



ST. MARY'S

PATIENT REGISTRATION FORM

Today's Date _____

Patient's Name _____
(Last) (First) (MI)

Street or Box No. _____ City _____

State _____ Zip _____ Home Phone _____ Cell Phone _____ Other Phone _____

OK to leave message at home _____ Email Address _____

Birthdate _____ Married ___ Divorced ___ Single ___ Widowed ___

Sex: Female ___ Male ___ Social Security # _____

Employer _____ Occupation _____

Employer Address _____ Phone _____

This section should be completed with the Insured Individual's personal information.

PRIMARY INSURANCE

SECONDARY INSURANCE

Insurance Company _____

Insurance Company _____

Name of Insured _____
Last First

Name of Insured _____

BirthDate _____ Social Security # _____

BirthDate _____ Social Security # _____

Address _____

Address _____

City _____ State _____ ZIP _____

City _____ State _____ ZIP _____

Phone _____ Policy Holder Name _____

Phone _____ Policy Holder Name _____

Effective Date _____ Policy # _____

Effective Date _____ Policy # _____

Whom can we contact in Case of Emergency? _____

Relationship to Patient? _____

Phone # _____

Referring Physician _____

Pharmacy _____ Phone Number _____

How did you hear about us?

___ Internet ___ Newspaper ___ Friend/Family ___ Telephone Book ___ Physician ___ SMMC 4DOCLine

ADDITIONAL CONSENT TO RELEASE INFORMATION

I authorize St. Mary’s Physician Network to discuss and release medical information regarding my care and to schedule procedures to the following family members in specific:

| | |
|-------|--------------|
| _____ | _____ |
| Name | Relationship |
| _____ | _____ |
| Name | Relationship |

AGREEMENT TO PAY

I agree to pay for all fees or my portion not covered by medical insurance for myself or the above patient at the time of service. I realize I am also responsible for full payment of fees not paid by my insurance within thirty days of notification by this office. I agree to be responsible for any fees required to collect payment for services including: attorney and court costs, collection agency fees, pre-judgment and post/judgment interest at the current legal rate. I hereby authorize insurance payment directly to St. Mary’s Physician Network.

MEDICAL RECORDS RELEASE

If it is necessary for any of my medical records, including progress notes and laboratory results, to be sent to another health care provider for medical reasons and to facilitate timely healthcare, I authorize St. Mary’s Physician Network to do so.

I also authorize the release of medical information necessary to process my claim, to my insurance company, Workman’s Compensation plan, Social Security, Medicare or Medicaid, or any representatives acting on their behalf.

I further authorize the release of my medical records to any individual or organization, engaged by St. Mary’s Physician Network, or my third party payer (insurance company), to conduct quality improvement and/or utilization review. I permit a copy of this authorization to be used in place of the original. I hereby release St. Mary’s Physician Network for all legal liability that may arise from the disclosure of such information.

Prescriptions for contraceptive uses are prescribed by your healthcare professional in his or her limited private practice capacity, not by St. Mary’s Medical Center.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits for any services furnished to me by St. Mary’s Physician Network (or any party who accepts assignment) be made to either me or on my behalf to St. Mary’s Physician Network. I authorize the holder of medical or other information to release to the Health Care Financing Administration (Medicare) and its agents, any information needed to determine these benefits or benefits for related services. I further authorize St. Mary’s Physician Network to release any information needed for this or any related Medicare/Medicaid claim to the Social Security Administration or its intermediaries or carriers.

I have received a **Notice of Privacy Practice, Notice of Patients’ Rights and Responsibilities, and Notice of Financial Policy.**

Signature _____ Printed Name _____ Date _____



**Maternal-Fetal Medicine & Genetics Center
Patient Demographic Form**

Please complete prior to your appointment - all information you provide is confidential and used only in our office to assist in your care.

Date: _____

I Name _____ Date of Birth: ____ - ____ - ____

Maiden Name _____ Marital Status (circle): M S D W Soc. Sec # ____ - ____ - ____

Address: _____
Apt.# and/or Street City State Zip

Occupation _____

Home Phone: (____)-____-____ Best time to reach you at home: _____

Work Phone: (____)-____-____ Best time to reach you at work: _____

Patient Employer: _____ Employer's Phone (____)-____-____

Employer's Address _____
Street

City State Zip

II Spouse/Partner's Name: _____
Last First Middle

Date of Birth: ____ - ____ - ____ Soc. Sec. #: ____ - ____ - ____

Occupation: _____

Spouse/Partner's Employer: _____ Employer's Phone: (____)-____-____

Employer's Address: _____
Street

City State Zip

III Next of Kin (other than spouse/partner)
Name _____ Relationship to patient: _____

