Allergies
(place Allergy sticker here)

Obstetrical Record Keeping System

Arizona Section, American College of Obstetricians & Gynecologists

Patient Name ______________________
Address ______________________
City/State/Zip ______________________
Home Phone __________ Work Ph. __________
Occupation ______________________
Date of Birth __________ Age __________
Marital Status __________ Social Security __________

ALLERGIES ______________________
Insurance __________ Pre Cert. __________
Delivery Hospital __________ Pediatrician __________
Obstetrician __________ Breast ______ Bottle ______
Baby's Father's Name __________ Age ______
Occupation __________ Wk Phone __________
Racial Background: Patient __________ Father __________

PREGNANCY HISTORY Grav ____ Para ____ SAB ____ T/EAB ____ Stillborn ____ Neonatal Death ____ Other Loss ____ Premature ____

No.	Date	Weeks	Sex	Wt.	Delivery Mode	Length of Labor	Obstetrical Problems	Neonatal Problems

LABORATORY STUDIES

BASIC PRENATAL SCREEN

Date ______________________
WBC ______________________
HGB __________ HCT __________
MCV (90±9μμ3) ______________________

BLOOD TYPE & RH ______________________

Atypical Antibodies ______________________
Serology ______________________
Rubella Screen ______________________

	DATE	RESULT
Urinalysis		
HBSAg		
Triple/Quad Screen		

PAP SMEAR ______________________

GLUCOSE SCREEN

Date ______ Fasting ______ 1 hr. ______

REPEAT ANTIBODY SCREEN 24 wks ±, if Rh-Neg.

Date ______ Results ______

OPTIONAL LAB STUDIES

	DATE	RESULT
CF Screen		
GC Screen		
Chlamydia		
HIV Screen		
Sickle Cell		
Herpes		
Drug Screen		
Group B Strep		
Fetal Fibrinectin		
NT/1st Trimester Screen		
Varicella Screen		
Repeat Urinalysis		
IgG/IgM antibodies		

Glucose Tolerance ______ Hr ______ Result ______

REPEAT HGB/HCT

Date ______ Results ______

Other:

______ ______ ______
______ ______ ______
______ ______ ______
______ ______ ______
______ ______ ______

INITIAL PHYSICAL EXAMINATION

Wt ______ Pre-OB Wt ______ Height ______
BP ______ Pulse ______ HEENT ______

Thyroid ______________________
Breasts ______________________
Heart ______________________
Lungs ______________________
Abdomen ______________________
Back ______________________
Extremities ______________________
Vulva ______________________
Vagina ______________________
Cervix ______________________
Uterus ______________________ est. wks.
Adnexae ______________________
Pelvis ______________________

REMARKS

____
____
____
____
____

Exam by ______________________
Date ______________________
Check here if Physical Exam was dictated ☐

DETERMINATION OF GESTATIONAL AGE

LMP ______________________
Cycle length ______________________
Menstrual EDC ______________________
Date of Conception (if known) ______________________
Ultrasound EDC ______________________
Date Performed ______________________

ADDITIONAL ULTRASOUND DATA (OPTIONAL)

Date ______ Findings ______
Date ______ Findings ______
Date ______ Findings ______

CLINICAL EDC ______ **AS OF** ______

The **CLINICAL EDC** is the physician's best estimate of the due date and is the date used for clinical management.

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Patient Name ______________________________

ALLERGIES ______________________________

RISK FACTORS

BLOOD TYPE ________________ **RH** ________

Risk Factors for Prematurity: ______________________________

____

____

History of Pre-eclampsia? ☐ Yes ☐ No

History of Diabetes? ☐ Yes ☐ No

Previous Gyn Surgeries? ☐ Yes ☐ No

Comments: ______________________________

____

Other: ______________________________

PROBLEM LIST

NO.	DATE	
		Hospitalizations During Pregnancy

Comments: ______________________________

Age______ G______ P______ US EDC______ Clinical EDC______________ as of______ **EFW at 36 wks**______

(EDC values should be consistent with documentation on Page 1)

VISIT FLOW SHEET

Visit Date	Gestational Age Wks	Fnd Ht (cm)	Position	FHT	Fetal Activity	Urine P/S	Wt	BP	Return Visit	Notes	Initial
										NT/1st Trimester Screen Discussed ______ Ordered ______ Declined ______	
										Lab Work Ordered ______ Offered Amnio/CVS ______	
										CF Screening Discussed ______ Ordered ______ Declined ______	
	± 16-18 Wks									Triple / Quad Screen Discussed ______ Ordered ______ Declined ______	
	± 28 Wks									Glucose Screen Ordered______ Rh-neg antibody screen ______ Rh-neg Rh immune globulin given ______	

Copy of Records to L&D 20 wks ______ 35 wks ______

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Patient Name ____________________ **ALLERGIES** ____________________

NOTES (Progress/delivery/postpartum, etc.)

