Laura Greer, MD
Brian Rinehart, MD

MFMC
Maternal Fetal Medicine Consultants of Dallas

8160 Walnut Hill Lane Ste 324
Dallas, TX 75231
214-377-7252 (P)
1-888-761-4153 (F)

Patient Information		
Referring Doctor/Midwife:		Date:
Last Name:	First Name:	Middle Initial:
Home Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:
Email:		
SSN:	DOB:	Age:
Employer:		
Employer Address:		
City:	State:	Zip:
DL Number:		DL State:
Spouse/Partner Name:	SSN:	DOB:
Cell Phone:	Work Phone:	
Spouse/Partner Employer:		
Spouse/Partner Employer Address:		
City:	State:	Zip:

Primary Insurance		
Insurance Company:	Insurance Phone No:	
Claims Mailing Address:		
City:	State:	Zip:
Insured's ID Number:	Group Number:	
If patient is not the policy holder, please complete the following:		
Name of Insured:	DOB:	Relationship to Patient:
Address:		Phone Number:
City:	State:	Zip:

Emergency Contact Information (Please list someone not living in the same household.)		
Name:	Relationship:	
Cell or Home Phone:	Address:	
City:	State:	Zip:

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HEALTH INFORMATION FORM

Today's Date: _____

Last Name:	First Name:	M.I.:
DOB:	Age:	Baby's Father's Age:
Referring Physician:		
First Day of LMP:	Estimated Due Date:	
Reason for Consultation:		
Allergies:		
Are you allergic to Latex? Yes_____ No_____	Are you allergic to ultrasound gel? Yes _____ No _____	
Are you allergic to any medication? Yes_____ No_____		
Medication:	Reaction:	
Medication:	Reaction:	
Medication:	Reaction:	
Height:_____(inches)	Pre-pregnancy Weight_____	Current Weight:_____(lbs.)

All past pregnancies including ectopic, miscarriage, and/or termination

Year	Weeks at Delivery	Gender	Infant Weight	C-Section or Vaginal	Complications, birth defects, reason for C-Section	Is the child alive and well? If not, please explain

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Medical History: Do you or have you had any of the following:								
	Yes	**No**		**Yes**	**No**		**Yes**	**No**
Abnormal Uterus/Fibroids			High Blood Pressure			Inflammatory Bowel Disease		
Incompetent cervix			Asthma			Hepatitis/ Liver Disease		
Prior Cervical/Uterine Surgery			Cancer			Kidney Disease		
IVF or Donor Eggs			Diabetes/ Gestational Diabetes			Lupus/ Rheumatoid Arthritis		
Genetic Disorders			Thyroid Disease			Seizure Disorder/ Epilepsy		
Heart Disease			Thrombophilia			HIV		
Anemia/Blood Transfusions			Deep Venous Thrombosis/ Pulmonary Embolism			Anxiety/ Bipolar/ Depression		

Operations/Surgeries			
Year:	Surgery:	Year:	Surgery:
Year:	Surgery:	Year:	Surgery:
Year:	Surgery:	Year:	Surgery:
Year:	Surgery:	Year:	Surgery:
Year:	Surgery:	Year:	Surgery:

Ethnicity:_____ Baby's father's ethnicity:_____

Have you been exposed to any medications during this pregnancy?_____Yes_____No
What medications?

_____

_____

Have you been exposed to X-rays during this pregnancy**?** _____Yes_____No

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List of Current Medications

Medication	Dose	Route	Started	Stopped	Prescriber

Do you, the baby's father, or any family member have any of the following:					
	Yes	No		Yes	No
Mental Retardation			Down Syndrome		
Fragile X			Tay Sachs		
Mediterranean Anemia			Sickle Cell Disease		
Cystic Fibrosis			Muscular Dystrophy		
Neural Tube Defect			Heart Defect		
Birth Defect			Other:		
Personal Genetic Screening					
Have you had CF screening?			Have you had any other genetic/carrier screening?		
Have you had SMA screening?			What were the results of the genetic screening/testing?		
Have you had Fragile X screening?					

