

## Patient Registration Form

DATE \_\_\_\_\_

REFERRING DOCTOR \_\_\_\_\_

**PATIENT INFORMATION**

NAME LAST	FIRST	MI	SEX (CIRCLE) M F	DRIVER'S LICENSE #
HOME PHONE ( )	SS#	D.O.B.	Mo. / Day / Year	SPOUSE'S NAME
EMPLOYER	WORK PHONE ( )		EXT.	MARITAL STATUS S D Y M W STUDENT N
HOME ADDRESS		CITY		STATE ZIP
E-MAIL ADDRESS		BEEPER NO.( )		CELL PHONE NO.( )
EMERGENCY CONTACT: (NOT LIVING WITH YOU)		RELATIONSHIP		EMERGENCY PHONE ( ) EXT.

**RESPONSIBLE PARTY (If Not Patient)**

NAME LAST	FIRST	MI	RELATIONSHIP
SS#	D.O.B.	Mo. / Day / Year	DRIVER'S LICENSE # HOME PHONE( )
EMPLOYER	WORK PHONE ( )		EXT. CELL #( ) BEEPER #( )
HOME ADDRESS		CITY	STATE ZIP

**INSURANCE INFORMATION**

PRIMARY INSURANCE	ID#	GROUP#	CO-PAY
POLICYHOLDER'S NAME LAST	FIRST	MI	
DATE OF BIRTH	SEX (CIRCLE) M F	RELATIONSHIP TO PATIENT	
EMPLOYER		WORK PHONE	EXT.
SECONDARY INSURANCE	ID#	GROUP#	CO-PAY
POLICYHOLDER'S NAME LAST	FIRST	MI	
DATE OF BIRTH	SEX (CIRCLE) M F	RELATIONSHIP TO PATIENT	
EMPLOYER		WORK PHONE	EXT.

**I consent to treatment necessary for the care of the above named patient. I acknowledge full financial responsibility for services rendered by Brookwood Maternal Fetal Medicine. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment. I have read and fully understand the above consent for treatment and financial responsibility.**

Date \_\_\_\_\_ Signature \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

**MEDICARE EXTENDED PATIENT SIGNATURE AUTHORIZATION (Medicare Patients Only)**

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THE PHYSICIANS OF BROOKWOOD MATERNAL FETAL MEDICINE FOR ANY HOLDER OF MEDICAL INFORMATION ABOUT TO RELEASE TO HEALTHCARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NECESSARY TO DETERMINE THESE BENEFITS OR THE BENEFITS FOR RELATED SERVICES.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PERSON OTHER THAN PATIENT

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

**NOTICE OF PRIVACY PRACTICES RECEIPT**

I HAVE RECEIVED AND REVIEWED THE NOTICE OF PRIVACY PRACTICES PROVIDED BY BROOKWOOD MATERNAL FETAL MEDICINE.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

**FINANCIAL RESPONSIBILITY AND MEDICAL RECORDS**

I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE UNLESS OTHER FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO TREATMENT. I AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO BROOKWOOD PRIMARY CARE NETWORK, INC. I UNDERSTAND BROOKWOOD MATERNAL FETAL MEDICINE WILL ATTEMPT TO COLLECT ASSIGNED INSURANCE BENEFITS FOR A PERIOD OF 45 DAYS AFTER DATE OF SERVICE AT WHICH TIME PAYMENT OF THE FULL AMOUNT WILL BE MY RESPONSIBILITY. I REALIZE THAT BROOKWOOD PRIMARY CARE NETWORK, INC. MAY SEEK ASSISTANCE OUTSIDE THIS OFFICE TO EXPEDITE COLLECTION OF THE BALANCE DUE.

