William Groves MD
OBSTETRICS AND GYNECOLOGY

1890 W. Gauthier Rd., Ste. 130
Lake Charles, LA 70605
P:(337)480-5530 F:(337)480-5531
www.williamgrovesmd.com

PATIENT REGISTRATION FORM

Today's Date:	Primary Care Physician:	Pharmacy:

PATIENT INFORMATION

First name:	Middle:	Last:	Maiden Name:
SSN:	Preferred Name:	Title:	DOB:

Address:	City:	State:	Zip:

Cell#:	Home#:	Work#:
CIRCLE CONTACT# THAT IS PRIMARY: -- Cell -- Home -- Work	Marital Status:	Race:
Employer Name:	Address:	Phone:
Spouse Name:	Spouse SSN:	Spouse DOB:

Spouse Phone Number:	Referred to clinic by:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance: |

Policy holder's name:	Birth date:	Group #:	Policy #:	Co-payment:
				$

Patient's relationship to subscriber:

Please indicate secondary insurance: (if applicable):	Policy holder's name:	Policy and Group#:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

AUTHORIZATION AND ASSIGNMENT FOR INSURANCE PURPOSES: I authorize J. William Groves, Jr., M.D. to furnish information to insurance carriers only concerning my illnesses and treatments for the processing of the applicable claim(s). I assign J. William Groves, Jr., M.D. all payments for medical services rendered to me or to my dependents. I understand that I am responsible for any amount not covered by assigned Insurance. If for any reason should the account becomes delinquent, I agree to pay for all collection and/or legal fees.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

CONSENT TO TREATMENT: I, the undersigned do hereby authorize, J. William Groves, Jr., M.D. to provide medical care as may be deemed necessary in the judgement of the physician. This treatment may include but is not limited to: laboratory procedures, non-invasive diagnostic and therapeutic procedures and treatments, administration of pharmaceutical products, such as injections and other therapeutic solutions, and minor surgical procedures such as wound suturing.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

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PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives the individual the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual has the right to request confidential communication or communication by alternate means, such as sending correspondence to the individual's office instead of home.

PATIENT'S NAME: _____

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER:

___Home Telephone
- ___OK to leave a message with detailed information.
- ___Leave message with call-back number only.

___Work Telephone
- ___OK to leave a message with detailed information.
- ___Leave message with call-back number only.

___Cell Telephone
- ___OK to leave a message with detailed information.
- ___Leave message with call-back number only

_____ _____
PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

IT IS OUR GOAL AS YOUR MEDICAL PROVIDER, TO CALL YOU WITH RESULTS OF ANY TEST ORDERED BY OUR OFFICE WITHIN 1-2 WEEKS, DEPENDING ON THE PARTICULAR TEST PERFORMED. *IF FOR SOME REASON, YOU DO NOT RECEIVE A CALL WITH YOUR RESULTS DURING THIS TIME FRAME, PLEASE CONTACT OUR OFFICE.*

_____ _____
PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

I authorize the release of any medical or other information necessary to process claims. I also request payment of benefits either to myself to myself or to the party who accepts assignment on said claims. I authorize J. William Groves, Jr., M.D. to release medical records and reports to the referring physician or any other physicians or health care providers that need access to these records for my medical care. I also authorize any other physician, laboratory, hospital, or other provider to release all medical records and X-rays necessary for my care to J. William Groves, Jr., M.D.

_____ _____
PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

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PATIENT CONSENT TO MEDICAL TREATMENT OR SURGICAL PROCEDURE AND ACKNOWLEDGEMENT OF RECEIPT OF MEDICAL INFORMATION

INFORMATION ABOUT THIS DOCUMENT – READ CAREFULLY BEFORE SIGNING

TO THE PATIENT: You have been told that you should consider medical treatment/surgery. Louisiana law requires us to tell you (1) the nature of your condition, (2) the general nature of the medical treatment/surgery, (3) the risks of the proposed treatment/surgery, as defined by the Louisiana Medical Disclosure Panel or as determined by the doctor, (4) reasonable therapeutic alternatives and material risks associated with such alternatives, and (5) risks of no treatment.

