PREGNANCY SPECIALTY CENTER OF TEXAS

Clear Lake ★ North Houston ★ East Houston ★ Pasadena ★ Beaumont
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New Patient Information (please print and complete in full)

Last Name:_____First_____Middle_____

Street:_____Apt_____

City:_____State:_____Zip:_____

Phone numbers:

Cell_____Home_____Work_____

E-mail Address:_____

Date of birth:_____Age:_____SSN_____

Last menstrual period:_____ Certain (yes / no):_____

Marital status: (please select appropriate box)

☐ Single ☐ Married ☐ Divorced ☐ Separate ☐ Widowed ☐ Engaged

Referring Provider Name:_____

Do we have your permission to:
Leave a message on your answering machine at home? ___yes ___no

On your cell / home phone? ___yes ___no

Leave a message on your answering machine at work? ___yes ___no

Discuss your medical condition with any member of your house hold? ___yes ___no

If yes, with whom?_____Relationship:_____

Your Occupation:_____

Your Employer:_____

Employer's Address:_____

City:_____State:_____Zip:_____

PREGNANCY SPECIALTY CENTER OF TEXAS

Spouse or Partner's Name: _____

Phone: Cell_____Work_____Other_____

Emergency Contact (if other than partner or spouse):

Name: _____Phone:_____

Relationship:_____

Primary Insurance Information (Please complete if you are NOT the primary insured)

Insurance Company:_____

Policy ID#:_____Group#:_____

Claims Mailing Address:_____

City:_____State:_____Zip:_____

Policy Holder's Name:_____

Policy Holder's DOB:_____ Policy Holder's SSN_____

Relationship to patient:_____

Secondary Insurance Information (Please complete if you are NOT the primary insured)

Insurance Company:_____

Policy ID#:_____Group#:_____

Claims Mailing Address:_____

City:_____State:_____Zip:_____

Policy Holder's Name: _____

Policy Holder's DOB: _____ Policy Holder's SSN:_____

Relationship to Patient: _____

Please Note: If your insurance company requires that you bring a referral, you as the patient are responsible for contacting your primary care physician (which may different from your Ob/Gyn) prior to your visit to obtain a referral. If you do not obtain your referral prior to your appointment, we may need to reschedule your appointment. It is the patient's responsibility, solely, to understand their individual benefits.

_____

Patient Signature Date

PREGNANCY SPECIALTY CENTER OF TEXAS

Release and Assignment

I hereby authorize the Pregnancy Specialty Center of Texas to release my insurance carrier all information concerning my illness and treatment and hereby assign the Pregnancy Specialty Center of Texas all payments for medical services rendered to myself and/or my dependents. I understand that I am fully responsible for any amount NOT covered by my insurance carrier.

_____

Patient Signature Date

Receipt of Notice of Privacy Practice Written Acknowledgement Form

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payers for my health care services

I have been informed of my provider's Notice of Privacy Practices containing a more complete description of the uses of disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my provider has the right to change the Notice of Privacy Practices and that I may contact the office to obtain the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of healthcare operations, and I understand that you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

_____

Patient Signature Date

PREGNANCY SPECIALTY CENTER OF TEXAS

Authorization to Release Medical Records

I hereby authorize the Pregnancy Specialty Center of Texas to release any and all information related to my past and present medical history, diagnoses, and treatments to my referring provider and other PCP, or specialist that will be treating me during my illness and treatment. I understand that any records not related to my illness and treatment will not be released.

_____

Patient Signature Date

Financial Responsibility

I understand that I am personally responsible for any medical fees I will incur at the Pregnancy Specialty Center of Texas. I also understand that I will be responsible for any charges incurred by not providing the most current, correct insurance information to the Pregnancy Specialty Center of Texas. I understand that my insurance benefits may have an "allowable amount" for each procedure that is determined by the benefit contract I have with the insurance company and does not always equal the doctor's fee. We are contracted with most insurance companies and would make the necessary allowable adjustments accordingly. My insurance may pay a percentage of the "allowable," and I understand that I am responsible for payment of the remaining allowable balance. This payment may include my deductible (if not already satisfied), any co-payments, and any remaining portion of the doctor's bill that is not covered. The portion estimated to be my responsibility will be due at the time of service. I understand that medical benefit policies may not pay for their entire treatment.

I understand I am financially responsible for services received from the Pregnancy Specialty Center of Texas.