I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS TO THE REFERRING AND FAMILY PHYSICIANS AND TO MY INSURANCE COMPANY, IF APPLICABLE. I ALLOW FAX TRANSMITTAL OF MY MEDICAL RECORDS IF NECESSARY.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

**PATIENT HISTORY**

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Number of pregnancies including the present one: \_\_\_\_\_  
Number of live births: \_\_\_\_\_  
Number of pregnancies delivered at full term: \_\_\_\_\_  
Number of premature births: \_\_\_\_\_  
Number of miscarriages: \_\_\_\_\_  
Number of abortions: \_\_\_\_\_  
Number of tubal pregnancies \_\_\_\_\_  
Date that your last period began: \_\_\_\_\_

**Present problem**

What is the reason you have come to see the doctor: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Obstetrical history**

Is this your first Pregnancy? YES \_\_\_ NO \_\_\_

If the answer is "NO" please describe **ALL** your pregnancies including miscarriages, abortions, and tubal pregnancies. Start with your first pregnancy. Do not include information about the present pregnancy.

**Number 1.** Date of Delivery \_\_\_\_\_ How many weeks or months at the time of delivery? \_\_\_\_\_  
Labor induced \_\_\_\_\_ or spontaneous \_\_\_\_\_  
Duration of labor \_\_\_\_\_ Type of anesthesia \_\_\_\_\_  
Complications during the pregnancy \_\_\_\_\_  
Complications at delivery \_\_\_\_\_  
Newborn sex: \_\_\_\_\_ Newborn weight: \_\_\_\_\_  
Hospital where delivery took place \_\_\_\_\_

**Number 2.** Date of Delivery \_\_\_\_\_ How many weeks or months at the time of delivery? \_\_\_\_\_  
Labor induced \_\_\_\_\_ or spontaneous \_\_\_\_\_  
Duration of labor \_\_\_\_\_ Type of anesthesia \_\_\_\_\_  
Complications during the pregnancy \_\_\_\_\_  
Complications at delivery \_\_\_\_\_  
Newborn sex: \_\_\_\_\_ Newborn weight: \_\_\_\_\_  
Hospital where delivery took place \_\_\_\_\_

**Number 3.** Date of Delivery \_\_\_\_\_ How many weeks or months at the time of delivery? \_\_\_\_\_  
Labor induced \_\_\_\_\_ or spontaneous \_\_\_\_\_  
Duration of labor \_\_\_\_\_ Type of anesthesia \_\_\_\_\_  
Complications during the pregnancy \_\_\_\_\_  
Complications at delivery \_\_\_\_\_  
Newborn sex: \_\_\_\_\_ Newborn weight: \_\_\_\_\_  
Hospital where delivery took place \_\_\_\_\_

**Number 4.** Date of Delivery \_\_\_\_\_ How many weeks or months at the time of delivery?  
 Labor induced \_\_\_\_\_ or spontaneous \_\_\_\_\_  
 Duration of labor \_\_\_\_\_ Type of anesthesia \_\_\_\_\_  
 Complications during the pregnancy \_\_\_\_\_  
 Complications at delivery \_\_\_\_\_  
 Newborn sex: \_\_\_\_\_ Newborn weight: \_\_\_\_\_  
 Hospital where delivery took place \_\_\_\_\_

**Medical History**

**Allergies**

Do you have allergic reactions to any food or drugs? YES \_\_\_\_\_ NO \_\_\_\_\_

If "YES", list \_\_\_\_\_

Have you had any of the following medical conditions?

YES	NO	CONDITION
___	___	Asthma
___	___	AIDS
___	___	Anemia
___	___	Arthritis
___	___	Bleeding disorders
___	___	Bowel disorders/colitis
___	___	Bronchitis/emphysema
___	___	Chicken Pox
___	___	Cancer/Tumors
___	___	Diabetes
___	___	Epilepsy (seizures)
___	___	Gallbladder/Gallstones
___	___	Glaucoma
___	___	Headaches/Migraines
___	___	Heart trouble/Heart Murmur
___	___	Hepatitis (yellow jaundice)/liver problems
___	___	High Blood Pressure
___	___	Infertility
___	___	Kidney or bladder trouble, urinary tract infections
___	___	Nervous/emotional problems/depression
___	___	Rheumatic fever
___	___	Sexual abuse/Rape
___	___	Stomach problems/ulcers
___	___	Stroke or paralysis
___	___	Thyroid gland disease/goiter
___	___	Tuberculosis

