Maternal-Fetal Medicine, P.C.

Patient Name _____ Birthdate_____ Age _____
Address _____City _____ State ____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone_____
Social Security # _____ Driver's License # _____

☐ Single
☐ Married
☐ Widowed
☐ Divorced
☐ Legally Separated

Race:

☐ White/Caucasian
☐ Asian
☐ Black/African American
☐ Native Hawaiian/Pacific
☐ Unknown
☐ American Indian
☐ Hispanic
☐ Multiple
☐ Other
☐ Refused

Referring Physician _____ Allergies _____

Employer _____
Job Title _____
Employer Address _____
City _____ State ____ Zip _____

☐ Full Time
☐ Self Employed
☐ Retired
☐ Active Military
☐ Part Time
☐ Not Employed
☐ Disabled
☐ Student

Spouse's Name _____ Spouse's Birthdate _____
Spouse's Employer/Job Title _____

INSURANCE:

Circle all that apply: Blue Cross HAP BCN Medicaid Medicare Tricare Aetna Other_____
Primary Insurance Company _____
Subscriber _____ Subscriber Birthdate _____
SELF or Subscriber relationship to patient_____
Card # _____ Group #_____
Secondary Insurance Company _____
Subscriber _____ Subscriber Birthdate _____
SELF or Subscriber relationship to patient _____
Card # _____ Group #_____
In Case of Emergency Name _____
Phone _____ Relationship to Patient _____

Acknowledgement of Receipt of Notice of Privacy Practices:

With my signature below, I understand that Radha Cherukuri, M.D. & Daniel J. Wechter, M.D. may share my health information for treatment, billing and healthcare operations. A copy of the Notice of Privacy Practices is available at any time and describes how my health information is used and shared at my appointment. I understand Radha Cherukuri, M.D. & Daniel J. Wechter, M.D. have the right to change this notice at anytime. I have the right to revoke this consent, in writing, at any time, except to the extent that Radha Cherukuri, M.D. and Daniel J. Wechter, M.D. have taken action in reliance on this consent.

Insurance Assignment:

With my signature below, I authorize Radha Cherukuri, M.D. and Daniel J. Wechter, M.D. to furnish information to insurance carrier(s) concerning my illness and treatments. I hereby assign to Radha Cherukuri, M.D. and Daniel J. Wechter, M.D. all payments for medical services rendered to me or my dependents. I understand I am responsible for any amount not covered by insurance. **SEE BACK FOR FURTHER INSURANCE INFO AND SIGNATURE**.

_____ _____

Printed name of Patient

Signature of Patient
Date _____

[] signature on back

Important Notice
Regarding Billing and Insurances

You have been referred to see a specialist physician. Some insurance companies may not cover part or all of the services you will be receiving. This depends on your individual insurance coverage in addition to any deductible or co-pay mandated by your insurance that is your responsibility.

We participate with many insurance carriers and all Medicaid insurances, however, we are not in-network with all commercial insurances.

We will bill your insurance company and if requested by them provide supporting documentation from your appointment with us.

If your insurance company does not cover all or part of your services you will be responsible for the balance. We would be happy to set up payment arrangements with you.

Dated: _____

_____
Signature of Patient

PRENATAL GENETIC SCREEN

Will you be 35 years or older when the baby is due?	Yes ☐	No ☐

Have you, the baby's father, or anyone in either of your families ever had any of the following:

Down Syndrome	Yes ☐	No ☐
Other Chromosomal Abnormalities	Yes ☐	No ☐
Neural Tube Defect (such as Spina Bifida)	Yes ☐	No ☐
Hemophilia or other Blood Disorders	Yes ☐	No ☐
Cystic Fibrosis	Yes ☐	No ☐
Muscular Dystrophy	Yes ☐	No ☐
Birth Defect	Yes ☐	No ☐
Familial Disorder	Yes ☐	No ☐
Heart Defect	Yes ☐	No ☐
3 or more 1st trimester spontaneous pregnancy losses	Yes ☐	No ☐
Stillborn Child	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
Seizure Disorder	Yes ☐	No ☐
Thalassemia (Italian, Greek, Mediterranean or Asian background)	Yes ☐	No ☐
Tay-Sachs (Ashkenazi Jewish, Cajun, French Canadian)	Yes ☐	No ☐
Canavan Disease (Ashkenazi Jewish)	Yes ☐	No ☐
Familial Dysautonomia (Ashkenazi Jewish)	Yes ☐	No ☐
Huntington's Chorea	Yes ☐	No ☐
Maternal Metabolic Disorders (for example Type I diabetes, PKU)	Yes ☐	No ☐
Mental Retardation or Autism	Yes ☐	No ☐
If yes to line above, was person tested for Fragile X	Yes ☐	No ☐
Other: _____	Yes ☐	No ☐

Please list details if any of the above were answered yes: _____

What is the ethnic background (for example Irish, German, etc.) of yourself and the baby's father

Self: Baby's father:

Excluding iron and vitamins, have you taken any medications (prescription or over-the counter) or drugs (cocaine, crack, heroin, etc.) since being pregnant or since your last menstrual period?

Yes ☐ No ☐

If yes, give name of medication and time taken during pregnancy: _____

Have you smoked cigarettes or marijuana since being pregnant or since your last menstrual period?

Yes ☐ No ☐

If yes, how much each day:

Do or did you drink any alcohol since being pregnant or since your last menstrual period?

Yes ☐ No ☐

If yes, when, how much and what type:

Did you have any genetic screening/testing test done with this pregnancy?

(AFP, Quad/Integrated/Sequential Screen, T21, etc) Yes ☐ No ☐

If yes, when and what were the results, if known:

Signed Date