TOPICS FOR DISCUSSION BY TRIMESTER - Initial | date when discussed

I. FIRST TRIMESTER

- ____ ______ Anticipated course of prenatal care.
- ____ ______ WIC information provided.
- ____ ______ Prenatal classes discussed.
- ____ ______ Discussion of nutrition and weight gain.
- ____ ______ Discussion of ADA Diet/Diabetic teaching.
- ____ ______ Discuss psychosocial Issues (i.e. safety/violence/ domestic abuse issues).
- ____ ______ Discuss indications for ultrasound.
- ____ ______ Review risk factors identified by prenatal history including smoking, ETOH, illicit drug use.
- ____ ______ Discussion of reaching doctor at night and on weekends; coverage arrangements.
- ____ ______ Discuss amniocentesis or chorionic villus biopsy, if indicated by age or history.
- ____ ______ Warning signs in early pregnancy/risk factors for pre-term labor. ______
- ____ ______ Toxoplasmosis prevention discussed (advice given not to change litter).
- ____ ______ Other: ______

II. SECOND TRIMESTER

- ____ ______ Discuss lab values (normal and abnormal).
- ____ ______ Select a pediatrician.
- ____ ______ Discussed/provided pamphlet on cord blood banking.
- ____ ______ Discuss influenza vaccine (if applicable).
- ____ ______ Review warning signs and symptoms of preterm labor in second trimester.
- ____ ______ Other: ______

III. THIRD TRIMESTER

- ____ ______ Discuss hospital facilities.
- ____ ______ Discuss labor medication/anesthesia options.
- ____ ______ Give patient labor instructions.
- ____ ______ Discussion regarding VBAC including risks.
- ____ ______ Post-dates counseling (40-41 weeks).
- ____ ______ Fetal well-being surveillance: (i.e. FM charting, other tests)

Desire for sterilization:

- ____ ______ a. Immediate versus the post partum period
- ____ ______ b. Failure, irreversibility
- ____ ______ c. In-office consent form signed: ☐ Yes ☐ No
- ____ ______ Review signs and symptoms of Pre-eclampsia and other emergencies.
- ____ ______ Discuss warning signs of impending labor (leaking fluid, bleeding, contractions, pelvic pressure).
- ____ ______ Instruct patient to call immediately or go to ER if signs of labor, especially prior to 36 weeks.
- ____ ______ Contact numbers/instructions for after-hours emergency care provided.
- ____ ______ Discuss possibility of C-section and indications.
- ____ ______ Postpartum depression
- ____ ______ Instructed on use of infant car seats and seat belts.
- ____ ______ Other: ______

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OBSTETRICAL MEDICAL HISTORY

Patient Name ____________________ Date Form Completed ____________

PHYSICIAN NOTES

PERSONAL HEALTH HISTORY

1. Are you allergic to any medications? ☐ Yes ☐ No
   If yes, please list: ____________________
2. Please mark any condition that you have or have had in the past:
   - ☐ Arthritis or Lupus
   - ☐ Asthma
   - ☐ Bladder or Kidney Infections
   - ☐ Bleeding Disorder
   - ☐ Blood Disease
   - ☐ Bowel Disease
   - ☐ Cancer
   - ☐ Chicken Pox
   - ☐ Depression
   - ☐ Diabetes
   - ☐ Emotional Disorders
   - ☐ Epilepsy
   - ☐ Fibromyalgia
   - ☐ Group B Strep
   - ☐ Headaches
   - ☐ Heart Problems
   - ☐ Hepatitis
   - ☐ Herpes
   - ☐ High Blood Pressure
   - ☐ HIV
   - ☐ Hyperactivity
   - ☐ Kidney Disease
   - ☐ Migraine Headaches
   - ☐ Thyroid Disorder
   - ☐ Other

   Describe, if needed: ____________________
3. Please indicate any operations or surgery you have had: ____________________
4. Please describe any health problems or symptoms you are having at this time: ____________________