Have you ever received a blood transfusion or blood products? YES \_\_\_\_\_ NO \_\_\_\_\_

If "YES" please give date and reason for the transfusion \_\_\_\_\_

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List any other serious illnesses or injuries you have had (give dates): \_\_\_\_\_

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Have you ever had surgery? YES \_\_\_ NO \_\_\_

If "YES", please give dates and reason for the operation(s):

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### Gynecologic History

Age at onset of menstrual cycle: \_\_\_ Days between periods \_\_\_

Duration of menstrual bleeding \_\_\_ Age at the time of first sexual relation \_\_\_

Number of partners \_\_\_ Have you ever had abnormal pap smears: YES \_\_\_ NO \_\_\_

If "YES", when? \_\_\_ Did you have treatment: YES \_\_\_ NO \_\_\_

Have you had any sexually transmitted disease (herpes, syphilis, chlamydia, trichomonas, venereal warts, etc)

YES \_\_\_ NO \_\_\_ If "YES", when? \_\_\_ Did you receive treatment? YES \_\_\_ NO \_\_\_

### Social History

Married \_\_\_ Single \_\_\_ Divorced \_\_\_

Do you smoke? YES \_\_\_ NO \_\_\_ If "YES", how many cigarettes per day? \_\_\_

Do you drink? YES \_\_\_ NO \_\_\_ If "YES", how many drinks per week? \_\_\_

Do you use street drugs? YES \_\_\_ NO \_\_\_ If "YES", when was the last use? \_\_\_

What kind of drug? \_\_\_ Amount \_\_\_

What is the age of the baby's father? \_\_\_ Is he involved? YES \_\_\_ NO \_\_\_

Is there a history of sexual, physical or verbal abuse? YES \_\_\_ NO \_\_\_

### Family History

Has any member of your family had any of the following conditions:

CONDITION

RELATIONSHIP

Diabetes

\_\_\_\_\_

High Blood pressure

\_\_\_\_\_

Heart Disease

\_\_\_\_\_

Strokes

\_\_\_\_\_

Epilepsy

\_\_\_\_\_

Kidney disease

\_\_\_\_\_

Blood clots

\_\_\_\_\_

Toxemia of pregnancy

\_\_\_\_\_

Patient, baby's father, or anyone in the family with:

	YES	NO
Patient's age equal or older than 35	_____	_____
Italian, Greek, Mediterranean or Oriental background	_____	_____
Neural tube defect (open spine)	_____	_____
Down Syndrome	_____	_____
Jewish ancestry	_____	_____
Sickle Cell	_____	_____
Hemophilia	_____	_____
Muscular Dystrophy	_____	_____
Cystic Fibrosis	_____	_____
Huntington's Chorea	_____	_____
Mental Retardation	_____	_____
Was person tested for Fragile X?	_____	_____
Patient or baby's father has a child with Birth defect not listed above?	_____	_____

**Medications**

List ALL the medications that you use on a regular basis, including birth control pills, and non-prescription items such as laxatives, over the counter pain medication, cold medication, vitamins and natural products:

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**Review of systems**

Have you ever had any of the following:

