in the office and that I can take on of these copies with me. The Notice of Privacy Practices is required to be provided to me under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, including as it has been amended by the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 and any implementing regulations.
Effective Date of Notice: September 23, 2013

Patient/ Representative_____ Date: _____
(Print name)

Patient Signature: _____

Authorization to release information

I hereby authorize to Physicians in this office to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claim.

Signature_____ Date_____

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PERINATAL Center of Florida

Phone: (954) 447-2704 • Fax: (954) 447-2708/954-322-8984
www.perinatalcenterFL.com • PCFMiramar@shcr.com

Medical Records Request Form

Patient Name: _____
LAST FIRST MIDDLE

Address: _____

D.O.B. _____ City: _____ State: _____ Zip: _____

Telephone: _____ Email:_____

I hereby authorize _____ to release the Health

Information indicated below that is contained in my patient record to ***Perinatal Center of Florida.***

Dr._____ **Specialty:**_____

Telephone: _____ **Fax:** _____

	ULTRASOUND REPORTS		PRENATAL CHARTS
	HISTORY/PHYSICAL		OTHER:
	LABS REPORTS		
	DISCHARGE SUMMARY		

_____ _____ _____
Patient Signature DATE Patient Print Name Relationship

_____ _____ _____
Witness Signature DATE Witness Print Name Relationship

The information contained in this transmission may contain privileged and confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender and destroy all copies of the original message.

Important Information Regarding Ultrasound Examination

What is an ultrasound?
Ultrasound uses the same principle as sonar. Sound eaves 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.

Are ultrasounds safe?
There has been extensive evaluation of the safety of diagnostic ultrasound. There is no documented evidence that diagnostic ultrasound causes harm to either that 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 an ultrasound determine if there are chromosomal abnormalities?
Findings on 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 cell by amniocentesis, chronic 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 ultrasounds, 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.

_____ _____
Signature Date

_____ _____
Printed Name Date of Birth

PERINATAL Center of Florida

Patient History

Name_____**Date of Birth**_____**Date**_____

Race/Ethnicity_____**Age**_____**Total # of pregnancies (including this one)**_____

What do you do for work? _____

How many babies have you had?_____**How many miscarriages?** _____**How many abortions?**_____

Father of the baby's name _____ **Date of Birth** _____ **Age** _____

Father's Occupation _____**Father's Ethnicity/ Race** _____

Please list each of your pregnancies below, in chronological order, including the year the pregnancy was completed, whether you had a C/S, vaginal delivery, miscarriage or abortion, the gestational age - how far along you were when the pregnancy ended (eg "12 weeks", "9 months"), how much the baby weighed, and any complications you or the baby might have had during the pregnancy, delivery, or afterward.

Year	Miscarriage/Abortion Vaginal or C/S	Gestational Age at Delivery or Term	Baby's Weight	Complications (eg high blood pressure diabetes, preterm labor, problems w/ baby)

Circle all medical problems that apply: high blood pressure, diabetes, asthma, lupus, MTHFR - Factor V - Prothrombin mutations, heart problems, lung problems, kidney problems, genital herpes, syphilis, HIV, bowel problems, thyroid problems, blood clotting disorders, blood clots (DVT), birth defects, other _____

_____

List all your prior surgeries, including LEEP or cone biopsy:_____

Circle any problems that have occurred in both families (yours and the father's) : autism, birth defects, chromosomal abnormalities, mental retardation, genetic or inherited diseases, sickle cell disease or trait, thalassemia disease or trait, anemia of any kind, blood clotting disorders, stroke, blood clots, blood clotting mutations, problems at birth, problems that developed later in childhood, other / describe_____

Do you: (circle Y or N)

Smoke cigarettes: Y N If so, how many: _____ **Use alcohol (how much)? Y N** _____

Use street drugs (eg cocaine, marijuana, etc - how much and which ones)? Y N _____

Any current or previous domestic violence, physical or sexual abuse? Y N _____

Are you allergic to any medications (which ones)? Y N _____

Which medications/ vitamins have you used during this pregnancy? _____

_____

Have you had a prior ultrasound during this pregnancy? Y N

_____ _____ _____

Patient signature Provider signature Date

Review of Systems

Please √ all that apply

Patient Name: _____

DOB: _____

Constitutional:	Yes	No
Fever		
Chills		
Weight Loss		
Malaise/fatigue and diaphoresis		
Eyes:		
Blurred vision		
Double vision		
Photophobia		
Pain		
Discharge and redness		
Hent:		
Hearing loss		
Ear pain		
Nosebleeds		
Congestion		
Sore throat		
Neck pain		
Tinnitus and ear discharge		
Respiratory:		
Cough		
Hemoptysis		
Sputum production		
Shotness of breath		
Wheezing and stridor		
Cardiovascular:		
Chest pain		
Palpitations		
Orthopnea		
Claudication		
Leg swellng		
Gastrointestinal:		
Heartburn		
Nausea		
Vomiting		
Abdominal pain		
Diarrhea		
Constipation		
Blood in stool and melena		
Allergic/Immunologic:		
Anaphylaxis		
Angioedema		
Hay fever		
Environmental, allergies or hives		

Genitourinary:	Yes	No
Dysuria		
Urgency		
Frequency		
Hematuria and flank pain		
Skin:		
Itching and rash		
Hematologic/lymphatic:		
Bleeding problems		
Blood clots		
Blood transfusions		
Bruising		
Fatigue		
Jaundice		
Night sweats		
Pallor		
Swollen lymph nodes/weight loss		
Musculoskeletal:		
Myalgias		
Back pain		
Joint pain and falls		
Neurological:		
Dizziness		
Tingling		
Tremors		
Sensory ideas		
Speech change		
Focal weakness		
Seizures		
Loss of consciousness		
Weakness and headaches		
Behavioral/Psych:		
Depression		
Suicidal ideas		
Hallucinations		
Memory loss/Substance abuse		
Nervous/anxious w/o insomnia		
Endocrine:		
Heat intolerance		
Cold intolerance		
Excessive urination		
History of diabetes		
History of thyroid problems		
Other:		

Zika Virus	Yes	No
Did you or your partner travel outside the U.S.?		
If so, when? _____		
Did you or your partner travel to Miami Dade County?		
If so, when? _____		
Exposure to Zika Virus		
Symptoms (self)		
Symptoms (partner)		
Myalgias		
Headaches		
Rash		
Fever		
Conjunctivitis		

Patient Initials	
MA Initials	
Physician Initials	