Home Address: _____
Apt.# and/or Street City State Zip

Home Phone: (____)-____-____ Work Phone: (____)-____-____

Referring Doctor/Clinic: _____ Phone: (____)-____-____

Address: _____
Suite# and/or Street City State Zip

IV Who referred you to this office? Your doctor _____ yourself _____ other _____

Why were you referred to this office? _____

Personal Information

| | Patient | Spouse/Partner |
|---|---------|----------------|
| Name you prefer to be called | | |
| Age now | | |
| Age at due date (patient only) | | |
| Ethnic background/Race | | |
| Birthplace | | |
| Religious Affiliation | | |
| Education (highest degree obtained: H.S., college, master's etc.) | | |

VI This pregnancy

First day of last period _____ Ultrasound date _____ due date _____

Please describe any **complications in this pregnancy**: _____

How many times have you been pregnant? (include this one): _____

Did you take **oral contraceptives/hormones** within 2 months of this pregnancy? (circle one) Yes or No

Please describe any **fertility treatment** in this pregnancy: _____

Do you **smoke**? (circle one) Yes or No - If yes, how many cigarettes in a day? _____ How many years? _____

Have you cut down or **quit smoking** since finding out you were pregnant? (circle one) Yes or No

Do you drink alcohol? (circle one) Yes or No - If yes, what do you drink? _____

How many **drinks per week** before this pregnancy? _____

How many per week since finding out you were pregnant? _____

Please describe **chronic medical problems** you have (e.g., diabetes, hypertension, etc.) _____

Please list any **medications** you have taken, prescribed or over-the-counter _____

VII Your Past Pregnancy History:

A. Please use the back of this page if you need more room for the following questions:

| Full Name | (circle sex) M or F | Birth date mm/dd/yy | Birth weight lbs/oz | Pre-term (20-36 wks) or full term (37-40 wks) at delivery? Alive circle one Deceased | |
|-----------|------------------------|------------------------|------------------------|--|-----------|
| | | | | pre-term | full term |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

B. For any **pregnancy loss**: miscarriage (**mis**), still birth (**SB**), or elective abortion (**EAb**):

| Type of loss (circle one) | Month/year | How far along? | Cause of loss if known |
|---------------------------|------------|----------------|------------------------|
| mis SB EAb | | | |
| mis SB EAb | | | |
| mis SB EAb | | | |
| mis SB EAb | | | |

VIII Spouse Children

For each of your spouses children living or deceased

| Full Name | Date of birth | Birth wt. lbs/oz | Alive/Deceased | Cause of death |
|-----------|---------------|------------------|----------------|----------------|
| M or F | | | | |
| M or F | | | | |
| M or F | | | | |

IX. Family History

Have you or a family member ever seen a genetic counselor or had an amniocentesis performed?
 (circle one) Yes or No If yes, who & what was the reason?

Do you know of any member of your family or your partner's family who has any of the following?
 (Think of your children, grandchildren, parents, grandparents, aunts, uncles, cousins, nieces, or nephews,
 brothers and sisters and half brothers and sister)

| | your side | his side | describe relationship to person affected and what they have |
|---|--------------|-------------|--|
| Neural Tube Defect like Spina Bifida or Anencephaly | | | |
| Congenital Heart Defect or Murmur | | | |
| Facial Abnormality like Cleft Lip or Palate | | | |
| other birth defects | | | |
| Bleeding problems like Hemophilia | | | |
| Muscular disorder like Muscular Dystrophy | | | |
| Neurologic disorder like Huntington Disease | | | |
| Other inherited condition like Cystic Fibrosis or Sickle Cell Anemia | | | |
| Chromosomal disorder like Down Syndrome | | | |
| Mental retardation with no known cause | | | |
| More than 2 pregnancy losses or any unexplained infant death | | | |
| any other condition which concerns you | | | |
| Fragile X Syndrome | | | |

Inherited Conditions

Some inherited conditions are more common in certain populations around the world. If you or your partner are a member of certain ethnic groups, additional information is available regarding these conditions.

- (circle one)
- Are you or your partner of **Ashkenazi** (Eastern European) Jewish descent? Yes or No
 - Have you ever been tested for **Tay-Sachs** carrier status? Yes or No
 - Are you or your partner of **Asian or Mediterranean** descent? Yes or No
 - Have you ever been tested for **thalassemia** carrier status? Yes or No
 - Are you or your partner of **African** descent? Yes or No
 - Have you ever been tested for **sickle cell** carrier status? Yes or No
 - Are you and the baby's father related in any way? Yes or No