NEW PATIENT PREGNANCY REGISTRATION FORM

PATIENT INFORMATION:

First: ___________________________ Middle: ___________________________ Last: ___________________________

Date of Birth: ______ / ______ / ______ SS#: _______ - _______ - ________ Gender: __________________

CONTACT INFORMATION:

Address / City / State / Zip: ____

Phone: ___________________________ Email Address: ____

EMERGENCY CONTACT:

Name: ____ Relation: ______________________ Phone: __________________

PARENT OR FINANCIALLY RESPONSIBLE PARTY (if different than patient):

First: ___________________________ Middle: ___________________________ Last: ___________________________

Date of Birth: ______ / ______ / ______ SS#: _______ - _______ - ________ Gender: __________________

Address / City / State / Zip: ____

Phone: _____________________________ Relationship to Patient: ________________________________

PRIMARY INSURANCE:

Insurance Name: ____ ID #: ________________________________

Cardholder's Relationship to Patient: ____ Co-Pay Amount: ____________________

SECONDARY INSURANCE: (if applicable)

Insurance Name: ____ ID #: ________________________________

Cardholder's Relationship to Patient: ____ Co-Pay Amount: ____________________

Please present insurance cards and picture ID at reception desk

EMPLOYER INFORMATION:

Patient's Employer: _______________________________________ Occupation: ________________________________

Address / City / State / Zip: ____

GENERAL INFORMATION:

How did you hear about us? _________________________________ Did anyone refer you? _________________________________

Have you received prenatal care prior to this appointment for this pregnancy? _________ Please specify: ______________________________

FATHER OF THE BABY:

Name: _________________________________ Contact Number: ____________________ If married, how long? ___________

Employer / Occupation: ____

PREFERRED PHARMACY:

Name of Pharmacy: ____

Address / Street: ____

***Please list any medication allergies*: ____

CURRENT MEDICATIONS/SUPPLEMENTS:

PLEASE CHECK IF YOU'VE EXPERIENCED ANY OF THE FOLLOWING:

___ High Blood Pressure ___ ADHD ___Heart Attack ___ COPD ___ Heart Disease

___ Autism ___ Heartburn/GERD ___ Crohn's Disease ___ High Cholesterol ___ Seasonal Allergies

___ Asthma ___ Ulcerative Colitis ___ Bipolar Disorder ___ Hearing Loss ___ Arthritis

___ Kidney stones ___ Cystitis ___ Depression ___ Anxiety ___ Migraines

___ Diabetes ___ Seizures ___ Stroke ___ Diverticulitis ___ Stomach Ulcers

___ Fibromyalgia ___ Gout ___ Hypothyroidism ___ Hyperthyroidism ___ Congestive Heart Failure

___Hashimoto's ___ Lupus ___ Cancer: ____

SURGICAL HISTORY:

___ Appendix Removed ___ Mastectomy ___ Artificial Joints ___ Pacemaker ___ Pins / Plates Inserted

___ Spleen Removed ___ Ear Tubes ___ Thyroid Removed ___ Gall Bladder Removed ___ Tonsils Removed

___ Hernia ___ Tubal Ligation ___ Other: ____

How was your pregnancy confirmed?	How do you feel about this pregnancy?
How do you want to feed your baby?	If your baby is a boy, do you want him circumcised?
When you deliver your baby, what type of pain management do you want?	
What type of birth control do you want to use after baby is born?	
Last period:	Are your periods regular every 28-30 days?
Date of last pap smear: Was it normal?	Number of pregnancies:
Number of vaginal deliveries:	Number of cesarean deliveries:
Number of miscarriages:	Number of abortions:

FAMILY HEALTH HISTORY:

Pregnancy	Month / Year	Gestational Age	Gender	Infant Weight	Vaginal / Cesarean	Pain Management	How is baby fed?	Infant's Name	Hours in Labor	Details or Complications
#1		weeks								
#2		weeks								
#3		weeks								
#4		weeks								
#5		weeks								

PLEASE CHECK IF ANY OF THE FOLLOWING RELATE TO YOU OR YOUR FAMILY:

