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:			Apt #:
City:	State:	Zip:	
Cell Phone:	Work 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:	Claims Address:	Phone #:
Member/Subscriber's ID #:	Group #:	Relationship to Patient:
Policy Holder's Name:	DOB:	Address:
Secondary Insurance		
Insurance Company:	Claims Address:	Phone #:
Member/Subscriber's ID #:	Group #:	Relationship to Patient:
Policy Holder's Name:	DOB:	Address:

Emergency Contact Information (Please list someone not living in the same household.)		
Name:	Relationship:	
Cell 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.)

Please List All Past Pregnancies
Including Ectopic, Miscarriage, and Termination

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

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Your Medical History Do you or have you had any of the following:								
	Yes	**No**		**Yes**	**No**		**Yes**	**No**
Abnormal Uterus/Fibroids			High Blood Pressure			Crohn's/Ulcerative Colitis		
Incompetent cervix			Asthma			Hepatitis/ Liver Disease		
Prior Cervical/Uterine Surgery			Cancer			Kidney Disease		
IVF or Donor Eggs			Diabetes/ Gestational Diabetes			Lupus/ Rheumatoid Arthritis/Auto Immune Disease		
Genetic Disorders			Thyroid Disease			Seizure Disorder/ Epilepsy		
Heart Disease			Thrombophilia			HIV		
Anemia/Blood Transfusions			Deep Venous Thrombosis/ Pulmonary Embolism			Anxiety/ Bipolar/ Depression (circle all that apply)		

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 Disability			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 Cystic fibrosis screening?			Have you had any other genetic/carrier screening?		
Have you had Spinal Muscular Atrophy 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 order exams, tests, procedures, and any other care deemed necessary or advisable for diagnosing and treating 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

As a result, I authorize payment of medical benefits billed to my insurance to Maternal Fetal Medicine Consultants of Dallas (MFMC). As a result, I accept responsibility for any service(s) provided to me that my insurance does not cover.

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 when the service is rendered.

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

**** Please note that account statements are mailed monthly. ****

_____ _____

Patient Name (please print) Relationship to Patient

_____ _____

Date of Signature Signature of Patient or Guardian

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Acknowledgment 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, which contains a complete description of the uses of my protected health information disclosures. 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. I know you are not required to agree to my requested restriction, but if you do agree, you are bound to abide by such restrictions.

By signing below, you acknowledge that you have received this Notice of Privacy Practices before 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 request the following restrictions on the use and 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, patient relationship: _____