MID SOUTH MATERNAL FETAL MEDICINE
PATIENT INFORMATION
PLEASE PRINT

Last Name:	Emergency Contact :
First Name:	Emergency Contact Relationship:
Middle Initial:	Emergency Contact Phone:
Sex:	**PRIMARY INSURANCE INFORMATION:**
DOB:	Primary Insurance Co:
SSN:	Policy Number:
Address :	Policy Holder:
	Policy Holder SSN:
City:	Policy Holder DOB:
State:	Relationship to patient: F/M
ZIP:	**SECONDARY INSURANCE INFORMATION:**
Home phone :	Secondary Insurance Co:
Cell phone :(	Policy Number:
Work phone :	Policy Holder:
Email:	Policy Holder SSN:
Marital Status:	Policy Holder DOB:
Race:	Relationship to patient: F/M
Referring Physician :	
Employer:	

In order to control the costs of billing, we request that office visits be paid at the time service is rendered. We would rather control our billing costs than be forced to raise our fees. A billing fee may be assessed after 60 days.
____ Please NOTE: You will receive a separate bill from the lab for any lab services performed in this office.
____Please NOTE: There will be a 35.00 charge for returned checks to be electronically debited from your checking account.

AUTHORIZATION: I hereby authorize Mid South Maternal Fetal Medicine P.C. to release any information concerning by treatment and hereby irrevocably assign to them as insurance benefits for my treatment. I understand that I am financially responsible for payment of all charges at the time they are rendered including any charges in excess of my insurance reasonable and customary, whether or not covered by Medicare or other insurance. I understand that I am responsible for verifying by insurance coverage & pre-certifying my benefits with my insurance company. I also understand that I am responsible for reasonable collection costs and/or attorney fees incurred in the collection of this account. A photocopy of this statement is considered to be as valid as an original. I acknowledge receipt of the Notice of Privacy Practices that was given to me by this Practice.
My signature below acknowledges consent to treat.

SIGN:_____ **DATE:**_____

MID-SOUTH MATERNAL FETAL MEDICINE, P.C.

Roy Bors-Koefoed, M.D.
Christy Smith, W.H.N.P., MSN
Shelia Thomas, F.N.P.

Accredited by AIUM in obstetrical and fetal echo ultrasound

6266 Poplar Memphis, TN 38119
901-682-2595 office 901-682-2549 fax

History and Review of Systems

Please complete entire form to better help us in meeting your medical/health needs.

Patient Name:_____ **Age:**_____ **Today's Date:** _____

Reason you are here today: _____

Allergies to medications or foods? _____

Medications you are currently taking: _____

_____

Reproductive History:

Who is your OB doctor? _____
When was your last period? _____ What is your due date? _____
Is this pregnancy the result of IVF or IUI? _____ What was the date of implant? _____
Use of own eggs? ____ Donor eggs? _____ Donor sperm? _____ Age of eggs at retrieval? _____
How many times have you been pregnant? (include miscarriages, abortions and current pregnancy) _____
How many of your pregnancies were miscarriages? _____
How many living children do you have? _____

Birth Year	Vaginal or C-section	Boy or Girl	Weight	How many weeks were you at delivery	Any complications? (Preterm labor, short cervix, high blood pressure, diabetes, etc…)	Is the child(ren) living now?

Do you have a history of blood clots? ____; HELLP? ____; Toxemia? ____; Small baby? ____
When was your last PAP smear? _____
Have you ever had an abnormal PAP smear? ___ Were any procedures performed on your cervix for the abnormal PAP smear? _____
Have you ever had a cervical cerclage? _____ When? _____ By what doctor? _____
How old were you when you started your period the first time? _____
Do you have a history or recent diagnosis of any STD (including Gonorrhea, Chlamydia, Trichomonas, Herpes, Syphilis, Genital warts, HIV)? _____

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Personal History:

Do you have any health problems? (for example: High blood pressure, diabetes, seizures, blood clots, thyroid, etc…)

_____

Have you ever had surgery? _____ For what? _____

What was your weight **before** you became pregnant? _____ How tall are you? _____

Social:

Marital Status: _____ Do you work? _____ Full time/Part time? _____

Do you smoke cigarettes (tobacco or e-cigarettes)? _____ How many a day? _____

How many years have you smoked? _____ If you have quit, when did you quit? _____

Do you use marijuana? _____ How often? _____ When was the last time? _____

Do you use any street drugs? _____ What do you use? _____

How often? _____ When was the last time you used? _____

Do you take steroids or NSAIDS (Advil, ibuprofen, naproxen, etc…)? _____

Have you drank alcohol with this pregnancy? _____ What did you drink? _____

How much did you drink? _____ When did you last drink? _____

Do you drink caffeine? _____ How much? _____ How often? _____

Do you have indoor pets? _____

Do you have any spiritual beliefs or values that may affect your care? _____

Family: (Blood relatives only)

# of brothers living ____ # of brothers not living ____ Cause of death: _____

# of sisters living _____ # of sisters not living _____ Cause of death: _____

Mother: living ___ not living ___ What did she die from? _____ How old was she? _____

Father: living ___ not living ____ What did he die from? _____ How old was he? _____

Maternal grandmother (your Mom's mom): living ___ not living ___ Cause of death? _____

Maternal grandfather (your Mom's dad): living ___ not living ___ Cause of death? _____

Paternal grandmother (your Dad's mom): living ___ not living ___ Cause of death? _____

Paternal grandfather (your Dad's dad): living ___ not living ___ Cause of death? _____

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Do any of your blood relatives have? AND Who has the problem?

