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:
Spouse/Partner Employer:		
Spouse/Partner Employer Address:		

Primary Insurance		
Insurance Company:	Insurance Phone No:	
Billing Address:		
City:	State:	Zip:
Name of Insured:	Relationship:	
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:		
Pregnancy Complications:		
Are you allergic to any medication? Yes _____ No _____		
Medication:	Reaction:	
Medication:	Reaction:	
Medication:	Reaction:	
Height : _____(inches)	Prepregnancy Weight _____	Current Weight: _____ (lbs)

All past pregnancies including ectopics, miscarriages, and/or terminations

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			Hearth 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. 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.

**** 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 a number of 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 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.

I have read and acknowledged the above information. (Please initial.) _____

Authorization to Release Information to Others

Many of our patients allow family members or others close to them to call and request information regarding their condition and/or treatment. Under the requirements for HIPAA we are not allowed to give this information out without the patient's consent. If you wish to have your condition and/or treatment disclosed to someone else, indicate below. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance of your prior consent.

_____ 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: _____ Date: _____

Name: _____ Relationship: _____ Date: _____

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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