EXPOSURES AFFECTING HEALTH

1. Do you use tobacco? ☐ Yes ☐ No If yes, how much per day? ____________
2. Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how often? ____________
   What type of drink(s)? ____________________
3. Please list any medications taken since your last period, including over-the-counter medications: ____________________
4. Have you had an influenza (flu) vaccine? ☐ Yes ☐ No If yes, when? ____________
5. Please list any drugs used in the past (i.e. cocaine, marijuana, pain medication, meth, etc.): ____________________
   Dates last used: ____________________
6. Do you have a history of blood transfusion, intravenous drug use, multiple sexual partners or sexual exposure to a gay or bi-sexual male, exposure to an intravenous drug user, or have any other reason to believe you may have been exposed to AIDS? ____________________
7. Do you work with chemicals or radiation (i.e. x-rays)? ☐ Yes ☐ No
8. Are you on a special diet? ☐ Yes ☐ No
   If yes, please describe: ____________________
9. Do you have cats? ☐ Yes ☐ No

GYNECOLOGIC HEALTH HISTORY

1. When was your last menstrual cycle (period)? ____________________
2. When was your last Pap Smear? ____________ Have you ever had an abnormal Pap Smear? ☐ Yes ☐ No If yes, when? ____________
   What was the diagnosis? ____________________
   What was done? ____________________
3. Have you ever had gonorrhea, chlamydia or pelvic inflammatory disease? ☐ Yes ☐ No
   If yes, when and where were you treated? ____________________
4. Have you ever had herpes? ☐ Yes ☐ No
5. Did you receive the HPV vaccine (Gardasil)? ☐ Yes ☐ No
6. Do you use contraceptives? ☐ Yes ☐ No If yes, what type: ____________
7. Have you had bladder or kidney infections? ☐ Yes ☐ No
   If yes, what was done? ____________________
8. Do you have a history of infertility? ☐ Yes ☐ No If yes, please describe when and treatment received: ____________________
9. Please list any other concerns you have related to your past health history: ____________________

____________ Patient Signature ____________ Print Name ____________ Date

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Patient Name ______________________ **ALLERGIES** ______________________

OBSTETRICAL MEDICAL HISTORY, PAGE 2

10. Do you have any religious or other objections to any form of medical treatment you would like to make us aware of (i.e. refusal of blood transfusion)? ______________________

11. Do you have any special needs for: Hearing: ☐ Yes ☐ No Vision: ☐ Yes ☐ No Language: ☐ Yes ☐ No

FAMILY HISTORY & GENETIC HISTORY

1. Have either you or the baby's father had a child born with a birth defect? .... ☐ Yes ☐ No
   If yes, please describe: ______________________

2. Did either you or the baby's father have a birth defect yourselves? .... ☐ Yes ☐ No
   If yes, please describe: ______________________

3. Please describe any abnormalities that have occurred in children in your family or the baby's father's family (for example, mental retardation, birth defects, deformities, or inherited diseases like hemophilia, muscular dystrophy or cystic fibrosis). ______________________
   ____
   How is the affected child/person related to you? ______________________

4. Do either you or the baby's father have a history of pregnancy losses (miscarriages or stillborn)? .... ☐ Yes ☐ No
   If yes, have either of you had genetic counselling? .... ☐ Yes ☐ No
   If yes, have either of you had chromosomal studies? .... ☐ Yes ☐ No
   Where and results: ______________________

5. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if either you or the baby's father is of one of these backgrounds:

   Jewish ancestry? ☐ Yes ☐ No If yes, have you had Tay-Sachs screening tests? .... ☐ Yes ☐ No
   Date: __________ Result: ______________________

   African-American? ☐ Yes ☐ No If yes, have you had Sickle Cell screening? .... ☐ Yes ☐ No
   Date: __________ Result: ______________________

6. Please mark if anyone in your family or the baby's father's family has:

Condition	Yes	No	
Diabetes	☐ Yes	☐ No	If yes, how is that person related to you? __________
Bleeding Disorder	☐ Yes	☐ No	If yes, how is that person related to you? __________
High Blood Pressure	☐ Yes	☐ No	If yes, how is that person related to you? __________
Cancer	☐ Yes	☐ No	If yes, how is that person related to you? __________
Hepatitis	☐ Yes	☐ No	If yes, how is that person related to you? __________
HIV	☐ Yes	☐ No	If yes, how is that person related to you? __________
Twins/multiple gestation pregnancy	☐ Yes	☐ No	If yes, how is that person related to you? __________

