2021

PATIENT CHART # ____________________

PCP / OB DOCTOR ____________________ PCP / OB PH# ____________________ FAX# ____________

NAME: ____________________ SEX: ☐F ☐M EMAIL: ____________________

SOCIAL SECURITY # ____________________ BIRTHDATE: __________ MARITAL STATUS: ☐M ☐S ☐W ☐ D

RELIGION __________ AGE _____ HOME # ____________ CELL # ____________ WORK # ____________

STREET ADDRESS: ____________________ APT # __________

CITY ____________________ STATE ____________________ ZIP ____________________

DRIVER LICENSE # ____________________ DRIVER'S LICENSE STATE ____________

EMPLOYER / SCHOOL ____________________ TITLE ____________ PHONE # ____________

STREET ADDRESS: ____________________ CITY ____________ STATE ______ ZIP __________

SPOUSE NAME: ____________________ AGE ____________ DOB ____________

SPOUSE EMPLOYER ____________________ TITLE ____________ PHONE # ____________

STREET ADDRESS: ____________________ CITY ____________ STATE ______ ZIP __________

TRANSLATOR NEEDED ☐YES ☐NO PRIMARY LANGUAGE SPOKEN ____________ REFERRED BY: ____________

SOMEONE TO CONTACT LOCALLY IN CASE OF EMERGENCY OTHER THAN SOMEONE LIVING WITH YOU

NAME ____________________ PHONE ____________________ RELATIONSHIP ____________

ADDRESS ____________________ CITY ____________________ STATE _____ ZIP __________

IF PATIENT IS A MINOR OR IF INSURANCE IS UNDER PARENTS OR GUARDIAN PLEASE COMPLETE FOLLOWING

FATHER'S NAME: ____________________ MOTHER'S NAME: ____________________

EMPLOYED BY: ____________________ EMPLOYED BY: ____________________

POSITION: ____________________ POSITION: ____________________

PHONE: ____________________ PHONE: ____________________

PRIMARY INSURANCE	**SECONDARY INSURANCE**
INSURANCE CO. NAME ____________________	INSURANCE CO. NAME ____________________
ADDRESS ____________________	ADDRESS ____________________
CITY ____________ STATE _____ ZIP __________	CITY ____________ STATE _____ ZIP __________
I.D.# ____________________	I.D.# ____________________
GROUP NAME OR # ____________________	GROUP NAME OR # ____________________
INSURED'S FULL NAME ____________________	INSURED'S FULL NAME ____________________
IS THIS AN EMPLOYER PLAN: ____________________	IS THIS AN EMPLOYER PLAN: ____________________
INSURED'S SOCIAL SEC # ____________________	INSURED'S SOCIAL SEC # ____________________
INSURED'S D.O.B. ____________________	INSURED'S D.O.B. ____________________
RELATIONSHIP TO INSURED ____________________ (Self –Husband – Wife – Child – Other)	RELATIONSHIP TO INSURED____________________ (Self –Husband – Wife – Child – Other)

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

I,______________________________AUTHORIZE **S.E.PERINATAL ASSOCIATES** 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:

1. ______________________________ Relation: ________________ Phone #: ____________________________

2. ______________________________ Relation: ________________ Phone #: ____________________________

3. ______________________________ Relation: ________________ Phone #: ____________________________

- *****PLEASE BE ADVISED THAT ANY PERSON NOT REFERRED ABOVE ON THIS LIST WILL NOT BE GIVEN ANY INFORMATION. YOU MAY CHANGE, RESTRICT OR EXPAND THIS LIST AT ANY TIME.**
- ***** YOU ARE NOT REQUIRED TO LIST ANY NAME IF YOU DO NOT WISH TO**

PHARMACY INFORMATION

NAME: ______________________________ PHONE #: ______________________ City: _______________________

Guarantor of payment

I fully understand that I am responsible for payment to the physicians in the 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 fees and cost in the event it becomes necessary to file suit to effect payment. I authorize payments to be made directly to my doctor.

Authorization to release information

I hereby authorize the 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 claims.

Assignment of insurance benefits

If insurance claims are filed by his 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 fully responsible for any charges not covered by insurance. I permit copy of the authorization to be used in place of the original.

Signature ________________________________ **Date of birth:** ____________________ **Date:** ____________________

Advanced Directive

Do you have an advance directive/living will? _____________ if yes, please provide us with a copy for our records. If no, please let us know if you require information.