Social History – Do you or have you used any of the following during your pregnancy?					
	Yes	No		Yes	No
Alcohol			Regular Exercise		
Tobacco			Seat Belt Use		
Drug use			Other		

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Review of Systems- Please check any of the following that CURRENTLY apply.			
Constitutional		**Genitourinary**	
Fatigue		Dysuria	
Fever		Frequency	
Weight Gain		Blood in urine	
Weight Loss		Urgency	
Eyes		**Musculoskeletal**	
Double Vision		Pain	
Glasses/Contacts		Spasm	
Seeing spots		Weakness	
Vision changes		**Neurological**	
Ears/Nose/Throat		Numbness	
Headaches		Seizures	
Sinus infection		Fainting	
Ringing in ears		Difficulty walking	
Ulcers		**Hematologic**	
Cardiovascular		Enlarged glands	
Chest pain		Bleeding	
Swelling of legs		Frequent bruising	
Shortness of breath		**Endocrine**	
Abnormal Heartbeat/arrhythmia		Diabetes	
Respiratory		Overactive thyroid	
Coughing		Underactive thyroid	
Shortness of Breath		**Psychiatric**	
Wheezing		Anxiety	
Gastrointestinal		Depression	
Constipation		Bipolar	
Diarrhea		**Skin**	
Nausea		Rash	
Pain		Stretch marks	
Vomiting		Ulcer	
Other:			

Today's Date **Patient Signature** **Physician Signature**

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Consent to Treat

By signing this consent, I am authorizing Maternal Fetal Medicine Consultants of Dallas to perform and/or order exams, test, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Maternal Fetal Medicine Consultants of Dallas unless revoked by me orally or in writing.

Patient Name (please print)	Relationship to Patient
Date of Signature	Signature of Patient or Guardian

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Assignment of Benefits and Financial Agreement

I hereby authorize payment of medical benefits billed to my insurance to Maternal Fetal Medicine Consultants of Dallas (MFMC). I hereby accept responsibility for any service(s) provided to me that is not covered by my insurance.

I also accept responsibility for fees that exceed the payment made by my insurance if the practice does not participate in my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered.

I understand that before MFMC processes a refund, all dates of service must be paid and/or processed by insurance company. MFMC issues refunds within 60 days of determining a refund is due.

**** Please note that we do not file secondary insurance and account statements are mailed monthly. ****

_____
Patient Name (please print)

_____
Relationship to Patient

_____
Date of Signature

_____
Signature of Patient or Guardian

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Acknowledgement of Receipt of Notice of Privacy Practices

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

1. Provide and coordinate my treatment among other health care providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers for my health care services.

I have been informed of the 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 confidential information is used or disclosed to conduct 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.

By signing below, you acknowledge that you have received this Notice of Privacy Practices prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

Authorization to Release Information to Others

_____No, you may not disclose my information to anyone but me.

_____Yes, you may disclose my information to the following people listed below:

_____

Name Relationship

_____

Name Relationship

Patient Name: _____ Patient Date of Birth: _____

(Please Print Name)

SIGNATURES:

Patient/Legal Representative:_____Date:_____

If Legal Representative, relationship to patient: _____

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MEDICAL RECORDS REQUEST FORM

By signing this form, I authorize physician/person/facility/entity listed below to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below:

Physician/Facility Name:

Address:	City:	State:	Zip:
Phone:	Fax:		

From_____(date) To_____(date)

The information that you may release subject to this signed release for is as follows:

____Complete records	____History and Physical	____Progress Notes
____Care plan	____Lab reports	____Radiology reports
____Pathology Reports	____Treatment Record	____Operative Reports
____Hospital Reports	____Medication record	____Other (please specify)

Release my protected health information to the following the physician/person/facility/entity listed below:

Maternal Fetal Medicine Consultants of Dallas
8160 Walnut Hill Lane Suite 324
Dallas, Texas 75231
Phone: 214-377-7252
Fax: 1-888-761-4153

The purpose/reason for this release of information is as follows:

_____ _____
Patient Name Signature of Patient or Authorized Representative

_____ _____
Patient Date of Birth Date