_____

Patient Signature Date

PREGNANCY SPECIALTY CENTER OF TEXAS

Medical History

Have you ever had:	Yes	No	Comments
Anemia			
Arthritis			
Asthma			
Back problems			
Blood clotting disorder			
Blood transfusion			
Cancer			
Cervical Surgery (i.e. LEEP/CONE)			
Depression			
Diabetes			
Heart problem/murmurs			
Chronic hypertension			
Lupus/autoimmune disorder			
Seizures			
Migraines			
Sexually transmitted disease			
Surgery			
Thyroid disease			
Hepatitis			
Other:			

Do you smoke cigarettes? ___yes ___no
If yes how many a day? _____

Do you drink alcohol? ___yes ___no
If yes how many drinks a day? _____

Do you use any drugs? ___yes ___no
If yes how which kind and how often?_____

Medications:
Are you taking prenatal vitamins? ___yes ___no

Any other medications (prescription or over the counter)? ___yes ___no
If yes please note type and dosage:_____
_____

Did you take any other medication(s) earlier during this pregnancy? ___yes ___no
If yes please note type and dosage:_____
_____

Are you allergic to any medications? ___yes ___no

If yes please let us know to which medications and what reactions you develop_____
_____

PREGNANCY SPECIALTY CENTER OF TEXAS

Pregnancy History

Estimated due date given to you by your primary provider:_____

Do you have any complaints presently? Yes_____ No_____

If yes, please describe:_____

Total number of pregnancies including this one:_____

Live births:

Date	Weight	Full term?	Boy/Girl	Vaginal/CS	Complications

Miscarriage(s):

Date	Gestational Age	Reason if known

Terminations(s):

Date	Gestational Age	Medical or Surgical

Blood type (if known):___A ___B ___AB ___O

Rh ___positive ___negative

PREGNANCY SPECIALTY CENTER OF TEXAS

Family History

Partner's DOB:_____Age:_____

Your Race:_____Partner's Race:_____

Ethnic Background (Italian ,Irish ,Asian, German, Polynesian, African, etc.):

Yours:_____Partner's:_____

Have you or your partner ever had genetic screening / testing? _____

Family history: Have you, your partner, your children or any other members of your family had any of the following conditions?

	Yes	No	Who	Explain
Blindness				
Blood Clotting Disorders (i.e., Pulmonary Embolism / DVT / MTHFR / Protein C or S Deficiency)				
Bone disorders or short stature				
Cancer of early onset (under 45 years of age)				
Chromosome abnormality				
Cleft lip and/or palate				
Cystic fibrosis				
Deafness				
Down syndrome				
Epilepsy/seizure disorder				
Genital abnormality				
Heart defect (as child)				
Hemophilia / bleeding disorder				
Huntington's disease				
Hydrocephaly (fluid or water on the brain)				
Infertility/Multiple miscarriages (more than 2)				
Kidney Defects				
Limb Defects				
Mental Illness				
Intellectual disability / significant learning disability				
Muscular Dystrophy				
Neurofibromatosis				
Sickle Celle Disease / Thalassemia				
Spina Bifida / Anencephaly				
Tay Sachs Disease				
Multiple family members with the same trait				

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PRUDENT USE AND CLINICAL SAFETY OF DIAGNOSTIC ULTRASOUND

Approved March 19, 2007

Diagnostic ultrasound has been in use since the late 1950's .Given its known benefits and recognized efficacy for medical diagnosis, including human pregnancy, The American Institute of Ultrasound in Medicine herein addresses the clinical safety of such use:

No independently confirmed adverse effects caused by exposure from present diagnostic ultrasound instruments have been reported in human patients in the absence of contrast agents. Biological effects have been reported in mammalian systems at diagnostically relevant exposures, but the clinical significance of such effects is not yet known. Ultrasound should be used by qualified health professionals to provide medical benefit to the patient.

PRUDENT USE IN OBSTETRICS

Approved March 19, 2007

The American Institute of Ultrasound in Medicine advocates the responsible use of diagnostic ultrasound and strongly discourages the non-medical use of ultrasound for entertainment purposes. The use of ultrasound without a medical indication to view the fetus, obtain a picture of the fetus or determine the fetal gender is inappropriate and contrary to responsible medical practice. Ultrasound should be used by qualified health care professionals to provide medical benefit to the patient.

INFORMED CONSENT FOR ULTRASOUND

Your physician has requested that you undergo a diagnostic procedure known as an ultrasound. Simply stated, this procedure involves the transmission of sound waves reflected off your womb and your fetus, which will be monitored and recorded to obtain information concerning your pregnancy. This test is believed to carry with it very little risk to you or your fetus.

The standard ultrasound may provide information concerning placenta location, fetal position, multiple gestation, approximate gestational age, and the possible presence of gross fetal malformations. This test, however is not definitive for the absence of fetal malformations, and despite normal interpretation of the test, some babies are born with anomalies not identified by the examiner during the ultrasound study. Thus, although ultrasonography is a helpful diagnostic tool, it does not absolutely determine the absence of fetal defects. This type of exam is also done prior to performing genetic amniocentesis.

Should you have any questions concerning ultrasonography, discuss them with your referring physician before undergoing the procedure. You are requested to sign this document prior to the performance of this exam, thereby acknowledgement that you have read and have understood the information contained herein, and have given an informed consent to this procedure, and are aware of the risks involved.

_____

Patient Signature Date