I hereby authorize the use of and/or disclosures of any telephone number, provided by me or on my behalf, that is assigned to a residential line, cellular telephone services, paging services, fax machine, computer, or any other services or devices for which the called party is charged for the call for purpose of billing and collection payment for medical services rendered to me. This consent applies to any call made using an automatic telephone dialing system of an artificial or prerecorded voice.

Southeast Perinatal Associates
Committed to turning high-risk pregnancies into low-risk deliveries.

Jaime Rodriguez, M.D., F.A.C.O.G.
Cesar Rosa, M.D., F.A.C.O.G
Cesar Barada, M.D., F.A.C.O.G

OFFICE PHILOSOPHY

As a Perinatal Specialist, We feel it is extremely important to spend as much time as necessary with each patient to fully address you and your baby's medical problems. This enables me to explain my suggestions and recommendations in depth and answer any questions you may have during your visit. My staff schedules patients accordingly and we do try to be as efficient as possible in order to expedite your entrance and departure from this office. Please be reassured that this office and staff does value your time, however, it is not uncommon to have a prolonged waiting period. On many occasions I am delayed for such matters as patients' medical problems, which require immediate attention, hospital calls, physician calls, etc…, and/or emergencies. These issues are unforeseen and are handled appropriately. I do not leave this office until all of the patients are seen and all medical problems are addressed, regardless of whatever time is necessary.

After the patient is seen, a full report is sent to the referring physician in a timely fashion. I have well-trained staff members available to assist you with any difficulties that may arise before, during or after your visit.

We encourage your comments and suggestions.

Thank You,
Jaime Rodriguez, M.D., F.A.C.O.G
Cesar Barada, M.D., F.A.C.O.G
Cesar Rosa, M.D., F.A.C.O.G

I acknowledge and understand the above-stated Office Philosophy

Name:________________________

Date:________________________

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Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received the Notice of Privacy Practices for the company and its subsidiaries and affiliates. I understand that copies of the Notice of Privacy Practice are available on the company's website and paper copies are out and available in the office and that I can take one 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 or the American Recovery and Reinvestment Act of 2009 and any implementing regulations.

Effective Date of Notice: September 23, 2013

Patient: ______________________________ Date: ______________
(Print name)

Patient Signature: ______________________

Or

Patient's Representative: ________________ Date: ______________

Relationship to Patient: _________________

Envision
PHYSICIAN SERVICES

[illegible] [illegible]

Thank you for choosing our practice to assist you with your care. We appreciate your trust and are committed to providing you with high quality, compassionate care.

We value our patients and tailor their treatment plans according to their unique needs, in doing so, we allocate time for each appointment accordingly. We realize that circumstances may occur beyond your control that may not allow you to provide 24 notification. Failure of a patient to notify the office to cancel or change their appointment without 24 hour notice is considered a "No-Show". To help remind patients of their appointments we have implemented an automated reminder system. Please assure we have your correct and most up to date phone numbers or email address at all times throughout the course of your treatment to allow us to better serve you.

The "no show "appointments will be documented in the patient record.

Charges for "no-show appointments are as follows:

- Office visit $50.00
- Procedure or surgical center visit $100.00

This letter will serve as notice about the office no show policy and fees.

I acknowledge that I have read and understand the policy.

Print Name

Signature

Date

IMPORTANT INFORMATION REGARDING ULTRASOUND EXAMINATION

What is an ultrasound?

Ultrasound uses the same principle as sonar. Sound waves 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 the 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 cells by amniocentesis, chorionic 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 ultrasound, 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.

Patient/Guardian Signature	Date
Printed Name	Date of Birth

Southeast Perinatal Associates
Maternal - Fetal Medicine
Health Information Form

Name:______________________ DOB:__________ Age:______ Today's Date:__________

Referred by:______________________ Reason for Visit:______________________

First day of last menstrual period:______________________ Estimated due date:______________________

Pregnancy History (including miscarriages, stillbirths, ectopics and terminations)

Year	Weeks pregnant at delivery	Birth Weight	Boy / Girl	Vaginal Delivery	Cesarean Section	Reason for C-Section	ALLERGIES TO MEDICATIONS
							Complications

Family and genetic history: **Ethnic background (for example, Irish, Italian, African American, etc.):**

Describe your ethnic background: Baby's father's ethnic background:

Check all that apply to you:

☐ You will be 35 or older when the baby is born

☐ Baby's father will be 50 or older

☐ Exposed to medication during pregnancy

☐ Exposure to X-Ray during pregnancy

Do you, the baby's father or any other family member have any of the following:

Mental retardation	Yes	No	Mediterranean anemia	Yes	No	Autism	Yes	No
Down syndrome	Yes	No	Sickle cell disease	Yes	No	Neural tube defect	Yes	No
Fragile X	Yes	No	Cystic fibrosis	Yes	No	Heart defect	Yes	No
Tay sachs	Yes	No	Muscular dystrophy	Yes	No	Birth defect	Yes	No
						Other:		

Gynecological History - Have you had any of the following?