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved.

In keeping with the Louisiana Law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. We wish to inform you as completely as possible. Please read the form carefully. Ask about anything you do not understand, and we will be pleased to explain.

1. **Patient Name:** _____

2. **Treatment/Procedure:** **Vaginal delivery with or without episiotomy and possible blood transfusion or Cesarean section.**
   (a) **Purpose:** **To deliver baby through vaginal opening or through an incision in my abdomen and uterus, with subsequent repair.**

3. **Patient's Condition:**
   Patient's diagnosis, description of the nature of the condition or ailment for which the medical treatment, surgical procedure, or other therapy described in item number 2 is indicated and recommended: **Pregnancy.**
   _____

4. **Material Risks of treatment procedure:**
   (a) **All medical or surgical treatment involves risks.** Listed below are those risks associated with this procedure that we believe a reasonable person in your (the patient's) position would likely consider significant when deciding whether to have or forego the proposed therapy. Please ask your physician if you would like additional information regarding the nature or consequences of these risks, their likelihood of occurrence, or other associated risks that you might consider significant buy may not be listed below.
   *** See attachment for risks identified by the Louisiana Medical Disclosure Panel**
   *** See attachment for risks determined by your doctor.**
   (b) **Additional risks (if any) particular to the patient because of a complicating medical condition are:**
   _____
   _____
   (c) **RISKS GENERALLY ASSOCIATED WITH ANY SURGICAL TREATMENT/PROCEDURE, INCLUDING ANESTHESIA ARE:** death, brain damage, disfiguring scars, quadriplegia (paralysis from the neck down), paraplegia (paralysis from the waist down), the loss or loss of function of any organ or limb, infection, bleeding, and pain.

5. **Reasonable therapeutic alternatives (no circumcision) and risks associated therewith, risks of no treatment:** **to be discussed if appropriate.**

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6. ACKNOWLEDGMENT – AUTHORIZATION AND CONSENT

a) No guarantees: All information given to me and, in particular, all estimates made as to the likelihood of occurrence of risks of this or alternate procedures as to the prospects of success, are made in the best professional judgment of my physician. The possibility and nature of complications cannot always be accurately anticipated and, therefore, there is and can be no guarantee, either expressed or implied, as to the success or other results of the medical treatment or surgical procedure.

b) Additional Information: Nothing has been said to me, no information has been given to me, and I have not relied upon any information that is inconsistent with the information set forth in this document.

c) Particular Concerns: I have had an opportunity to disclose to and discuss with the physician providing such information, those risks or other potential consequences of the medical treatment or surgical procedure that are of particular concern to me.

d) Questions: I have had an opportunity to ask and I have asked, any questions I may have about the information in this document and all such questions were answered in a satisfactory manner.

e) Authorized Physician: The physician (or physician group) authorized to administer or perform the medical treatment, surgical procedures, or other therapy described in item 2 is: **J. William Groves, Jr., M.D. and Associates.**

f) Physician Certification: I hereby certify that I have provided and explained the information set forth herein, including any attachment, and answered all questions of the patient, or the patient's representative, concerning the medical treatment or surgical procedure, to the best of my knowledge and ability.

_____ _____

J. William Groves, Jr., M.D. Date/Time

CONSENT

I hereby authorize and direct the designated authorized physician/group, together with associates and assistants of his choice, to administer or perform the medical treatment or surgical procedure described in item 2 of this Consent Form, including any additional procedure or services as they may deem necessary or reasonable, including the administration of any general or regional anesthetic agent, x-ray, or other radiological services, laboratory services, and the disposal of any tissue removed during a diagnostic or surgical procedure, and I hereby consent thereto.

I have read and understand all information set forth in this document, including any attachment(s), and all blanks were filled in prior to my signing. This authorization for and consent to medical treatment or surgical procedure is and shall remain valid until revoked.

I acknowledge that I have had the opportunity to ask any questions about the contemplated medical procedure or surgical procedure described in item 2 of the consent form including risks and alternatives. My questions have been answered to my satisfaction.

