NORTH FLORIDA perinatal associates, inc.

☐ Gainesville
☐ Panama City

Patient Information Form

Please print all information in the space provided.
Sign and date at the bottom of each form.

Patient Information		
Referring Doctor / Midwife:		Date:
Last Name:	First Name:	M.I.
Home Address:		Apt:
City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:
Email Address:		Appt. Reminders: [ ] Phone [ ] Text [ ] Email
SSN:	DOB:	Age:
Employer:	Employer Address:	
DL Number:	DL State:	
Spouse's / Partner's Name:	SSN:	DOB:
Spouse's / Partner's Employer:		
Spouse's / Partner's Employer Address:		

Primary Insurance		
Insurance Company :	Phone Number:	
Billing Address:		
Name of Insured:	Relationship:	
Insured's ID Number:	Group Number:	
If patient is under parent's insurance, please complete the following:		
Name of Insured:	DOB:	Relationship:
Employer:	Phone Number:	

Emergency Contact Information *(Please list someone not living in the same house hold.)*		
First Name:	Last Name:	Relationship:
Home Phone:	Work Phone:	Cell Phone:

I hereby authorize payment of medical benefits billed to my insurance to North Florida Perinatal Associates. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered.

Please note we do not file secondary insurance and account statements are mailed monthly.

_____ Date of Signature

_____ Signature of Patient or Guardian

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Acknowledgement of Receipt of Notice Privacy Practices
Authorization to Release Information to Others
Advance Directive / Living Will

Acknowledgement of Receipt of Notice of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services

I have been informed of my provider's Notice of Privacy Practices containing a more complete description of the uses of disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my provider has the right to change the Notice of Privacy Practices and that I may contact the office to obtain the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of healthcare operations, and I understand that you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I have read and acknowledged the above information. *(Please initial.)* _____

Authorization to Release Information to Others

Many of our patients allow family members or others close to them to call and request information regarding their condition and/or treatment. Under the requirements for HIPAA we are not allowed to give this information out without the patient's consent. If you wish to have your condition and/or treatment disclosed to someone else indicate below. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

No, you may not disclose my information to anyone but me. _____
Yes, you may disclose my information to the following people listed below. _____

Name: Relationship to Patient: Date:

Name: Relationship to Patient: Date:

Please provide phone numbers at which we can contact you or leave a message regarding lab results, appointment reminders, changes to scheduled appointments and billing information.

Home Phone: Work Phone: Cell Phone:

Advance Directive / Living Will

Do you have an advance directive or living will? Yes_____ No_____
If no, are you interested in receiving information pertaining to one? Yes_____ No_____

_____ _____
Patient Name *(Please print.)* Relationship to Patient *(Please print.)*

_____ _____
Date of Signature Signature of Patient or Guardian

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Health Information Form

Today's Date:

Last Name:	First Name:		M.I.:
Referring Physician:	Date of Birth:	Age:	Baby's Father's Age:
First Day of Last Menstrual Cycle (Full Date):		Estimated Due Date:	
Reason For Consultation:			
Pregnancy Complications:			
Are you allergic to any medication? Yes / No	If yes, indicate:		
Height: _____(*inches*)	Weight: _____(*lbs.)*		

ALL Past Pregnancies: Please include miscarriages and/or terminations.

Year	Weeks at Delivery	Birth Weight	Gender	Type	Complications, Birth Defects and/or Reason for C-Section
1)			M / F	Vaginal / C-Section	
2)			M / F	Vaginal / C-Section	
3)			M / F	Vaginal / C-Section	
4)			M / F	Vaginal / C-Section	
5)			M / F	Vaginal / C-Section	

Medical History – Do you or have you had any of the following:

	Yes	No		Yes	No		Yes	No
Abnormal Uterus / Fibroids			High Blood Pressure			Inflammatory Bowel Disease		
Incompetent Cervix			Asthma			Hepatitis / Liver Disease		
Prior Cervical / Uterine Surgery			Cancer			Kidney Disease		
IVF or Donor Eggs			Diabetes / Gestational Diabetes			Thyroid Disease		
Genetic Disorders			Lupus / Rheumatoid Arthritis			Seizure Disorder / Epilepsy		
Anemia / Blood Transfusions			Thrombophilia			HIV		
Heart Disease / Murmur			Blood Clots / Pulmonary Embolism			Anxiety / Bipolar / Depression		

Other:

Operations / Surgeries

Date:	Procedure:	Date:	Procedure:
Date:	Procedure:	Date:	Procedure:
Date:	Procedure:	Date:	Procedure:

Genetic History

Ethnicity: African American / Asian / Cajun / Caucasian / French Canadian / Hispanic / Jewish / Mediterranean / Other:

Baby's Father's Ethnicity: African American / Asian / Cajun / Caucasian / French Canadian / Hispanic / Jewish / Mediterranean / Other:

Please answer the following questions:	Yes	No
Have you had any medication exposure during the pregnancy?		
Have you had any x-ray exposure during the pregnancy?		
Have you had a rash or fever during the pregnancy?		