___ Multiple births (twins, triplets)
___ Cancer
___ High Blood Pressure
___ Urinary Tract Problems
___ Operations / Accidents
___ Lung Disease
___ Hematologic
___ Breast Disease
___ Heart Disease
___ Neurological
___ GYN Problems (abnormal pap smears)
___ Immunological / Infectious Disease
___ Infertility / Recurrent Miscarriages
___ History of sexual or physical abuse/trauma
___ Endocrine / Metabolic (Diabetes / Thyroid)
___ STD, HPV, Group B Strep
___ Phlebitis / Varicosities
___ Psychiatric / Mental Illness
___ Gastrointestinal Problems
___ Other: ________________

PLEASE CHECK IF ANY OF THE FOLLOWING RELATE TO YOU, FATHER of BABY, OR EITHER FAMILIES:

___ Patient's age > 34 at delivery
___ Neural Tube Defect
___ Hemophilia / Blood Disorder
___ Cystic Fibrosis
___ Still birth
___ PKU
___ Tay Sachs
___ Huntington's Chorea
___ Recurrent pregnancy loss (>2)
___ Gestational Diabetes
___ Canavan Disease / Gauchers
___ Thalassemia
___ Congenital Heart Defect
___ Autism
___ Other Inherited or Chromosomal Disorder: ____
___ Other Structural Birth Defect: ____
___ Other: ____

PREGNANT PATIENT'S SOCIAL HISTORY:

Marital Status	Married	Single	Divorced	Widowed
Highest Level of education completed:				
How do you learn best?	Listening	Demonstration	Reading	
Are you enrolled in any of the following programs?	WIC	S. Security	AFDC	Food Stamps
Do you live in a/an:	House	Apartment/Condo	Other	
Does your home have:	Electricity	Water	Cooking Facilities	Stairs
Your form of transportation:	Own a Car	Family/Friends	Public	TennCare
Religious Preference				
Any spiritual/cultural needs that would affect how we care for you?				

Caffeine Use	Yes No	Coffee Soda Tea	Avg Amount: _________ / Day
Alcohol Use	Yes No	Beer Liquor Wine	Avg Amount: _________ / Week
Smoke / Tobacco / Vape	Yes No	Type / Amount:	
Recreational Drug Use	Yes No	Type / Amount:	

Do you have a living will, durable power of attorney, or advanced directives?	Yes	No
If no, would you like information on it?	Yes	No

Please list any other information you feel that your health care provider should know:

____

Name of person documenting above medical history and information (if not patient):

Name: ______________________ Signature: ______________________ Date: ____________

RELEASE OF MEDICAL RECORDS AUTHORIZATION

Patient Name: ____ **Date of Birth:** _________________________

Release records from:

Cole Family Practice
Main: (615) 874-3422
Fax: (615) 874-3465

Release records to:

Collaborating Midwives/OBGYN Group

____

____

____

I understand and give consent to release my prenatal records including but not limited to medical history, visit notes, medication lists, laboratory results, imaging reports, etc. I understand that my medical record may also include information on diagnosis/treatment related to psychiatric or psychological conditions, drug and/or alcohol abuse, acquired immune deficiency syndrome (AIDS), and/or HIV status, and/or sexually transmitted infections.

☐ I authorize this information to be released. Please initial: ______________

☐ I do NOT authorize this information to be released. Please initial: ______________

I understand no information may be disclosed by either agency to any individual or agency unless by written consent. I give my consent freely and voluntarily.

Patient Signature: ____ Date: _____________________

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 60 days after delivery.

HIPAA / PERMISSION FORM

The Health Insurance Portability and Accountability Act (HIPAA) require Cole Family Practice to notify patients regarding how their Protected Health Information is handled. Our HIPAA policy is posted in the Lobby. You have the right to review policy and take a copy of the policy. With your permission, we may disclose your Protected Health Information to a family member, close friend, or any other person that you identify.

I, ____, authorize Cole Family Practice to release any personal information relating to my health care –

☐ To No One

To: ____ Relationship to Patient: ____

To: ____ Relationship to Patient: ____

To: ____ Relationship to Patient: ____

To: ____ Relationship to Patient: ____

I have reviewed the HIPAA Notice of Privacy Practices for Cole Family Practice. I hereby acknowledge that I am familiar with and understand the terms of this policy.