7. Please list any other concerns you have about birth defects or inherited disorders:
   ____
   ____

8. Will you be 35 or older at the time the baby is born? .... ☐ Yes ☐ No

9. Will the father be 50 or older? .... ☐ Yes ☐ No

______________________ ______________________ ______________
Patient Signature Print Name Date

Physician Notes: ______________________
____
____
____

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PRENATAL FLOWSHEET SUPPLEMENT

Patient Name ____

RISK FACTORS **PROBLEM LIST**

See Preceding Page

Age_______ G_______ P_______ US EDC_______________ Clinical EDC_______ as of_______ **EFW at 36 wks**_______

(EDC values should be consistent with documentation on Page 1)

VISIT FLOW SHEET

Visit Date	Gestational Age Wks	Fnd Ht (cm)	Position	FHT	Fetal Activity	Urine P/S	Wt	BP	Return Visit	Notes	Initial

Notes ____

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Notes

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Patient Name ______________________

DELIVERY INFORMATION

Delivery date ________ Weeks gest. ________ Delivered by ______________ Hospital ______________

Labor
- ☐ Augmented
- ☐ Induced
- ☐ No labor
- ☐ Spontaneous

Tubal Sterilization
☐ Yes ☐ No

Vaginal Delivery
- ☐ Classical
- ☐ Episiotomy
- ☐ Forceps
- ☐ Lacerations
- ☐ Vacuum
- ☐ VBAC
- ☐ SVD

Cesarean Delivery
- ☐ Primary (for ____________)
- ☐ Repeat Elective
- ☐ Repeat/Failed VBAC

Incision
- ☐ Low Transverse
- ☐ Low Vertical

Anesthesia
- ☐ Epidural
- ☐ General
- ☐ Local
- ☐ None
- ☐ Spinal
- ☐ Other

Length of labor ______________

Comments ______________

NEWBORN INFORMATION

Baby's name ______________ Gender ________ Pediatrician ______________

Birth weight ______________ Apgar ________ Cord PH ______________

Complications ______________ Anomalies ______________

Disposition ☐ Home with Mother ☐ Infant in hospital ☐ Neonatal death ☐ Stillbirth

Comments ______________

POSTPARTUM INFORMATION

☐ Breast feeding ☐ Bottle feeding Contraceptive Method ______________

Length of stay ________ Immunizations: ☐ D(Rho[D]) Immune Globulin ☐ Rubella Other ________

Medications/Special Instructions ______________

PP Complications: ☐ None ☐ Hemorrhage ☐ Infection ☐ Hypertension Other ________

Other Medical problems ______________

Comments ______________

POSTPARTUM VISIT NOTE

Date ________ Allergies ________ Medication/Contraception ________

Weight today ________ Pre-OB weight ________ BP ________ Pulse ________

Labs
- ☐ Hgb
- ☐ Hct
- ☐ Other ______________

Pap

Last Pap done ________ Results ________

Pap due date ________ Pap done today? ☐ Yes ☐ No

Physical Exam (check if normal):

☐ Abdomen ☐ Cervix ☐ Extremities ☐ Rectal ☐ Vagina

☐ Adnexae ☐ Episiotomy ☐ Incision (C/S) ☐ Uterus ☐ Vulva ☐ Other ________

Breast Exam ________ Instructed in Self Breast Exam ________

Remarks ______________

Exam by ______________ Return Visit ______________

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Notes

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HISTORIA MEDICA DE OBSTÉTRICA

Nombre del Paciente ____________________ Fecha de Completar el Formulario __________

HISTORIA PERSONAL DE LA SALUD

1. ¿Tiene alergia a alguna medicina?... ☐ Sí ☐ No
   Si es sí, Favor de hacer una lista: ____________________
2. Por favor marque cualquier condición que usted tiene o halla tenido en el pasado:
   - ☐ Alta Presión de Sangre
   - ☐ Artritis o Lupus
   - ☐ Asma
   - ☐ Cáncer
   - ☐ Depresión
   - ☐ Desorden de la Tiroides
   - ☐ Desorden Emocional
   - ☐ Desorden de Sangramiento
   - ☐ Diabetes
   - ☐ Dolores de Cabeza
   - ☐ Enfermedad de la Sangre
   - ☐ Enfermedad del Corazón
   - ☐ Enfermedad Intestinal
   - ☐ Enfermedad del Riñón
   - ☐ Epilepsia
   - ☐ Fibromyalgia
   - ☐ Estreptococo Grupo B
   - ☐ Hepatitis
   - ☐ Herpes
   - ☐ Hiperactividad
   - ☐ Infecciónes de la Vejiga o Riñón
   - ☐ Migrañas
   - ☐ Otro
   - ☐ Varicela
   - ☐ VIH (Virus del Sida)