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List of Current Medications

List all prescription, over-the-counter, herbal, vitamin, and diet supplement products.

Patient Name: D.O.B.:

Medication:	Dose:	How Often You Take the Medication:	Route of Administration (oral, topical, injection):	Date Started:	Prescriber:	Stopped:	Date Stopped:
						☐ Yes	
						☐ Yes	
						☐ Yes	
						☐ Yes	
						☐ Yes	
						☐ Yes	
						☐ Yes	
						☐ Yes	
						☐ Yes	
						☐ Yes	

New Medications, if applicable:

Medication:	Dose:	How Often You Take the Medication:	Route of Administration (oral, topical, injection):	Date Started:	Prescriber:	Stopped:	Date Stopped:
						☐ Yes	
						☐ Yes	
						☐ Yes	
						☐ Yes	

Reviewed by Patient (every visit):

☐ ____/____/20____ _____ Patient Signature	☐ ____/____/20____ _____ Patient Signature	☐ ____/____/20____ _____ Patient Signature	☐ ____/____/20____ _____ Patient Signature
☐ ____/____/20____ _____ Patient Signature	☐ ____/____/20____ _____ Patient Signature	☐ ____/____/20____ _____ Patient Signature	☐ ____/____/20____ _____ Patient Signature

☐ ____/____/20____ _____ Patient Signature	☐ ____/____/20____ _____ Patient Signature	☐ ____/____/20____ _____ Patient Signature	☐ ____/____/20____ _____ Patient Signature
☐ ____/____/20____ _____ Patient Signature	☐ ____/____/20____ _____ Patient Signature	☐ ____/____/20____ _____ Patient Signature	☐ ____/____/20____ _____ Patient Signature

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Patient Name:	*DOB:* / /
Referring Physician:	*Misys MR #:*

Do you, the baby's father or any family member have any of the following:					
	Yes	**No**		**Yes**	**No**
Mental Retardation			Down Syndrome		
Fragile X			Tay Sachs		
Mediterranean Anemia			Sickle Cell Disease		
Cystic Fibrosis			Muscular Dystrophy		
Neural Tube Defect			Heart Defect		
Birth Defect			Other:		
Have you had CF Carrier Testing? If so, what were the results?			Have you had any other genetic testing? If so, what test(s) and what were the results?		

Social History – Do you or have you used any of the following during your pregnancy:					
	Yes	**No**		**Yes**	**No**
Alcohol			Regular Exercise		
Tobacco			Seat Belt Use		
Drug Use			Other:		

Review of Systems – Please check any of the following that **CURRENTLY** apply.			
	✔		✔
Constitutional		**Genitourinary**	
Fatigue		Dysuria (Painful Urination)	
Fever		Frequency	
Weight Gain		Hematuria (Blood in Urine)	
Weight Loss		Urgency	
Eyes		**Muscle / Skeletal**	
Double Vision		Pain	
Glasses / Contacts		Spasm	
Seeing Spots		Weakness	
Vision Changes		**Neurological**	
Ears / Nose / Throat		Numbness	
Headache(s)		Seizures	
Sinusitis (Sinus Infection)		Syncope (Fainting)	
Tinnitus (Ringing in Ears)		Difficulty Walking	
Ulcers		**Hematologic**	
Cardiovascular		Adenopathy (Enlargement of Lymph Node)	
Chest Pain		Bleeding	
Edema (Ex: Swelling of Legs)		Bruising (Frequent)	
Orthopnea (Shortness of Breath)		**Endocrine**	
Palpitations (Abnormal Heart Beat)		Diabetes Mellitus	
Respiratory		Hyperthyroid (Over Active Thyroid)	
Coughing		Hypothyroid (Under Active Thyroid)	
Shortness of Breath		**Psychiatric**	
Wheezing		Anxiety	
Gastrointestinal		Bipolar	
Constipation		Depression	
Diarrhea		**Skin**	
Nausea		Rash	
Pain		Striae (Stretch Marks)	
Vomiting		Ulcer	
Other:			

_____	_____	_____
Today's Date	Patient Signature	Physician Signature