**PATIENT INFORMATION**

**(PLEASE COMPLETE ALL FORMS IN BLACK INK)**

LAST NAME ______________________ FIRST ______________________ MIDDLE ______________

DATE OF BIRTH ____________ SEX ________ MARITAL STATUS ___________ SS# ______________________

ADDRESS ______________________________ CITY __________________ STATE ______ ZIP ________

PHONE: HOME ______________________ CELL/OTHER __________________ WORK ______________

EMAIL ADDRESS: ______________________________________________

EMPLOYER: ______________________________ OCCUPATION: ______________________

**RACE**:
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Hispanic or Latino (no race info available)
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Hispanic or Latino & one or more races
- ☐ More than one race (Hispanic/Latino not known)
- ☐ Unknown

**ETHNICITY:**
- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino

**PREFERRED LANGUAGE:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ English | ☐ Spanish | ☐ Japanese | ☐ Chinese | ☐ Italian | ☐ Hindi |
| ☐ Portuguese | ☐ Russian | ☐ French | ☐ Guatemalan | ☐ Tagolog | ☐ Arabic |
| ☐ Bosnian | ☐ Vietnamese | ☐ Laotian | ☐ German | ☐ Gujarati | |

**INSURANCE INFORMATION**

COMMERCIAL INSURANCE ☐ MEDICAID ☐ TRICARE STANDARD ☐ TRICARE PRIME* ☐ SELF-PAY ☐

***referral required for all Tricare Prime BEFORE first visit**

**(*WE WILL NEED CARD WITH INSURANCE COMPANY NAME, POLICY NUMBER, GROUP NUMBER AND CONTACT INFORMATION)**

**PATIENT RELATIONSHIP TO SUBSCRIBER: ☐SELF ☐SPOUSE ☐DEPENDENT CHILD**

LAST NAME ______________________ FIRST ______________________ MIDDLE ______________

ADDRESS ______________________ CITY ______________________ STATE ______ ZIP ________

DATE OF BIRTH ______________________ SS# ______________________________

PHONE: HOME ______________________ CELL/OTHER __________________ WORK ______________

INSURANCE COMPANY: ______________________________________________

INSURANCE ID #: ______________________________ GROUP #: ______________________

CLAIMS MAILING ADDRESS:
(USUALLY FOUND ON BACK OF CARD)

______________________________________

______________________________________

CITY ____________ STATE ______ ZIP ________

**SECONDARY INSURANCE INFORMATION**

**PATIENT RELATIONSHIP TO SUBSCRIBER: ☐SELF ☐SPOUSE ☐DEPENDENT CHILD**

LAST NAME ______________________ FIRST ______________________ MIDDLE ______________

ADDRESS ______________________ CITY ______________________ STATE ______ ZIP ________

**PLEASE TURN OVER AND COMPLET REMAINING INFORMATION ON BACK SIDE**

**PATIENT NAME:** ____________________________________________

DATE OF BIRTH ___________________________________ SS# ______________________________________________________________

PHONE: HOME ______________________________________ CELL/OTHER ______________________________ WORK ___________________________

INSURANCE COMPANY: ____________________________________________________________________________________________________

INSURANCE ID #: _____________________________________________________ GROUP #: _________________________________________

CLAIMS MAILING ADDRESS: __________________________________________________________
(USUALLY FOUND ON BACK OF CARD)

__________________________________________________________

CITY ____________________ STATE ___________ ZIP ______________

**SPOUSE/SIGNIFICANT OTHER**

LAST NAME ________________________________________ FIRST ____________________________________ MIDDLE __________________

DATE OF BIRTH ____________________ SEX _____________ SS# ______________________________

EMPLOYER: __________________________________________________________ OCCUPATION: ______________________________________________

PHONE: HOME ______________________________________ CELL/OTHER ______________________________ WORK ___________________________

**PARENT OR GUARDIAN OF MINOR**

NAME _____________________________________________________________ RELATIONSHIP TO PATIENT ____________________________________

ADDRESS ___________________________________________ CITY _____________________________ STATE ___________ ZIP ______________

PHONE: HOME ______________________________________ CELL/OTHER ______________________________ WORK ___________________________

**ALTERNATIVE CONTACT INFO (other than Spouse/Signficant Other)**

NAME ______________________________________________________________________ RELATIONSHIP TO PATIENT ____________________________

PHONE: HOME ______________________________ WORK ____________________________________ CELL/OTHER ________________________________

**PREFERRED PHARMACY**

PHARMACY NAME: ____________________________________________ PHONE #: __________________________________________

LOCATION: _____________________________________________________________________________________________________________

**PREFERRED LAB**

If your insurance requires that you use a particular lab, you must let us know. It is the patient's responsibility to inform us if there is a preferred lab, or if any change in your insurance requires that this information be changed. Please be sure to notify us if this information changes so that we may update your information and so that you will not incur additional expense.

