

The Midwives & Associates, Inc.

NAME _____
Last First MI

DATE OF BIRTH _____ MARITAL STATUS _____

ADDRESS _____
Street City State Zip Code

HOME # _____ WORK# _____ CELL# _____

SOCIAL SECURITY# _____ FAMILY DOCTOR _____

YOUR EMPLOYER _____ LOCATION _____

____ SPOUSE ____ SIGNIFICANT OTHER: NAME _____
(please check one)

DATE OF BIRTH _____ SOCIAL SECURITY#: _____

EMERGENCY CONTACT# _____ INSURANCE _____

SUBSCRIBER _____ SUBSCRIBER'S EMPLOYER _____

RELATIONSHIP _____ SECONDARY INS: _____
(Ex: husband/ parent)

HOW DID YOU HEAR ABOUT US? _____

New regulations are now in effect as to how we handle your protected health information. This is known as HIPAA (Health Insurance Portability & Accountability Act of 1996). We will provide a copy of our "Notice of Privacy Practices" to you. We request your signature to verify that you have received this information. In the questions below, we are giving you the opportunity to specify how we may communicate with you and you may designate others to also be given your health information.

Release of Information

It is the policy of The Midwives & Associates, Inc. and staff to not release protected health information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning telephone calls and the answering machine picks up, we will not leave health information if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. over...

I authorize The Midwives & Assoc. Inc. and staff to communicate health information pertaining to my care by the following methods and will assume responsibility to notify them when this information changes:

Home Telephone ___ Yes ___ No Answering Machine ___ Yes ___ No

Work Telephone ___ Yes ___ No Voice Mail ___ Yes ___ No

Cell phone/or voice mail ___ Yes ___ No Pager ___ Yes ___ No

Any special requests in contacting you or confirming appointments? _____

Please list names of authorized people with whom we may discuss your care:

Spouse _____ Yes ___ No

Parent _____ Yes ___ No

Others: Name _____ Relationship _____

Name _____ Relationship _____

I have been presented with a copy of the **Notice of Privacy Practices**, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Client/Guardian Signature _____ Date _____

Print Name _____ Relationship if not self _____

Assignment of Benefits

I hereby authorize The Midwives & Associates, Inc. to release to my insurance carriers or its intermediaries, any information needed for processing my claims, including the medical record. I request payment of medical benefits to The Midwives & Associates, Inc. I understand that any service not covered by my insurance company is my responsibility to pay.

Client/Guardian Signature _____ Date _____

Print Name _____ Relationship if not self _____

Responsible party: Please complete ONLY if you are a minor:

Mother's Name: _____ SS#: _____ DOB: _____

Father's Name: _____ SS#: _____ DOB: _____

Other Responsible party: _____ SS#: _____ DOB: _____

Address: _____ Phone#: _____



OBSTETRICAL CLIENT MEDICAL HISTORY

Yes	No	Do you:	Comments:
<input type="checkbox"/>	<input type="checkbox"/>	1. Have Diabetes?	_____
<input type="checkbox"/>	<input type="checkbox"/>	2. Have seizures or epilepsy?	_____
<input type="checkbox"/>	<input type="checkbox"/>	3. Have kidney disease?	_____
<input type="checkbox"/>	<input type="checkbox"/>	4. Does your husband/boyfriend have a history of treatment for cancer?	_____
<input type="checkbox"/>	<input type="checkbox"/>	5. Have any dermatological disorders including skin moles, acne, light or dark patches of skin?	_____
<input type="checkbox"/>	<input type="checkbox"/>	6. Have rheumatoid arthritis or systemic lupus erythematosus (SLE)?	_____
<input type="checkbox"/>	<input type="checkbox"/>	7. Have a history of being on a special diet as a baby or small child due to PKU or another condition?	_____
<input type="checkbox"/>	<input type="checkbox"/>	8. Have any other medical condition not mentioned?	_____
<input type="checkbox"/>	<input type="checkbox"/>	9. Know the results of your routine prenatal blood test for rubella (german measles)? () immune () susceptible (non immune)	_____

FAMILY HISTORY

<input type="checkbox"/>	<input type="checkbox"/>	10. Are you 35 years old or older?	_____
<input type="checkbox"/>	<input type="checkbox"/>	11. Is your husband/boyfriend 55 years old or older?	_____
<input type="checkbox"/>	<input type="checkbox"/>	12. Are you and your husband/boyfriend blood relatives? (e.g. cousins)?	_____
<input type="checkbox"/>	<input type="checkbox"/>	13. Are you or your husband/boyfriend of : () Jewish () Black () Mediterranean descent?	_____
<input type="checkbox"/>	<input type="checkbox"/>	14. Have you had a stillbirth or more than one miscarriage?	_____
<input type="checkbox"/>	<input type="checkbox"/>	15. Have any birth defects, handicapping condition or disorder that might be hereditary?	_____
<input type="checkbox"/>	<input type="checkbox"/>	16. Have any previous children with birth defects, handicaps, or genetic disease?	_____
<input type="checkbox"/>	<input type="checkbox"/>	17. Have any children who died (other than in accidents)?	_____
<input type="checkbox"/>	<input type="checkbox"/>	18. Have a brother, sister, or parent with a handicap, birth defect or genetic disorder?	_____
<input type="checkbox"/>	<input type="checkbox"/>	19. Have uncles, cousins, nieces, nephews, grandparents with birth defects or genetic disorders?	_____
<input type="checkbox"/>	<input type="checkbox"/>	20. Know of any family member with mental retardation (even mild) or learning disabilities?	_____

Have you or anyone in your family experienced any of the following? Check which apply.