_____ _____

Witness/Date & Time Patient/Authorized Person to Consent

_____ _____

Date/Time Date/Time

If consent is signed by someone other than patient, state the reason and relationship:

_____.

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Blood Transfusion Consent Form

1. **Patient Name:** _____
2. My physician, **J. William Groves, Jr., M.D.,** has explained to me that a transfusion of blood or a blood component _____(is now) _____(may be) needed for proper medical care.
3. The benefits and the risks of the blood or blood component transfusion have been explained to me by my physician. I understand that, even though the blood or blood components are carefully tested with all available tests, some risk remains and that the following risks or hazards may occur in connection with the procedure: fever, transfusion reaction which may include kidney failure or anemia, heart failure, hepatitis, AIDS (acquired immune deficiency syndrome), and/or other infections. It is not possible to test for all transfusion transmitted diseases at this time.
4. It has been explained to me and I understand that emergencies do on occasion arise when it may be necessary for the patient's well-being to use stocks of blood which may not include the most compatible blood types.
5. The alternatives to transfusion, including the risks and consequences of not receiving this therapy, have been explained to me.
   Alternative therapies include the following:
   Autologous Transfusion: I understand that, in some instances, it may be possible to donate one's blood for elective procedures. I ____(have) ____(have not) made prior arrangements for designated donors.

   Designated Donation: I understand that, in some cases, it is possible to arrange for designated donations (donations made from friends or relatives). I____(have)____(have not) made prior arrangements for designated donors.

6. Particular concerns: I have had the opportunity to disclose to and discuss with the physician providing such information, those risks or other potential consequences of the medical treatment or surgical procedures that are of particular concern to me. I have had the opportunity to ask questions of my physician.

I accept all of the risks referred to above and authorize the hospital to infuse the most compatible blood type available at this time.

_____	_____
J. William Groves, Jr., M.D.	Date/Time
_____	_____
Witness	Patient or Person Authorized to Consent
_____	_____
Date/Time	Date/Time

If consent is signed by someone other than the patient, state the reason and relationship: _____
_____.

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MATERIAL RISKS IDENTIFIED BY THE LOUISIANA MEDICAL DISCLOSURE PANEL

Patient Name: _____

Procedure: **Delivery (Vaginal)**

Material Risks:

1. Possible need for operative vaginal delivery including forceps and/or vacuum assisted delivery.
2. Possible need for episiotomy.
3. Vaginal lacerations.
4. Possible difficulty delivery including shoulder dystocia.
5. Injury to bladder and/or rectum, including fistula (abnormal hole) between bladder and vagina and/or rectum and vagina.
6. Hemorrhage possible requiring blood administration, D&C, and/or hysterectomy and/or artery ligation to control.
7. Sterility.
8. Brain damage, injury, or even death occurring to the fetus before or during labor and/or vaginal delivery whether or not the cause is known.
9. Uterine disease or injury requiring hysterectomy.
10. Pulmonary Embolus.
11. Risk of infection.
12. Possible painful intercourse.

_____ _____
J. William Groves, Jr., M.D. Date/Time

_____ _____
Patient or Person Authorized to Consent Date/Time

_____ _____
Witness Date/Time

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MATERIAL RISKS IDENTIFIED BY THE LOUISIANA MEDICAL DISCLOSURE PANEL

Patient Name: _____

Procedure: **Delivery (Cesarean Section)**

Material Risks

1. Infection.
2. Injury to bladder, bowel, and/or rectum, including fistula (abnormal hole) between bladder and vagina and/or rectum and vagina.
3. Hemorrhage possibly requiring blood administration and/or hysterectomy and/or artery ligation to control.
4. Sterility.
5. Brain damage, injury, or even death occurring to the fetus before or during labor and/or delivery whither or not the cause is known.
6. Uterine disease or injury requiring hysterectomy.
7. Pulmonary Embolus.
8. Disfiguring scarring.