Infertility	Yes	No	Previous cervical surgery	Yes	No	Abnormal pap smear	Yes	No
Conceived by IVF or assisted reproduction?	Yes	No	Incompetent cervix	Yes	No	History of any sexually transmitted disease	Yes	No
			Fibroids	Yes	No			
Donor Egg/Sperm	Yes	No	Abnormal uterus	Yes	No			

Medical History - Have you had any of the following:

High blood pressure	Yes	No	Seizures/epilepsy	Yes	No	Anemia/blood transfusions	Yes	No
Diabetes	Yes	No	Hepatitis	Yes	No	Kidney infections	Yes	No
Asthma	Yes	No	Ulcers	Yes	No	Arthritis / joint pain	Yes	No
Heart trouble / murmur	Yes	No	Thyroid disease	Yes	No	HIV	Yes	No
Rheumatic fever	Yes	No	Cancer	Yes	No	Lupus	Yes	No
Depression	Yes	No	Migraines	Yes	No	Other:		

List of current medication(s):

Surgical History:

Social History:

Smoking	Yes	No	Number smoked per day:
Alcohol	Yes	No	Number consumed per day:
Drug use	Yes	No	Type of drug(s):
Seat belt use	Yes	No	
Regular exercise	Yes	No	

Please check if any of the following apply to you now or in the past: ☐ **None of the below problems apply**

☐ Severe fatigue
☐ Double vision
☐ Spots before eyes
☐ Vision changes
☐ Ear aches
☐ Ringing in ears
☐ Shortness of breath
☐ Mouth sores
☐ Dental problems
☐ Chest pain
☐ Swelling of legs
☐ Palpitations
☐ Wheezing
☐ Seizures
☐ Abnormal thirst
☐ Bloody stool
☐ Constipation
☐ Diarrhea
☐ Nausea / vomiting
☐ Dizziness
☐ Numbness
☐ Depression
☐ Anxiety
☐ Blood in urine
☐ Urgency
☐ Sinus problems

Completed by: ☐ **Patient** ☐ **Office Staff** ☐ **Physician**

Signature of patient:______________________

Physician signature:______________________ **Date reviewed with patient:**__________

Patient Name:

Patient ID#

Date of Birth:

List of Current Medications:

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

Medications:	**Dose:**	**How often do you take the Medication:**	**Route of Administration (oral, topical, infection):**	**Stopped:**	**Date Stopped:**
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	

ANNUAL QUESTIONNAIRE

Patient Name: ________________________ Date: ________________

1. Have you had a Pneumonia Vaccination? ☐ Yes ☐ No If yes, When: ________________

2. Have you had a Flu Vaccination? ☐ Yes ☐ No If yes, When: ________________

3. Do you have little interest or pleasure in doing things? ☐ Yes ☐ No

   If yes, check one: ☐ Several Days ☐ More than half the days ☐ Everyday

4. Are you feeling down, depressed or hopeless? ☐ Yes ☐ No

   If yes, check one: ☐ Several Days ☐ More than half the days ☐ Everyday

IF "NO" TO QUESTIONS 3 and 4, SKIP TO QUESTION #5

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all 0	Several Days 1	More than half the days 2	Everyday 3
Trouble falling or staying asleep or sleeping too much?				
Feeling tired or having little energy?				
Poor appetite or overeating?				
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television.				
Moving or speaking so slowly that other people could have noticed. Or the opposite? Being so fidgety or restless that you have been moving around a lot more than usual.				
Thoughts that you would be better off dead and/or of hurting yourself in some way.				

5. Have you fallen in the past year (If 65 or older please answer)? ☐ Yes ☐ No

   If yes, please complete:

   ☐ 1 fall with injury in the past year

   ☐ 1 fall without injury in the past year

   ☐ 2 or more falls with injury in the past year

   ☐ 2 or more falls without injury in the past year