	Mom	Dad	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Your brother	Your sister	Your Child
High blood pressure									
Diabetes									
Thyroid problems									
Genetic disorder									
Mental retardation									
High blood pressure with pregnancy		N/A		N/A	N/A	N/A	N/A		N/A
High Cholesterol									
Heart attack									
Heart problems									
Sickle cell disease									
Sickle cell trait									
Strokes									
Blood clots									
Cancer									

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Name: _____ DOB:_____ Today's Date: _____

Have you had or are you having:

Constitutional: ___Fever ___Chills
___Significant change in your weight (gain or loss)
Eyes: ___Change in vision ___Seeing of spots in your vision
___**Last Eye Exam-**_____
___**Have seen an eye doctor-**_____
ENT: ___Sinus congestion ___Sinus drainage
Respiratory: ___Problems with asthma ___Cough ___Sore throat
___Shortness of breath
___**Have seen a Pulmonologist/Lung doctor-**_____
Heart: ___Irregular heart beat ___Dizziness ___Passing out
___High blood pressure
___**Last EKG** _____
___**Have seen a Cardiologist/Heart doctor-**_____
Blood: ___Bleeding gums ___Bruise easily
___**Have seen a Hematologist/Blood doctor-**_____
GI: ___Heartburn/Indigestion ___Change in appetite ___Diarrhea
___Constipation ___Nausea ___Vomiting
___**Last Dental Exam-** _____
___**Have seen a Gastroenterologist/Stomach doctor-**_____
***OB:** ___Contractions ___Vaginal bleeding ___Leaking of fluid
___Vaginal discharge ___Vaginal itching ___Vaginal irritation
___Good fetal movement ___Decreased fetal movement
___**Have done the Glucola screen/"Sugar Test"-**_____
___**Have seen my OB-**_____
Endocrine: ___High blood sugars ___Low blood sugars
___**Have seen my Endocrinologist-**_____
___Have had a change in my medication-_____
Kidney: ___Pain with urination ___Urinary frequency ___Blood in urine
___**Have seen a Nephrologist/Urologist-**_____
Muscles: ___Joint pain
Skin: ___Rash ___Itching
___**Have seen a Dermatologist-**_____
Neuro: ___Headache ___Dizziness ___Last seizure-_____
___**Have seen my Neurologist-**_____
___Have had a change in my medication-_____
Psychological: ___Problems with depression ___Problems with anxiety
___Have thoughts of hurting myself or others
___**Have seen a therapist or Psychologist-**_____
___Have had a change in my medications-_____

Have there been any changes in your health since your last visit in our office? _____

Is there anything else you feel like we should know today? _____

Patient Signature: _____ Date: _____

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CONSULT NOTES

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Mid-South Maternal Fetal Medicine P.C.

AUTHORIZATION TO RELEASE INFORMATION

Patient Name _____

I hereby authorize Mid-South Maternal Fetal Medicine to release information regarding my protected health information-including account status, test results, and scheduled appointment times and information regarding my health care to the following persons listed below:

***Please note that any person NOT listed below WILL NOT be able to obtain ANY information whatsoever; however you do NOT need to list your OB Physician OR Insurance Companies.**

PLEASE PRINT ALL NAMES: (leave blank if you do not desire to list anyone)

* _____

* _____

* _____

* _____

When notifying me of lab or test results, or matters relating to prescriptions, the practice may call:

Home: YES_____ NO_____ Home phone number with area code _____

Can the practice leave you a message on your answering machine or voice mail? YES_____ or NO_____

Cell: YES_____ NO_____ Please provide phone # with area code:_____

Work: YES_____ NO_____Work # with area code:_____

Patient Portal: YES_____ NO_____

Please list your PHARMACY and phone number for any medications that may be prescribed:
Preferred Pharmacy:_____ Phone:_____

Please list any other special instructions we should know about you:

_____

_____

Patient Signature:_____ Date:_____

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NOTICE

Medical Related Forms

Please note that effective April 1,2017 there will be a $35.00 fee to complete all forms and/or to copy your medical records. This includes all insurance forms and medical leave forms. We ask that this fee be paid at the time of the request. Forms that are faxed to us will not be completed until fee is paid.

In order to comply with your requests in a professional and efficient manner, we ask that you allow 2-3 working days for the forms to be completed. If you are going to pick the forms back up at our office, please call to ensure forms are ready.

If you like for the forms to be mailed to you or forwarded elsewhere, please supply us with a self-addressed envelope with the current address.

We appreciate your consideration and patience along with the ability to better serve you.

_____ _____

Patient signature **Date**