_____ _____
J. William Groves, Jr., M.D. Date/Time

_____ _____
Patient or Person Authorized to Consent Date/Time

_____ _____
Witness Date/Time

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PATIENT CONSENT TO MEDICAL TREATMENT OR SURGICAL PROCEDURE AND ACKNOWLEDGEMENT OF RECEIPT OF MEDICAL INFORMATION

INFORMATION ABOUT THIS DOCUMENT – READ CAREFULLY BEFORE SIGNING

TO THE PATIENT: You have been told that you should consider medical treatment/surgery. Louisiana law requires us to tell you (1) the nature of your condition, (2) the general nature of the medical treatment/surgery, (3) the risks of the proposed treatment/surgery, as defined by the Louisiana Medical Disclosure Panel or as determined by the doctor, (4) reasonable therapeutic alternatives and material risks associated with such alternatives, and (5) risks of no treatment.

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved.

In keeping with the Louisiana Law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. We wish to inform you as completely as possible. Please read the form carefully. Ask about anything you do not understand, and we will be pleased to explain.

1. **Patient Name:** **Newborn Male-**
   (please add child's last name)
2. **Treatment/Procedure:** Circumcision
   (a) Description, nature of the treatment/procedure: To remove penile foreskin.
   (b) Purpose: parental desire for circumcision for cultural or religious beliefs; or medical reasons.

3. **Patient's Condition:**
   Patient's diagnosis, description of the nature of the condition or ailment for which the medical treatment, surgical procedure or other therapy described in item number 2 is indicated and recommended: uncircumcised male/presence of foreskin

4. **Material Risks of treatment procedure:**
   a) All medical or surgical treatment involved risks. Listed below are those risks associated with this procedure that we believe a reasonable person in your (the patient's) position would likely consider sign significant when deciding whether to have or forego the proposed therapy. Please ask your physician if you would like additional information regarding the nature or consequences of these risks, their likelihood of occurrence, or other associated risks that you might consider significant but may not be listed below.
      (x) See attachment for risks identified by the Louisiana Medical Disclosure Panel
      ( ) See attachment for risks determined by your doctor.
   b) Additional risks (if any) particular to the patient because of a complicating medical condition are: NONE
   c) RISKS GENERALLY ASSOCIATED WITH ANY SURGICAL TREATMENT/PROCEDURE, INCLUDING ANESTHESIA ARE: death, brain damage, disfiguring scars, quadriplegia (paralysis from the neck down), paraplegia (paralysis from the waist down), the loss or loss of function of any organ or limb, infection, bleeding, and pain.

5. **Reasonable therapeutic alternatives (no circumcision) and risks associated therewith, risks of no treatment:** No circumcision

6. **ACKNOWLEDGMENT – AUTHORIZATION AND CONSENT**
   a) No Guarantees: All information given me and, in particular, all estimates made as to the likelihood of occurrence of risks of this or alternate procedures as to the prospects of success, are made in the best professional judgment of my physician. The possibility and nature of complications cannot always be accurately anticipated and, therefore, there is

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and can be no guarantee, either expressed or implied, as to the success or other results of the medical treatment or surgical procedure.

b) Additional Information: Nothing has been said to me, no information has been given to me, and I have not relied upon any information that is inconsistent with the information set forth in this document.
c) Particular Concerns: I have had an opportunity to disclose to and discuss with the physician providing such information, those risks or other potential consequences of the medical treatment or surgical procedure that are of particular concern to me.
d) Questions: I have had an opportunity to ask and I have asked, any questions I may have about the information in this document and any other questions were answered in a satisfactory manner.
e) (X) I have been given the brochure "Circumcision Information for parents" by the American Academy of Pediatrics.
f) Authorized Physician: The physician (or physician group) authorized to administer or perform the medical treatment, surgical procedures or other therapy described in item 2 is: (Name of authorized physician or group) Groves and Associates.
g) Physician Certification: I hereby certify that I have provided and explained the information set forth herein, including any attachment, and answered all questions of the patient, or the patient's representative, concerning the medical treatment or surgical procedure, to the best of my knowledge and ability.

_____ _____

J. William Groves, Jr., MD **Date/Time**

CONSENT

Consent: I hereby authorize and direct the designated authorized physician/group, together with associates and assistants of his/her choice, to administer or perform the medical treatment or surgical procedure described in item 2 of this Consent Form, including any additional procedure or services as they may deem necessary or reasonable, including the administration of any general or regional anesthetic agent, x-ray, or other radiological services, laboratory services, and the disposal of any tissue removed during a diagnostic or surgical procedure, and I hereby consent thereto.