YES	NO	
___	___	Unexpected weight change of more than 10 lbs in the last year?
___	___	Any serious problems with your eyes or ears?
___	___	Any persistent swollen glands or unusual lumps?
___	___	Any breast lumps or nipple discharge?
___	___	Your heart frequently racing or skipping beats?
___	___	Unusual or severe shortness of breath?
___	___	Frequent swelling of ankles, hands or face?
___	___	Inflamed veins or clots in your veins?
___	___	Is your skin very sensitive to the sun light?
___	___	Frequent coughing or wheezing?
___	___	Serious difficulties swallowing?
___	___	Frequent or severe stomach or abdominal pain?
___	___	Frequent nausea or vomiting?
___	___	Severe constipation or diarrhea?
___	___	Blood in the stool or black stools?
___	___	Unusual skin problems or persistent sores?
___	___	Redness, severe pain or swelling of your joints?
___	___	Frequent or severe back pain?
___	___	Do you bruise easily?
___	___	Have you ever had a severe head injury?
___	___	Have you ever lost consciousness?
___	___	Have you ever broken any bones?
___	___	Have you ever had abnormal periods?
___	___	Have you ever had vaginal infections?
___	___	Have you ever had serious sexual difficulties?
___	___	Have you had or do you have serious problems at home or work?
___	___	Have you ever been exposed to poisons, fumes, toxins or chemicals, smoke, radioactive materials at home or work?

Do you have religious beliefs that preclude you from receiving certain medical care?

YES\_\_\_ NO\_\_\_

What is your present weight? \_\_\_\_\_

What was your weight before you became pregnant? \_\_\_\_\_

How tall are you? \_\_\_\_\_

Effective Date: August 18, 2008

## Notice of Privacy Practices

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not fear about providing information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and its physicians and staff will :

- Adhere to the standards set forth in the Notice of Privacy Practices.
- Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TOP, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments only with their consent.
- Recognize that PHI collected about patients must be accurate, timely, complete and available when needed. Our practice and its physicians and staff will:
  - Implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy. Our practice and its physicians and staff will respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will:
  - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
  - Not disclose PHI data unless the patient (or his or her authorized representative) has properly consented to or authorized the release, or law otherwise authorizes the release.
- Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its physicians and staff will:
  - Permit patients access to their medical records when their written requests are approved by our practice. If we deny such requests, we will inform the patients that they may

request a review of our denial. In such cases, we will have an onsite healthcare professional review the patients' appeals.

- Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- All physicians and staff of our practice will maintain a list of all disclosures of PHI for purposes other than TOP for each patient. We will provide this list to patients upon request, so long as their requests are in writing.
- All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.
- All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.
- Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

**PATIENT CONSENT FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for BROOKWOOD MATERNAL FETAL MEDICINE to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (BROOKWOOD MATERNAL FETAL MEDICINE Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. BROOKWOOD MATERNAL FETAL MEDICINE reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Peri Cabral, Privacy Officer at Brookwood Maternal Fetal Medicine – 2010 Brookwood Medical Center Dr., Homewood, AL 35209.

With this consent, BROOKWOOD MATERNAL FETAL MEDICINE may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, BROOKWOOD MATERNAL FETAL MEDICINE may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that BROOKWOOD MATERNAL FETAL MEDICINE restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to BROOKWOOD MATERNAL FETAL MEDICINE use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, BROOKWOOD MATERNAL FETAL MEDICINE may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

**CONSENT FOR THE RELEASE OF MEDICAL INFORMATION TO  
SPECIFIED INDIVIDUALS**

Brookwood Medical Center Maternal Fetal Medicine is committed to the protection of our patient's personal health information. However, we recognize that individuals other than themselves attend to many of our patient's healthcare needs. In accordance with new HIPAA regulations, we ask that you take a moment to give us the names of individuals with whom we are able to discuss your medical appointments, condition, treatment options, insurance payment information, or other information necessary to our responsibility in your treatment. Please list the names (and phone numbers, if readily available) of any individuals with whom we may have communication, which may include all, or part of your personal health information. If you fail to list any names, we will not discuss your medical information with anyone other than yourself.

Examples include: spouse, parent, child, brother/sister, friend, etc.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Contact/Relationship to patient:

Telephone Number:

1 \_\_\_\_\_

\_\_\_\_\_

2 \_\_\_\_\_

\_\_\_\_\_

3 \_\_\_\_\_

\_\_\_\_\_

( ) Home answering machine message only

( ) Voicemail message only

( ) Cell/Pager # \_\_\_\_\_