

**Regional Obstetrical Consultants**

**NEW PATIENT INFORMATION - PLEASE FILL IN ALL BLANKS**

**PATIENT NAME**

Last: \_\_\_\_\_

First: \_\_\_\_\_ Middle: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ E-mail \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_

Cell Phone: (    ) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: F \_\_\_ M \_\_\_

Social Security #: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

MARITAL STATUS: Married: \_\_\_\_\_ Single: \_\_\_\_\_

Preferred Language Spoken: \_\_\_\_\_

**PATIENT EMPLOYMENT**

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: (    ) \_\_\_\_\_

Full-Time    Part-Time    Retired    Not Employed

Which OB Provider referred you to our office? \_\_\_\_\_

Which location do you see your OB provider? \_\_\_\_\_

Emergency Contact (someone not living in your home): \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: (    ) \_\_\_\_\_

**Primary Insurance Company:** \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_

**I certify that the information contained herein is accurate and correct to the best of my knowledge.**

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Date**

**(Please Check One)**

**Spouse** \_\_\_\_\_ **Guarantor** \_\_\_\_\_

Last: \_\_\_\_\_

First: \_\_\_\_\_ Middle: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ E-mail \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_

Cell Phone: (    ) \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Guarantor Relationship to the Patient: \_\_\_\_\_

Divorced: \_\_\_\_\_ Other: \_\_\_\_\_

**SPOUSE/GUARANTOR EMPLOYMENT**

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: (    ) \_\_\_\_\_

Full-Time    Part-Time    Retired    Not Employed

## REGIONAL OBSTETRICAL CONSULTANTS

### DISCLOSURE PROTECTED HEALTH INFORMATION

I acknowledge that I have received a copy of Regional Obstetrical Consultants notice of Privacy Practices. I hereby authorize the following people to be made aware of my test results, appointment times, medical information and patient account status. I understand that if someone inquires about any of the information listed above and is NOT on this consent, information will NOT BE RELEASED. **(PLEASE PRINT)**

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NAME/RELATIONSHIP TO PATIENT

NAME/RELATIONSHIP TO PATIENT

### FINANCIAL AGREEMENT

- We require payment in full on the date of service for co-pay and offices charges defined under your policy as your responsibility, unless arrangements have been made between our office and your insurance company. If you choose not to pay at the time of services are rendered, a **\$10 administrative fee** for delayed payment will be added to your balance. This \$10 fee is not billable to your insurance company; it is your responsibility. To avoid this fee, you must pay at the time of service.
- I understand that payment is due and expected in full at the time services are rendered unless other arrangements have been made PRIOR to this appointment. This includes deductibles, co-payments, co-insurance and non-covered charges.
- I understand that my insurance will be filed, as a courtesy, and that I am responsible for any and all balances not covered by my insurance plan. I also understand that all insurance cards, both primary and secondary, must be given at the time services are rendered. If insurance cards are not given at the time of the initial visit, then the practice has no obligation to file claims on my behalf. If cards are not given then any filing with insurance will be my responsibility.
- I understand that my insurance may disallow charges as above “reasonable and customary” and that these amounts are my responsibility and NOT a contractual write-off.
- I understand that R.O.C. is not contracted with **AETNA, BCBS OF GEORGIA (POS & HMO) and TRICARE PRIME.**
- I understand that I am fully responsible for any referrals or prior authorizations required by my insurance company for payment to be made on my claims. If these are not obtained and payment for services is denied from my insurance carrier, all balances will be my responsibility.
- I understand that I will be responsible for any attorney’s fees, court costs, and/or collection fees added to this account if it becomes necessary to refer my account to outside collections.
- Any patient whose check is returned to Regional Obstetrical Consultants and marked “NSF” (non-sufficient funds) or “Account Closed” will be charged an additional \$20.00 for administrative fees in addition to the amount on the check.

### AUTHORIZATION:

I authorize Regional Obstetrical Consultants to release any medical information pertaining to my care to my referring physician, any physician I am referred to from this office, and any other physician/office participating in my care. I authorize treatment from this office and payment of medical benefits to the physician/supplier for those services rendered not to exceed the total billed charges for those services. I authorize the release of any information necessary to process insurance claims and I **certify** the information contained herein is correct. I permit a copy of this authorization to be used in place of the original. Regulations pertaining to medical assignment of benefits apply.