I have read and understand all information set forth in this document, including any attachment (s) , and all blanks were filled in prior to my signing. This authorization for and consent to medical treatment or surgical procedure is and shall remain valid until revoked.

I acknowledge that I have had the opportunity to ask any questions about the contemplated medical procedure or surgical procedure described in item 2 of this consent form, including risks and alternatives, and acknowledge that my questions have been answered to my satisfaction.

_____ _____

Witness **Patient or Person Authorized to Consent**

_____ _____

Date/Time **Date/Time**

If someone other than the patient signs consent, state the reason and relationship:_____

_____

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MATERIAL RISKS IDENTIFIED BY THE LOUISIANA MEDICAL DISCLOSURE PANEL

Patient Name: Newborn Male- .
(Please add child's last name)

Procedure: CIRCUMCISION (Removal of penile foreskin)

Material Risks:

1. Ulceration and scarring of urine hole at tip of penis (meatal stenosis).
2. Bleeding
3. Infection (minor or serious).
4. Removal of too much or too little skin.
5. Skin bridge.
6. Fistula (abnormal hole in urine tube).
7. Buried penis.

_____ _____
J. William Groves, Jr., MD **Date**

_____ _____
Witness **Patient or Person Authorized to Consent**

_____ _____
Date **Date/Time**

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Informed Consent and Agreement for HIV Testing

I consent to HIV testing during pregnancy as recommended by Dr. Groves and standard pregnancy testing guidelines.

_____	_____	_____
Patient Name	Patient Signature	Date

Informed Consent for Antepartum Drug Testing

I consent to allow Dr. Groves and/or his associates, to take a specimen of my urine to submit for a drug test screen. I further consent to allow the laboratory testing service to make the results of such screen available to Dr. Groves and/or associates.

_____	_____	_____
Patient Name	Patient Signature	Date

Informed Consent for Genetic Testing

I understand that genetic testing for me and my baby and the father of the baby is available, but is not routinely done unless specifically requested and discussed. This includes but is not limited to Down Syndrome, Cystic Fibrosis, and Sickle Cell Anemia. If there are genetic diseases or syndromes that run in my family or that I want testing for, I will bring this up with Dr. Groves. I understand ultrasound is a basic screening test for fetal anatomy but it is not a good test for many genetic abnormalities.

_____	_____	_____
Patient Name	Patient Signature	Date

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Appointment Cancellation / No Show Policy: We make every effort to provide a reminder call of your upcoming appointment; however, it is your responsibility to remember your appointment & cancel or change, if needed. Please call the office at least **THE DAY BEFORE YOUR SCHEDULED APPOINTMENT** to reschedule. **IT IS ACCEPTABLE TO LEAVE A VOICE MESSAGE IF IT IS OUTSIDE NORMAL OFFICE HOURS.** We reserve the right to charge a missed appointment fee of $25.00 to patients who do not show up to a scheduled appointment, or who cancel the same day as their appointment. This allows our office to offer the appointment time to other patients needing immediate care. This fee is your responsibility, since insurance will not cover this assessment & must be paid before any additional appointments can be scheduled. In the event a patient has 3 or more missed appointments or same day cancellations, we reserve the right to terminate future care.

Late Policy: We are committed to prompt service and will work very hard, barring emergencies, to stay on time. Admittedly, this can be difficult in an obstetric/surgery practice, but we value your time. **We may ask you to reschedule if you arrive for your appointment more than 15 minutes after your scheduled appointment.** Always arrive at least 10 minutes early for an appointment to complete any necessary paperwork.

Non-Sufficient Funds Fee: There will be a $25.00 fee for any returned checks. This will be applied to your account and you will be placed on a cash or credit card only basis for all future payments.

Delinquent Accounts: We reserve the right to refer any delinquent account(s) to a collection agency and report them to the credit bureau.

Completion of Forms: There is a $10.00 fee for completion of forms.