Preferred Laboratory: ____________________________________________________________________________________________________

PATIENT SIGNATURE: ___________________________________________________________________________ DATE: _____________________________

## OUR FINANCIAL POLICY

Full payment is due at time of service. We accept cash, checks and credit cards. Our practice is committed to providing the best treatment for our clients and our charges are usual and customary for our area. **I am** responsible for payment regardless of insurance company's arbitrary determination of usual and customary rates or decisions regarding services not covered. I agree to pay collection fees deemed necessary to collect on any outstanding balances on my account.

SIGNATURE_______________________________________________DATE_____________________

## RELEASE AND ASSIGNMENT

I hereby authorize the release by The Midwife Group/ The Family Health and Birth Center, Inc. of any of my medical records deemed necessary to process my insurance claim.

SIGNATURE_______________________________________________DATE_____________________

I hereby authorize payment of medical benefits to The Midwife Group/ Family Health and Birth Center, Inc. or its providers for services rendered to me. I fully understand that I am responsible for all charges incurred as a result of services rendered to me and any balance remaining after my insurance pays.

SIGNATURE_______________________________________________DATE_____________________

I, the undersigned, a patient in this facility, hereby authorize the health providers (and whomever they may designate as their assistants) to administer such treatment as is necessary. I hereby certify that I have read and fully understand this authorization for medical treatment. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

SIGNATURE_______________________________________________DATE_____________________

SIGNED FOR PATIENT BY_____________________________RELATIONSHIP_______________________

## PARTICIPATION IN EDUCATION

I hereby give my permission for the participation of students in my care. Students will always be supervised by a CNM or FNP. I may refuse student involvement at any time.

SIGNATURE_______________________________________________DATE_____________________

## CONSENT FOR HIV TESTING IN PREGNANCY

The HIV test is advised as routine screening in pregnancy and in sexually active individuals. I understand that I have the right to refuse HIV testing. I understand that test results will become part of my medical record. I give my consent for HIV testing.

SIGNATURE_______________________________________________DATE_____________________

## CONSENT FOR DRUG TESTING IN PREGNANCY

Because the use of illegal drugs/ substances is potentially harmful to you and your fetus, drug testing is a routine part of our laboratory testing. I understand that I have the right to refuse drug testing. I understand that test results will become part of my medical record. I give my consent for drug testing.

SIGNATURE_______________________________________________DATE_____________________

## PRIVACY INFORMATION

The privacy of your medical record and information is important to us. In the course of your care, all of the providers in our practice may have access to your medical records. Additionally, our medical consultants review some records to assist us with your care. The office personnel use information from your medical record to make appointments, referrals and to bill your insurance company or to bill you for your care. Nursing or midwifery students, under the supervision of an onsite provider may also see your record.

Your medical record is kept in a locked cabinet in a locked office except when in use in the practice. All medical records are labeled as confidential.

In the event of referral or transfer to another provider or at your request, your record may be mailed or faxed to another provider. You may also ask that a copy of your record be given to you for review. If you find errors in your record, you may request in writing that changes be made. The Birth Center Director will review requests and a written reply will be sent to you. All transfers of your medical record require a signed a release form from you. Parents or legal guardians must sign for minor children.

All pregnant women will be asked to sign permission to release records in an emergency. The medical record will then accompany the woman to the hospital labor and delivery or to the office of our designated Ob-Gyn consultant.

Some information from the medical record will be sent to a designated laboratory on various requests for laboratory tests. The Ultrasonographer will use your medical record at the time of testing. The Registered Nurses who are employed to assist you in the Birth Center in labor and delivery will review your medical record on assuming your care and will chart in your record while you are the Center. Medicaid or your insurance company will be given information to process your claims to pay your bill. If you fail to pay your bill, information will be sent to our collection agency.

If you wish to allow access to your medical information by your spouse or other persons, you will need to place their name(s) in the disclosure section below. We cannot give any information in person or over the phone without confirming identification by using your social security number or birth date.

## DISCLOSURE OF CONFIDENTIAL INFORMATION

In the case that you are not available when we call your phone or home to leave information or a message, please list other individuals with whom we can leave a message or information. **You have my permission to disclose information about my care to the following individuals.**

NAME(s):______________________________________________________________________________

If you have questions about any of these policies, please ask to speak with Nancy Belin, CNM Birth center Director and Privacy Officer.

I have read this information and understand these policies.

SIGNATURE__________________________________________________DATE______________________
WITNESS
SIGNATURE__________________________________________________DATE______________________

## CONFIDENTIALITY AGREEMENT FOR PARTICIPATION IN GROUP PRENATAL CARE

Privacy is something everyone is concerned about when they participate in group appointments. You have the right to expect that what is said remains private and confidential. Along with our commitment to maintain your privacy, you also have a responsibility to respect and protect each other's privacy.

Please share useful information outside of the group, but what you hear and learn about individual group members should stay here.