- | | | |
|---|---|--|
| <input type="checkbox"/> Anencephaly (open skull) | <input type="checkbox"/> Limb defects | <input type="checkbox"/> Blindness or eye problems |
| <input type="checkbox"/> Malformation or birth defects | <input type="checkbox"/> Bone disorders | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Cleft lip/palate |
| <input type="checkbox"/> Neurofibromatosis | <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Neurologic or degenerative disorder |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Short stature (under 5 ft) | <input type="checkbox"/> Downs syndrome |
| <input type="checkbox"/> Sickle cell anemia | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Skeletal problems (easily broken bones or curvature of the spine) |
| <input type="checkbox"/> Heart defect | <input type="checkbox"/> Skin disease (including dark or light patches) | <input type="checkbox"/> Spina bifida (open spine) |
| <input type="checkbox"/> Hemophilia (bleeding tendency) | <input type="checkbox"/> Urinary tract abnormality | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Hydrocephalus (water on brain) | <input type="checkbox"/> Other | |
| <input type="checkbox"/> Kidney disease | | |

ENVIRONMENTAL EXPOSURES HISTORY

- | Yes | No | Have you... | | | | | | | | | | | | | | | | |
|---|---|---|---|--|---|---|--|---|---|-----------------------------------|--|--|---|--|-------------------------------------|---|--|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 21. Taken any prescription drugs or over the counter medications since becoming pregnant or since your last period? _____ | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 22. Taken any of the following since becoming pregnant or since your last period?
Check any that apply | | | | | | | | | | | | | | | | |
| | | <table border="0"> <tr> <td><input type="checkbox"/> Accutane or other dermatologic or acne medications</td> <td><input type="checkbox"/> Male hormones</td> </tr> <tr> <td><input type="checkbox"/> Antibiotics such as Tetracycline or Streptomycin</td> <td><input type="checkbox"/> Medications for epilepsy</td> </tr> <tr> <td><input type="checkbox"/> Anticoagulants (blood thinners)</td> <td><input type="checkbox"/> Multi-vitamins</td> </tr> <tr> <td><input type="checkbox"/> Anti-thyroid drugs</td> <td><input type="checkbox"/> Steroids</td> </tr> <tr> <td><input type="checkbox"/> Birth control pills</td> <td><input type="checkbox"/> Tranquilizers</td> </tr> <tr> <td><input type="checkbox"/> Chemotherapeutic drugs (anti-cancer)</td> <td><input type="checkbox"/> Vitamin A supplements</td> </tr> <tr> <td><input type="checkbox"/> Diet pills</td> <td><input type="checkbox"/> Other high dose vitamins</td> </tr> <tr> <td><input type="checkbox"/> Female hormones</td> <td><input type="checkbox"/> Herbal supplements</td> </tr> </table> | <input type="checkbox"/> Accutane or other dermatologic or acne medications | <input type="checkbox"/> Male hormones | <input type="checkbox"/> Antibiotics such as Tetracycline or Streptomycin | <input type="checkbox"/> Medications for epilepsy | <input type="checkbox"/> Anticoagulants (blood thinners) | <input type="checkbox"/> Multi-vitamins | <input type="checkbox"/> Anti-thyroid drugs | <input type="checkbox"/> Steroids | <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Chemotherapeutic drugs (anti-cancer) | <input type="checkbox"/> Vitamin A supplements | <input type="checkbox"/> Diet pills | <input type="checkbox"/> Other high dose vitamins | <input type="checkbox"/> Female hormones | <input type="checkbox"/> Herbal supplements |
| <input type="checkbox"/> Accutane or other dermatologic or acne medications | <input type="checkbox"/> Male hormones | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Antibiotics such as Tetracycline or Streptomycin | <input type="checkbox"/> Medications for epilepsy | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Anticoagulants (blood thinners) | <input type="checkbox"/> Multi-vitamins | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Anti-thyroid drugs | <input type="checkbox"/> Steroids | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Tranquilizers | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Chemotherapeutic drugs (anti-cancer) | <input type="checkbox"/> Vitamin A supplements | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Diet pills | <input type="checkbox"/> Other high dose vitamins | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Female hormones | <input type="checkbox"/> Herbal supplements | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 23. Have any illness or infection during pregnancy? | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 24. Had fever over 101 or taken saunas or hot whirlpool baths during pregnancy? | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 25. Had x-rays or surgery since becoming pregnant? | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 26. Been exposed to anesthetic gases, lead, other heavy metals or radiation in your occupation? | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 27. Been exposed to pesticides or potentially toxic chemicals at home or elsewhere? | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 28. <input type="checkbox"/> Drink well water <input type="checkbox"/> or city water <input type="checkbox"/> or bottled water? | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 29. Drink more than one glass of alcohol per week (including beer)? | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 30. Have a household cat? | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 31. Clean a cat litter box? | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 32. Eat raw or very raw meat? | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 33. Smoke more than 1/2 pack of cigarettes per day? | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 34. Use any other drugs or medications not previously listed? | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 35. Has rape, incest, domestic violence or other violence been a part of your life? | | | | | | | | | | | | | | | | |