Participating Insurances: We participate with most insurance companies. Copays or deductibles are **DUE AT THE TIME OF SERVICE**. Non-participating insurances & self pay: payment **IN FULL** is required at the time of service for any gynecological care; an optional payment plan will be designed for obstetrical care for **SELF PAY** patients only. For ALL insurances: Please review your benefit listings summary. Well Woman or Annual Exams are usually considered preventative care and sometimes covered at 100% by insurance plans. For Medicare: Based on certain criteria, there is coverage for breast, pelvic exam, & pap smears. We require a copy of all insurance cards & ask that you present them at each visit along with your driver's license. All new patients must complete our patient information before services are rendered. The forms of payments we accept are the following: cash, check, Visa, MasterCard, & Discover.

I understand & agree that health insurance coverage is an agreement between an insurance carrier and me. I understand that this office will prepare any necessary reports & forms to assist me in making collections from the insurance company & that any amounts authorized be paid directly to this office. However, I clearly understand & agree that all services rendered to me are charged directly to me.

Lab Results: I understand that it is my responsibility to call and check on any results regarding any test(s) performed. Dr. Groves or staff normally will make an effort to contact patient with results. Ultimately, it is my responsibility to obtain results from the office.

We reserve the right to terminate treatment to any patient with three or more missed appointments or same day cancellations.

I, _____ (print name), have read, agreed to and received a copy of Dr. William Groves' Financial Policy/Appointment Cancellation/No-Show/Late & NSF Fee Policies of the practice.

Patient's Signature _____ Date_____

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Patient Consent Form
Use of this form is optional and not required under the HIPAA privacy rule.

I hereby give my consent for J. William Groves, Jr., M.D. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by describes such uses and disclosures more completely).

I have the right to review The Notice of Privacy practices prior to signing this consent. J. William Groves, Jr., M.D. reserves the right to revise its Notice of Privacy practices at any time. A revised Notice of Privacy practices may be obtained by forwarding a written request to J. William Groves, Jr., M.D., 1890 W. Gauthier Rd., Ste. 130, Lake Charles, LA 70605.

With this consent, J. William Groves, Jr.,M.D. may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, J. William Groves, Jr., M.D. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential”.

With this consent, J. William Groves, Jr., M.D. may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that J. William Groves, Jr., M.D. restricts how the practice uses or discloses my PIH to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow J. William Groves., Jr., M.D. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, J. William Groves, Jr., M.D. may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient’s Name & Legal Guardian, if applicable Date

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Insurance Notice

As a courtesy to you, our patient, we are happy to file either private insurance or Medicaid (Louisiana Health Care connections) for your pregnancy. Due to insurance requirements and differences we are unable to file both private and Medicaid. If you do have two insurances, Medicaid by standard is always secondary. In this instance we would file private insurance for charges from our practice and you could use both insurances if accepted at the time for hospital and other care. If you begin your prenatal care with us using private insurance, it is expected that you remain with private insurance throughout the pregnancy and postpartum period. This means that changing to Medicaid during pregnancy or postpartum is highly discouraged. If your private insurance is no longer in effect, you need to notify our office immediately. This policy is in place so that we can devote as much time as possible to patient care and provide you with the most affordable and efficient insurance filing possible.

In addition we are not established as a non-obstetric Medicaid provider. This means that non-obstetric care occurring outside of the pregnancy and immediate post-partum period will be provided on a cash pay basis. Examples of this care would include follow up for abnormal pap smears, intrauterine device checks, and implant removals.

Please notify us immediately if these policies present any problem as we want you to receive the highest quality of care in the most affordable and efficient way possible.

Patient Signature _____ Date _____

William Groves MD
OBSTETRICS AND GYNECOLOGY

Obstetric Medical History

Patient name: _____
Date form completed: _____

PERSONAL HEALTH HISTORY

1. ☐ Yes ☐ No Are you allergic to any medications or substances including latex or iodine? If yes, please list: _____
_____

☐ Yes ☐ No Have you either been vaccinated for chickenpox or had a case of chickenpox in the past?