   Describa si es necesario: ____________________
3. Favor de indicar cualquier operación o cirugía que ha tenido: ____________________
4. Por favor describa cualquier problema de salud o síntoma que usted tiene en este momento: ____________________

EXPOSICIONES AFECTANDO LA SALUD:

1. ¿Usa tabaco? ☐ Sí ☐ No Si es sí, ¿Cuanto por día? ____________________
2. ¿Toma bebidas alcohólicas? ☐ Sí ☐ No Si es sí, ¿Con que frecuencia? ____________________
   ¿Que tipo de bebida(s)? ____________________
3. Por favor liste cualquier medicina tomada desde su ultimo período, incluyendo medicina disponible sin receta: ____________________
4. ¿Ha recibido vacuna contra la influenza (gripe)? ☐ Sí ☐ No Si es sí, Cuando? ____________________
5. Por favor liste cualquier droga usada en el pasado (por ejemplo: cocaína, marihuana, metanfetamina, etc.: ____________________
   Fecha de ultimo uso de drogas: ____________________
6. ¿Tiene usted historia de transfusion de sangre, uso de drogas intravenoso, múltiples compañeros sexuales o exposición a un hombre homosexual o bisexual, exposición a un usuario de drogas intravenoso, o tiene cualquier otra razón para creer que fue expuesto a el SIDA? ____________________
7. ¿Trabaja usted con químicos o radiación (por ejemplo: rayos-x)?.................................... ☐ Sí ☐ No
8. ¿Está usted en una dieta especial? ☐ Sí ☐ No Si es sí, por favor describa: ____________________
9. ¿Tiene usted gatos? .... ☐ Sí ☐ No

HISTORIA GINECOLÓGICA DE SALUD

1. ¿Cuándo fue su último ciclo menstrual (periodo)? ____________________
2. ¿Cuándo fue su última prueba de papanicolaou? ____________________
   ¿Ha tenido un papanicolaou anormal?.. ☐ Sí ☐ No
   Si es sí ¿Cuándo? __________ ¿Cual fue el diagnostico? __________
   ¿Qué se hizo al respecto? ____________________
3. ¿Ha tenido usted alguna vez gonorrea, clamidia, o enfermedad inflamatoria pelvica? .... ☐ Sí ☐ No
   Si es sí, ¿Cuándo y donde recibió tratamiento? ____________________
4. ¿Ha tenido Herpes?. .... ☐ Sí ☐ No
5. ¿Ha recibido la vacuna del Virus Humano Papiloma?.. ☐ Sí ☐ No
6. ¿Usa usted anteconceptivos? ☐ Sí ☐ No Si es sí, ¿Qué tipo? ____________________
7. ¿Ha tenido infecciones de la vejiga o riñon?. .... ☐ Sí ☐ No
   Si es sí, ¿Que se hizo al respecto? ____________________
8. ¿Tiene usted historia de infertilidad? ☐ Sí ☐ No Si es sí, por favor describa cuándo y el tratamiento que recibió. ____________________

Firma del Paciente ____________________ Nombre en letra de Imprenta ____________________ Fecha ____________________

NOTAS DE EL MEDICO

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Nombre del Paciente: ______________________ **ALERGIAS** ____________

NOTAS DE EL MEDICO

9. Favor de hacer una lista de otras preocupaciones que usted tiene en relacíon a su historia de salud:

10. ¿Tiene usted alguna objeción religiosa u otras objeciones para cualquier forma de tratamiento médico que a usted le gustaría hacernos saber (por ejemplo: negar una transfusión de sangre)?

11. ¿Tiene usted alguna necesidad especial para:
Oír: ☐ Sí ☐ No Visión: ☐ Sí ☐ No Lenguaje: ☐ Sí ☐ No

HISTORIA DE FAMILIA Y GENÉTICA

1. ¿Ha tenido ya sea usted o el padre del bebe un niño con un defecto de nacimiento? .. ☐ Sí ☐ No
   Si es sí, por favor describa: ____________
2. ¿Tienen ya sea usted o el padre del bebe un defecto de nacimiento? .... ☐ Sí ☐ No
   Si es sí, por favor describa: ____________
3. Favor de describir cualquier anormalidad que ha ocurrido en niños de su familia o en la familia de el padre del bebe: (por ejemplo, retardación mental, defectos de nacimiento, deformidades, o enfermedades heredadas como hemofilia, distrofia muscular, o fibrosis cística).