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PATIENT’S SIGNATURE

DATE

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PATIENT’S NAME (PLEASE PRINT)

**Attention:** To help us file prompt and accurate claims, please list all of your insurance coverage. Including policies covered by spouse, partner, parent, Medicaid, Medicare or legal guardian. **You are required to reveal ALL primary, secondary and tertiary insurance at the time of service. You may be held responsible for claims that are denied as a result of incomplete insurance disclosure.** I have carefully read, agree to and understand the Financial Agreement above. Initial \_\_\_\_\_

### Regional Obstetrical Consultants

Please answer these questions as completely as you can. This information helps us to provide the best care for you and your baby.

Your name \_\_\_\_\_ Reason for this visit \_\_\_\_\_

Your date of birth \_\_\_\_\_ How old will you be when the baby is due? \_\_\_\_\_

Name of baby's father \_\_\_\_\_ His age \_\_\_\_\_

- Do you or the baby's father have a child with a major birth defect or problems? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_
- Do you or the baby's father have a genetic condition or birth defect? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, explain: \_\_\_\_\_
- Do you have any medical conditions such as diabetes or a thyroid problem? Yes \_\_\_\_\_ No \_\_\_\_\_  
Please explain: \_\_\_\_\_
- Are you and the baby's father related by blood? (i.e. cousins)? Yes \_\_\_\_\_ No \_\_\_\_\_
- Have you or the father of the baby had a child or a blood relative with any of these problems:

Give details and indicate relationship to you.

Down syndrome	No	Yes	_____
Other chromosome disorder	No	Yes	_____
Spina bifida (open spine)	No	Yes	_____
Hydrocephaly (water on the brain)	No	Yes	_____
Hemophilia (free bleeder)	No	Yes	_____
Muscular dystrophy	No	Yes	_____
Cystic fibrosis	No	Yes	_____
Thalassemia	No	Yes	_____
Sickle cell disease	No	Yes	_____
Heart defect	No	Yes	_____
Cleft lip or palate	No	Yes	_____
Deaf/blind	No	Yes	_____
Mental retardation	No	Yes	_____
Learning problems/ADD/ADHD	No	Yes	_____
Any other inherited diseases	No	Yes	_____

- What is your ancestry/ethnicity? (for example Italian, Irish, Hispanic, Jewish, African American, other)  
On your mother's side \_\_\_\_\_ On your father's side \_\_\_\_\_
- What is the baby's father's ancestry/ethnicity?  
On his mother's side \_\_\_\_\_ On his father's side \_\_\_\_\_

- Do you or the baby's father have:

Jewish ancestry	No	Yes
African ancestry	No	Yes
Hispanic ancestry	No	Yes
Mediterranean ancestry	No	Yes
Middle Eastern ancestry	No	Yes
Asian or Southeast Asian ancestry	No	Yes
French Canadian ancestry	No	Yes

- Have you had any miscarriages? Yes\_\_\_\_\_ No\_\_\_\_\_ If yes, how many? \_\_\_\_\_
- When was your last period?\_\_\_\_\_ What is your due date? \_\_\_\_\_
- Have you had an ultrasound this pregnancy? Yes\_\_\_\_\_ No\_\_\_\_\_
- Were any problems seen on the ultrasound? Yes\_\_\_\_\_ No\_\_\_\_\_
- In this pregnancy (including before you knew you were pregnant) have you:

If yes, give details:  
(how much, when, name of medication).

Had alcohol?	No	Yes_____
Smoked cigarettes?	No	Yes_____
Used drugs?	No	Yes_____
Taken vitamins?	No	Yes_____
Taken prescription medications?	No	Yes_____
Taken over-the-counter medications?	No	Yes_____
Had X-ray or chemical exposure?	No	Yes_____

- Have you or the baby's father had any genetic testing (such as cystic fibrosis carrier testing, sickle cell testing, Tay-Sachs carrier testing, chromosome study, CVS, amniocentesis, other)?  
If yes, list and give results:\_\_\_\_\_
- Please list any questions or concerns that you have about your pregnancy, family history or medical history that have not been covered on this form. \_\_\_\_\_
- Please sign:  
The information I have given on this form is complete and accurate to the best of my knowledge.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



REGIONAL  
**OBSTETRICAL**  
CONSULTANTS P.C.

## NEW PATIENT PHARMACY INFORMATION FORM

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(if you do not know the full address, please at least provide street name)

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

***NOTE: If you utilize a mail-in pharmacy service, we must have a local pharmacy location as well.***