Print Patient Name: ____ Print Guardian Name (if applicable): ____

Patients / Guardian Signature: ____ Date: ___________________

<u>CONSENT TO LEAVE MESSAGES / VOICEMAILS</u>

☐ Leave a detailed message with my health information -- Phone Number: _______________________________

☐ Leave a message with *call back information only* -- Phone Number: _______________________________

Office Hours:
Monday – Friday
7:30am – 4:30pm, lunch 12:30pm-1:30pm

New Patients:

- You can download, print, and complete the forms prior to your appointment by going to our website www.colefamilypractice.org or fill out and email.
- You will also need to bring your insurance card and valid picture ID to every appointment.
- ALL patients are asked to arrive 15 minutes prior to your appointment time to register.
- New patients are asked to arrive 30 minutes before appointment time.

Appointment Policy:

- Our goal is to meet your family's medical needs in a caring and efficient manner. We value your time and will make every effort to accommodate you as soon as possible.
- Office visits are by appointment only. Same-day appointments are available for urgent or sudden illness.
- Patients are asked to arrive 15 minutes prior to your appointment time to complete paperwork and verify insurance.
- We allow a 15-minute grace period from the time of your scheduled appointment. After that time, you will be responsible for $25 fee and asked to reschedule. If there is an opening in the schedule, we will do our best to move your appointment.
- When scheduling an appointment, please tell the scheduler everything you would like to be seen for so that the correct amount of time may be reserved for you. We make every attempt to see you with the shortest wait possible. If an appointment is made for one or two issues and several other issues are brought up it is not fair to other patients and providers. If you have multiple problems you wish to discuss, let the scheduler know in advance. In that instance, a longer visit time can be scheduled depending on the complexity of the problem(s) or separate appointments may be necessary.
- Bring a list of all medications and supplements you are taking, including the dosage, to every visit.
- Appointments for routine care and physicals are best arranged well in advance, preferably at the end of the previous appointment.

Co-Payments:

- Co-payments and past due balances will be collected when you arrive, prior to your visit.
- We accept cash, credit cards, and debit cards.
- Insurance is not a substitute for payment. We will bill your insurance company for covered services, but you are responsible for co-payments, deductibles, and non-covered services at the time of service.
- You are responsible for updating insurance at every visit. If not updated, you will be responsible for service.

Cancellation and/or No-Show Policy ___________ (*Initials)*

- Please note that we charge a fee of $25 for any same day cancellations and no-show appointments. The second time another $25 fee will be charged, and the third time a $25 fee will be charged, and you may be dismissed from our care.
- This fee must be paid prior to scheduling another appointment with our office.
- Insurance companies will not cover this, and the fee will be the responsibility of the patient.

Disability Forms & FMLA:

- An appointment is required for any forms that require review and signature by a provider. A fee of $30 is required at time of service.

Telephone Call Policy:

- Every phone call is important to us, and we will attempt to answer your calls and return your messages as promptly as possible.
- Please be aware that the providers will not leave their scheduled patients to return routine phone calls; these are generally answered after the patient care is completed for the day and make take 24-48 hours.
- Good medical care cannot always be accomplished over the phone, so we may advise you to schedule an office visit or telemedicine visit to discuss your concerns, problems, or test results.

Refill Requests:

- We typically give routine medication refills to cover until your next office visit. ***That means if you are out of refills, it's because you are due for a visit. ******
- We typically see our patients yearly for a general physical with fasting bloodwork, then every 3 months or 6 months depending on your condition or medications.
- Please allow for 24-48 hours for your prescription to be called into the pharmacy.
- Antibiotic prescriptions require an appointment.
- Pain medication prescriptions will not be called in.
- If you are interested in a new medication, please schedule an appointment to speak with a provider. We do not call in any medications that have not been previously prescribed by this office.

Lab Results

- No news is good news for physical exam labs. We do not call if everything is within normal range. You are welcome to request a printout at your next visit.
- The medical assistant may call to give recommendations from the provider for slight abnormal values.
- An office visit or telemedicine visit is required to review any abnormal labs requiring treatment or a change in treatment.

After Hours:

- If you are experiencing a medical emergency, dial 911.
- While we encourage you to call our office during regular business hours for routine care, medication refills, and to schedule appointments, we understand that health emergencies not requiring an emergency room can occur at any time. That's why we always have a provider on call.
- If you need to contact us during the evening or on weekends, please call (615) 874-3422 to be directed to the provider on call.
- Medication refills will be issued only during office hours.
- Antibiotics are not called in after hours.
- Please disable any call-blocking features, or the provider may be unable to reach you.

I have read, understand, and agree with the policies of Cole Family Practice.

____

Printed Name

____

Signature

____

Date