

Prenatal Visit

Patient's Name (Baby): _____

Date of Prenatal Interview: _____ Estimated Date of Delivery _____

Patient's Address: _____

Home Phone: _____ E-Mail Address: _____

Referred by: _____

Parent's Name: _____	Parent's Name: _____
Age: _____	Age: _____
Occupation: _____	Occupation: _____
Cell Phone: _____	Cell Phone: _____
Business Phone: _____	Business Phone: _____

Family History

Please check off only if your new baby has an affected parent, sibling or grandparent.

- | | | |
|---|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Developmental Delay
e.g. Down Syndrome | <input type="checkbox"/> Tay-Sachs /
metabolic diseases |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease before
age 50 yrs. | <input type="checkbox"/> Muscular
Dystrophy |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tuberculosis |
-
-

Maternal / Pregnancy History

Number of Pregnancies
Prior to this One:

Complications with
Prior Pregnancies:

In Vitro / Insemination
With this Pregnancy:

Have you drunk alcohol, smoked cigarettes
or used drugs during pregnancy?

During this pregnancy,
did you take folic acid?

Prenatal vitamins?

Did you take any other medicines?

Mom's height:

Weight gain:

Complications with this
pregnancy (including anemia,
rubella, infections, accidents, high
blood pressure, diabetes, etc.):

Did you have an
amniocentesis? (If *yes*,
results)

How many ultrasounds
did you have? What were the
results?

Are you a vegetarian?

Did you exercise regularly
during this pregnancy?

Are you planning to
deliver naturally?

Are you planning to
breastfeed?

Who is your obstetrician?

Where will you deliver?

Notes: _____

Notice of Privacy Acknowledgement

Shores Pediatrics, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health insurance, I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices, I also understand that this practice has the right to change its Notice of Privacy Practices, I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name or Legal Guardian (print)

Date

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____

Attempt: _____

Staff Name: _____

PRIMARY LANGUAGE _____

DATE _____

PATIENTS' INFORMATION

PATIENT'S NAME _____
LAST FIRST MIDDLE

BIRTHDATE _____ SEX _____ ALLERGIES _____

SOCIAL SECURITY # _____ PHONE () _____

PERMANENT ADDRESS _____
CITY STATE ZIP

TO SEE DOCTOR _____ REFERRED BY _____

BROTHERS _____ SISTERS _____

PARENT'S INFORMATION

MARITAL STATUS _____

PARENT'S NAME _____ D.O.B _____ S.S # _____

ADDRESS _____
CITY, STATE ZIP _____ CELL # _____

EMPLOYED BY _____ BUSINESS PHONE () _____

E-Mail _____

PARENT'S NAME _____ D.O.B _____ S.S # _____

ADDRESS _____
CITY, STATE ZIP _____ CELL # _____

EMPLOYED BY _____ BUSINESS PHONE () _____

E-Mail _____

NEAREST RELATIVE(S) _____ PHONE () _____

HIPPA Notice Received & Reviewed

INSURANCE INFORMATION

(For Office Use Only)

Newborns must be registered under insurance within 30 days

Please check here if any of the above information has changed in the last 12 months.

AUTHORIZATION

Patient's Name: _____ Date of Birth: _____

May we leave the following types of messages at your home, work, cell or emergency contact numbers?

- | | |
|----------------------------|--------------------|
| (1) Appointment changes | _____ Yes _____ No |
| (2) Test Results | _____ Yes _____ No |
| (3) Prescription Info | _____ Yes _____ No |
| (4) Billing Answers | _____ Yes _____ No |
| (5) Telephone Nurse Advise | _____ Yes _____ No |

Yes	No	I hereby authorize the physician(s) of Shores Pediatrics, to provide medical treatment to the patient on this form.
Yes	No	In the event that my child's legal guardian(s) is/are not able to be present during an office visit, I allow the person who accompanies my child (i.e., family member/friend, nanny, etc.) to make medical decisions on my behalf. (Note: Responding "no" to this statement would require a notarized statement indicating the names of the persons authorized to make such decisions.)
Yes	No	I hereby authorize third parties to pay directly to the physician(s) any insurance benefits due for services rendered on behalf of the named patient.
Yes	No	I authorize the physician(s) to furnish my insurance company and / or third party payers (or their representatives), any medical information necessary to process our insurance claims.
Yes	No	I understand that I am responsible for payment and all charges for medical services rendered to the named patient
Yes	No	As required by the Privacy Regulations, I hereby acknowledge that I have reviewed a current copy of " <u>Notice of Privacy Policy</u> ". I have read the Privacy Policy and understand my rights contained in the notice.
Yes	No	By way of my signature, I provide Shores Pediatrics, my authorization and consent to use and disclose my child's protected healthcare information for the purposes of treatment, payment and healthcare operations described in the Privacy Policy.

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____