SIGNATURE__________________________________________________DATE______________________

| NAME | BIRTHDATE | TODAY'S DATE |
|---|---|---|

## HEALTH HISTORY QUESTIONNAIRE

| MEDICAL HISTORY | YES | NO | CNM NOTES |
|---|---|---|---|
| Do you have or have you ever had an allergic reaction to any medication or other substance? | | | |
| Do you take any medication(s) on a regular basis? | | | |
| Do you have or have you ever had heart problems or heart disease? | | | |
| Do you have or have you ever had diabetes? | | | |
| Do you have or have you ever had high blood pressure? | | | |
| Do you have or have you ever had varicose veins or blood clots in your legs? | | | |
| Do you have or have you ever had emotional problems? Have you been treated for anxiety or depression? | | | |
| Do you have or have you ever had epilepsy or seizures? | | | |
| Do you have or have you ever had stomach or bowel problems? | | | |
| Do you have or have you ever had pneumonia or asthma? | | | |
| Do you have or have you ever had thyroid problems? | | | |
| Do you have or have you ever had back or joint problems? | | | |
| Do you have migraine headaches? | | | |
| Do you have or have you ever had kidney or bladder problems? | | | |
| Have you ever been hospitalized for any serious illness? | | | |
| Have you ever had any surgeries or operations? | | | |
| Have you ever had blood transfusions? | | | |
| Do you have or have you ever had or been exposed to TB? | | | |
| Do you have any vision or hearing problems? | | | |
| Do you have any current dental problems? | | | |
| Are your immunizations up to date? | | | |

| GYNECOLOGICAL HISTORY | YES | NO | CNM NOTES |
|---|---|---|---|
| Age at first period? _______ Date of last period? _________ | ◆ | ◆ | |
| # of pregnancies____________ # of live births_____________ | ◆ | ◆ | |
| Last Pap smear? ____________________________________ | ◆ | ◆ | |
| Do you have or have you ever had an abnormal Pap smear? | | | |
| Do you have or have you ever had irregular periods? | | | |
| Menopause or symptoms of menopause? | | | |
| Do you know how to do a breast self exam? | | | |
| Do you have or have you ever had breast lumps or discharge? | | | |
| Do you have abnormal vaginal bleeding? | | | |
| Do you have or have you ever had endometriosis? | | | |
| Do you douche? | | | |
| Do you have problems with sex? | | | |
| Do you have or have you ever had vaginal infections? | | | |
| Do you have or have you ever had pelvic infections? | | | |
| Do you have or have you ever had sexually transmitted diseases? Herpes? Genital warts/ HPV? GC? Chlamydia? Hepatitis? | | | |
| Have you ever had any female surgery or procedures? | | | |

| NAME | BIRTHDATE | | | TODAY'S DATE |
|---|---|---|---|---|
| **FAMILY HISTORY (MOTHER, FATHER, GRANDPARENTS, SIBLINGS)** | | **YES** | **NO** | **CNM NOTES** |
| Has a family member had high blood pressure? | | | | |
| Has a family member had heart disease? | | | | |
| Has a family member had diabetes that requires insulin shots? | | | | |
| Has a family member had breast cancer? | | | | |
| Has a family member had colon cancer? | | | | |
| Has a family member had birth defects or genetic disease? | | | | |
| Has a family member had multiple births? (twins) | | | | |

| **PERSONAL/ SOCIAL HISTORY** | **YES** | **NO** | **CNM NOTES** |
|---|---|---|---|
| Height_____________________________________<br>Usual weight___________________________________ | ◆ | ◆ | BMI<br>(BMI = [WEIGHT IN LBS ÷HEIGHT IN INCHES ÷ HEIGHT IN INCHES] × 703) |
| Do you use or have you ever used tobacco? | | | |
| Do you use or have you ever used alcohol? | | | |
| Do you use or have you ever used street drugs (marijuana, meth, cocaine, crack, others)? | | | |
| Do you ever drive or ride in a car without wearing a seat belt? | | | |
| Do you eat three meals a day? | | | |
| Do you eat protein foods, grains, dairy, fruits and vegetables each day? | | | |
| Do you do something to be physically active (increased heart rate, increased breathing) for 30 minutes nearly every day? | | | |
| What is the highest level of education you have completed?<br>________________________________________ | ◆ | ◆ | |
| What is your occupation?<br>________________________________________ | ◆ | ◆ | |
| Who do you live with?<br>________________________________________ | ◆ | ◆ | |
| Have you ever been sexually or physically abused? | | | |
| Are you in a relationship now with anyone who physically or sexually abuses you? | | | |
| What if any religious beliefs may affect your health care?<br>________________________________________ | ◆ | ◆ | |
| Do you have written advance directives (a living will)? | | | |

| Patient signature | Date |
|---|---|
| Reviewed by CNM | Date |
| Reviewed by CNM | Date |
| Reviewed by CNM | Date |