   ¿Qué parentesco tiene con usted el niño(a) o persona afectada? ____________
4. ¿Tiene usted o el padre de el bebe historial de pérdidas de embarazos (abortos o nacido muerto)? .... ☐ Sí ☐ No
   Si es sí, ¿Han tenido ustedes consejería genética? .... ☐ Sí ☐ No
   Si es sí, ¿Han tenido cualquiera de ustedes estudios de cromosoma?........ ☐ Sí ☐ No
   Donde y resultados: ____________
5. Algunos problemas genéticos occuren más en parejas de ciertos antecedentes raciales o ancestrales. Por favor marque si ya sea usted o el padre de el bebe tiene alguno de estos antecedentes:

   ¿Ascendencia Judía? ☐ Sí ☐ No Si es sí, ¿Ha tenido usted un estudio de Tay-Sachs? .... ☐ Sí ☐ No
   Fecha: ________ Resultado ________

   ¿Afro-Americano? ☐ Sí ☐ No Si es sí, ¿Ha tenido usted estudios de Célula de Hoz? ..... ☐ Sí ☐ No
   Fecha: ________ Resultado ________
6. Por favor indique si alguien en su familia o en la familia del padre de el bebe tiene:

   Diabetes ☐ Sí ☐ No Si es sí, ¿Cual es el parentesco de esta persona con usted? ________
   Desorden de Sangramiento ☐ Sí ☐ No Si es sí, ¿Cual es el parentesco de esta persona con usted? ________
   Alta Presión de Sangre ☐ Sí ☐ No Si es sí, ¿Cual es el parentesco de esta persona con usted? ________
   Cancer ☐ Sí ☐ No Si es sí, ¿Cual es el parentesco de esta persona con usted? ________
   Hepatitis ☐ Sí ☐ No Si es sí, ¿Cual es el parentesco de esta persona con usted? ________
   VIH ☐ Sí ☐ No Si es sí, ¿Cual es el parentesco de esta persona con usted? ________
   Embarazo de gestación de gemelos/embarazo de gestación Múltiple ☐ Sí ☐ No Si es sí, ¿Cual es el parentesco de esta persona con usted? ________
7. Favor de hacer una lista de otras preocupaciones que usted tiene sobre defectos de nacimiento o los desórdenes heredados. ____________
8. ¿Tendrá usted 35 años o más cuando nazca el bebe?........ ☐ Sí ☐ No
9. ¿Tendrá el padre 50 años o más? .... ☐ Sí ☐ No

Firma del Paciente ________ Nombre en letra de Imprenta ________ Fecha ________

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Thunderbird Obstetrics and Gynecology, Ltd.
5757 West Thunderbird Road, Suite E451
Glendale, AZ 85306

PATIENT NAME: ______________________________ BIRTH DATE: ___________________ AGE: _______

ADDRESS: ___________________________________ MARITAL STATUS: M S D W

CITY/ZIP CODE: ______________________________ SOCIAL SECURITY #: __________________________

HOME PHONE: _______________________________ WORK PHONE: _______________________________

EMPLOYER: __________________________________ REF'D BY: ___________________________________

SPOUSE (OR PARENT IF MINOR)

NAME: _______________________________________

BIRTH DATE: __________________________________

EMPLOYER: ___________________________________

OCCUPATION: _________________________________

WORK PHONE: ________________________________

EMERGENCY CONTACT / Not living with you

NAME: ____

RELATIONSHIP: ______________________________

EMERGENCY #: _______________________________

PRIMARY CARE PHYSICIAN: __________________

PCP PHONE: __________________________________

PRIMARY INSURANCE

NAME: _______________________________________

ADDRESS: ____________________________________

____

ID #: ____

GROUP #: ____________________________________

INSURED: ____________________________________

RELATIONSHIP TO PATIENT: _________________

SECONDARY INSURANCE

NAME: ____

ADDRESS: _____________________________________

____

ID #: ____

GROUP #: _____________________________________

INSURED: _____________________________________

RELATIONSHIP TO PATIENT: __________________

CONSENT FOR TREATMENT / INSURANCE AUTHORIZATION & ASSIGNMENT

I hereby authorize my physician to release any and all information acquired in the course of my examination or treatment to my insurance carrier.

I hereby assign/authorize payment directly to the physician for the medical and/or surgical benefits otherwise payable to me for services provided. I understand that I am financially responsible for the charges not covered/allowed by my insurance. A photocopy of this authorization shall be accepted as the original.

SIGNATURE: _________________________________ **DATE:** _____________________________________