Patient Demographic

Date:

Patient ID: **Preferred Provider:**

Patient Name:

Address:

City: **State:** **Zip Code:**

Home Phone: **Work Phone:**

Cell Phone:

Date of Birth: **Social Security Number:**

Marital Status: **Employer:**

Pharmacy: **RX Phone Number:**

Race: **Ethnicity:**

Referred By: **Primary Care Provider**

INSURANCE INFORMATION

Primary Insurance Plan: **Insured's DOB:**

Insurance Address:

City: **State:** **Zip Code:**

Policy Number: **Group Number:**

Insured's Name: **Patient Relation to Insured:**

Secondary Insurance Plan: **Insured's DOB:**

Insurance Address:

City: **State:** **Zip Code:**

Policy Number: **Group Number:**

Insured's Name: **Patient Relation to Insured:**

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 orginal.

Signature: _____ **Date:** _____

HIPAA CONSENT FORM
Thunderbird Obstetrics & Gynecology, Ltd.
5757 W. Thunderbird Road, Suite W202
Glendale, AZ 85306

Please read this form carefully as our office will only speak to the persons you name below in regard to the health, billing, or scheduling information we collect about you. Keep in mind that if you check "I elect not to give consent...," we will not speak to anyone, including family members, friends, etc. who call for information. Remember that under the HIPAA privacy rule as outlined in our Privacy Policy, we do have the right to disclose medical information to certain individuals to aid in the continuity of your care.

Patient's Name: _____

Patient's Date of Birth: _____ **Account #** _____

HOW ARE WE AUTHORIZED TO CONTACT YOU?
(Check all that apply)

HOME PHONE	CELL PHONE	WORK PHONE
( )	( )	( )
☐ Leave call back number only	☐ Leave call back number only	☐ Leave call back number only
☐ Okay to leave detailed message	☐ Okay to leave detailed message	☐ Okay to leave detailed message

CHOOSE ONE OPTION BELOW:

☐ **I give the following individual(s) my consent** to call or act on my behalf. This consent is restricted to the options I have selected. If at any time I wish to change the individual(s) listed below, I am aware that I must notify the office in writing by completing a new consent form. **This consent is valid until we are notified by the patient of a change.**

Name(s): _____ Relationship: _____

Phone: _____ Alternate phone: _____

Name(s): _____ Relationship: _____

Phone: _____ Alternate phone: _____

*** For additional persons, please continue on back of form or attach 2nd form.**

Please mark only one box:

- ☐ All information (Treatment & Medication information, Lab & Radiology results, Appointments, Billing)
- ☐ Only Lab/Radiology results & Medications
- ☐ Only Appointments & Billing
- ☐ Other : _____

☐ **I elect not to give consent** for any individual(s) to call or act on my behalf. Any information pertaining to my treatment, lab & radiology results, medications, billing, or other information should only be disclosed to me. If at any time, I wish to add individual(s) to call or act on my behalf, I am aware that I must notify the office in writing by completing a new consent form.

Patient Signature: _____ **Date:** _____

THUNDERBIRD OBSTETRICS & GYNECOLOGY, LTD.

JACK D. KYMAN, M.D.
JUNE A. KWARK, M.D.
MAURIZIO GALASSO, M.D.
DAVID J. KAUFMAN, D.O.

HILLARY H. CHARLES, M.D.
MARIA J. APIGO, M.D.
JAY EPSTEIN, M.D

INFORMED CONSENT FOR ULTRASONOGRAPHY

I _____

authorize Dr. _____ and assistants of his choosing to perform an ultrasound examination. Ultrasound examination is a diagnostic procedure that uses sound waves to obtain details images. There is no evidence that diagnostic ultrasound causes harm to either the patient or the fetus.
There are three types of exams:

- A basic obstetrical sonogram provides information regarding placenta location, fetal position, gestational age, estimate fetal weight and evaluation of amniotic fluid.

- A complete or extensive obstetrical sonogram that consists in a more specific evaluation of fetal abnormalities in addition to the information of a basic scans.

