NORTH FLORIDA perinatal associates, inc.

❑ Panama City

North Florida Perinatal Associates
2202 State Ave., Suite 103, Panama City, FL 32405
Phone: 850.257.0202 Fax: 850.257.0217

Visit Information

The length of your visit will depend on the services requested by your health care provider.

New patients should arrive 15-20 minutes early to complete forms and allow time to park.

If you arrive LATE, you may have to wait until we can work you back into our schedule or we may need to reschedule your appointment.

In general, an initial sonogram performed after 17 weeks can take approximately 45-60 minutes (longer for twins).

Consultations may take between 15-50 minutes.

One visitor over the age of 18 may be present with you in the ultrasound room.

Children and Infants are not allowed in the office—there are no exceptions.

Because we specialize in high-risk pregnancies, emergencies may delay our schedule. We appreciate your patience.

Please complete and bring the Medical History Questionnaire Form to your visit.

Please call before your visit to inquire about any payments due on the day of your visit.

Your visit is not part of your "Global" prenatal care; additional services may be warranted and result in additional charges.

If you have Medicaid/Medicare, your status must be "Active" the day of your visit.

Office hours - Monday thru Thursday, 7:30 am until 4:30 pm, closed Friday
Please call 850-257-0202 if you have questions.

We look forward to meeting you!

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

PATIENT INFORMATION		
Referring Practice / 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: / /
Pharmacy:	Address:	Phone:

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 statement 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 discl osures 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 obta in 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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MEDICAL HISTORY QUESTIONNAIRE

Today's Date: _____

Last Name:	First Name:	M.I.:
Date of Birth:	Age:	Baby's Father's Age:
Referring Physician:		
First Day of Last Menstrual Cycle (Full Date):		Estimated Due Date:
Reason For Visit Today:		
Prior Ultrasound This Pregnancy? ❑ YES, When?		Where?
Pregnancy Complications:		
Did you have the early blood test for fetal gender? ❑ No ❑ Not Sure ❑ YES, Results:		
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	BirthWeight	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	
6)			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:

Procedure with Date	**Operations - Surgeries**

Genetic History/ Antecedentes

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**		**YES**	**NO**
Have you had any medication exposure during the pregnancy?			Did you smoke? - Cigarettes - Marijuana - Vape		
Have you had any x-ray exposure during the pregnancy?			Did you drink alcohol?		
Have you had a rash or fever during the pregnancy?			Did you use any street drug?		

Explain:

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Today's Date: _____/_____/_____

Name: _____

DOB: _____/_____/_____

Consent for Pelvic Examination

A Pelvic Examination is an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissues or organs. This procedure is used to diagnose and /or treat conditions that involve the pelvis. It may be performed using any combination of modalities, which may include the health care provider's gloved hand(s) or instrumentation. For purposes of the consent, vaginal sonography is included.

I understand that a pelvic examination as described above is needed for screening and/ or diagnosis and the results may be used to guide management of my care.

By my signature below, I acknowledge that I have read or have the document read to me and understand the contents of the form

Accepts the exam:

I authorize and direct North Florida Perinatal Associates and my treating health care provider, the employed and/or contracted medical personnel of North Florida Perinatal Associates and supervised students receiving training who may be involved in my care, to perform a pelvic examination, including vaginal sonography, as described above.

Patient signature: _____ Date: _____/_____/_____

Declines the exam:

I am choosing to decline the pelvic examination offered by North Florida Perinatal Associates and understand that this decision may result in an incomplete evaluation and may negatively impact the outcome of my care.

Patient signature: _____ Date: _____/_____/_____

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Infection Control Questionnaire

December 2021

Patient Name: _____

Patients DOB: _____/_____/_____

Today's Date: _____/_____/_____

Person competing paperwork: _____

Relationship to patient: _____

Please answer the following questions:

1. Are you currently suffering from fever, cough, body aches and/ or shortness of breath?
   ❑ Yes or ❑ no

2. Have you been tested for Covid-19 in the past 14 days?
   ❑ Yes or ❑ no

3. Have you been around anybody that was exposed to Covid-19 in the last 14 days?
   ❑ Yes or ❑ no

4. Have you traveled outside of the country in the last 14 days?
   ❑ Yes or ❑ no

5. Have you had the Covid-19 Vaccine?
   ❑ Yes or ❑ no