- A vaginal sonogram provides information regarding the uterus, the cervical canal, the ovaries and the location of a very early pregnancy. It consists of inserting a small covered probe (the size of a tampon) in the vagina. It is generally less uncomfortable than a Pap smear.

While a basic or complete obstetrical sonogram will detect many abnormalities, it is NOT a definitive for fetal malformations. Despite normal interpretation, some babies may be born with anomalies NOT identified during the sonogram. In case a fetal malformation is discovered, a second opinion sonogram would be requested. Thus, although ultrasonography is a very helpful tool, it should NOT be considered as absolute proof of the absence of fetal defects.

CONSENT
Should you have any questions do not hesitate to discuss them with Dr. _____ before, during and after the procedure.
You are requested to sign this consent prior to ultrasound examination and to thereby acknowledge you have read and fully understand this consent form.

_____ _____

PATIENT SIGNATURE WITNESS

_____

DATE

5757 WEST THUNDERBIRD RD, SUITE E451* GLENDALE, ARIZONA 85306
PHONE: 602.678.1111 * FAX: 602.678.7090

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	☐ Cancer	☐ Fibromyalgia	☐ HIV
☐ Asthma	☐ Chicken Pox	☐ Group B Strep	☐ Hyperactivity
☐ Bladder or Kidney Infections	☐ Depression	☐ Headaches	☐ Kidney Disease
☐ Bleeding Disorder	☐ Diabetes	☐ Heart Problems	☐ Migraine Headaches
☐ Blood Disease	☐ Emotional Disorders	☐ Hepatitis	☐ Thyroid Disorder
☐ Bowel Disease	☐ Epilepsy	☐ Herpes	☐ Other
		☐ High Blood Pressure	

   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. Please list any drugs used in the past (i.e. cocaine, marijuana, pain medication, meth, etc.):
   Dates last used: _____
5. 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?
6. Do you work with chemicals or radiation (i.e. x-rays)? ☐ Yes ☐ No
7. Are you on a special diet? ☐ Yes ☐ No
   If yes, please describe: _____

GYNECOLOGIC HEALTH HISTORY

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

Patient Signature _____ Print Name _____ Date _____

Patient Name _____ **ALLERGIES** _____

OBSTETRICAL MEDICAL HISTORY, PAGE 2

9. 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)? _____

10. 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:

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? _____

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: _____
_____
_____
_____

Patient Name _____ **ALLERGIES** _____

Address _____ Insurance _____ Pre Cert. _____

City/State/Zip _____ Delivery Hospital _____ Pediatrician _____

Home Phone _____ Work Ph. _____ Obstetrician _____ Breast ____ Bottle ____

Occupation _____ Baby's Father's Name _____ Age ____

Date of Birth _____ Age _____ Occupation _____ Wk Phone _____

Marital Status _____ Social Security _____ Racial Background: Patient _____ Father _____

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

No.	Date	Weeks	Sex	Wt.	Delivery Mode	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 Screen		

PAP SMEAR _____

GLUCOSE SCREEN

Date _____ Fasting _____ 1 hr. _____

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

Date _____ Results _____

DETERMINATION OF GESTATIONAL AGE

LMP _____

Cycle Length _____

Menstrual EDC _____

Date of Conception (if known) _____

Ultrasound Estimate of EDC _____

Date Performed _____

OPTIONAL LAB STUDIES

	DATE	RESULT
CF Screen		
GC Screen		
Chlamydia		
HIV Screen		
Sickle Cell		
Herpes		
Drug Screen		
Group B Strep		
Fetal Fibrinectin		
Varicella Screen		
Repeat Urinalysis		

Glucose Tolerance ____ Hr ____ Result ____

REPEAT HGB/HCT

Date _____ Results _____

Other:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

ADDITIONAL ULTRASOUND DATA (OPTIONAL)

Date _____ Findings _____

Date _____ Findings _____

Date _____ Findings _____

PRELIMINARY CLINICAL EDC _____

ADJUSTED EDC _____ **AS OF** _____

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 ☐

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