2. Please mark any condition that you have or have had in the past:

☐ Cancer	☐ HIV/AIDS	☐ Diabetes
☐ Epilepsy	☐ Thyroid Disorder	☐ Eating Disorder
☐ Heart Disease	☐ Headaches	☐ Depression
☐ High Blood Pressure	☐ Arthritis or Lupus	☐ Asthma
☐ Kidney Disease	☐ Frequent Infections	☐ Anemia
☐ Hepatitis	☐ Bowel Disease	☐ Herpes
☐ Von Willebrand's disease or other bleeding disorders		☐ Sexually transmitted diseases
☐ Blood clotting disorder (eg. Phlebitis)		☐ Other medical conditions
☐ Recurrent urinary tract infections		

Describe, if needed: _____

3. Please indicate any surgery or hospitalization that you have had: _____
_____

4. ☐ Yes ☐ No Do you or any family members have a history of problems with anesthesia?
5. ☐ Yes ☐ No Do you have any religious objections to any form of medical treatment (eg. refusal of blood transfusion)?
6. ☐ Yes ☐ No If pregnant before, have you delivered a child who was diagnosed with low platelets?

EXPOSURES AFFECTING HEALTH

1. ☐ Yes ☐ No Do you smoke cigarettes currently?
   If yes, how many per day? ___
2. ☐ Yes ☐ No Have you recently quit smoking?
   If former smoker, when did you quit? _____
3. ☐ Yes ☐ No Do you drink any alcoholic beverages now (1.5oz = 12oz beer)?
4. ☐ Yes ☐ No Before pregnancy did you drink any alcoholic beverages?
   If yes, how often? _____
   What type of drinks? _____
   _____
5. Please list any medications taken since your last period, including **prescriptions, over-the-counter drugs, multivitamins,** other **supplements, & any herbal medicines:** _____
_____

Please list any medications, vitamins, and/or supplements you are currently taking:
_____

(Physician's initials) _____

6. Please list any illicit or recreational drugs used in the last year and list the most recent use (eg. cocaine or marijuana): _____
7. ☐Yes ☐ No Are you currently using any illicit or recreational drugs including cocaine or marijuana?
8. ☐Yes ☐No Have you ever used IV drugs or shared needles in the past?
9. ☐Yes ☐No Do you have any reason to believe you may have been exposed to AIDS (eg. a history of blood transfusion, intravenous drug use, multiple sexual partners or exposure to a gay or bisexual male, or exposure to an intravenous drug user)?
10. ☐Yes ☐No Have you ever been exposed to genital herpes?
11. ☐Yes ☐No Are you ever exposed to chemicals or radiation (eg. x-rays)?
    If yes, please describe: _____
12. ☐Yes ☐No Are you on a restricted diet? If yes, please describe: _____

_____

GYNECOLOGIC HEALTH HISTORY

1. When was your last Pap test? _____
   ☐Yes ☐ No Have you ever had abnormal Pap test?
   If yes, when and how were you treated? _____
   _____
   What was the diagnosis? _____
2. ☐Yes ☐No Have you ever had: Gonorrhea☐
   Chlamydia☐
   Pelvic Inflammatory Disease ☐
   ☐Yes ☐No Have you ever had herpes?
   If yes, how often do you have outbreaks? _____
   ☐Yes ☐ No Have you ever had syphilis?
   If yes, how, when, and where were you treated? _____
3. ☐Yes ☐ No Have you ever used an IUD; if so, when was it removed? _____
   Any problems with the IUD? _____
4. ☐Yes ☐No Have you ever been treated for infertility? If yes, please describe when and the treatment you received: _____
5. ☐Yes ☐No Do you have any other concerns related to your past health history? If yes, please list them: _____
   _____

FAMILY HISTORY & GENETIC SCREENING

1. What is your ethnicity? _____ Ethnicity of the baby's father? _____
2. ☐Yes ☐No Have you or has the baby's father had a child born with a birth defect? If yes, please describe: _____
   ☐Yes ☐ No Did you or the baby's father have a birth defect? If yes, please describe: _____
   _____

(Physician's initials) _____

3. Please describe any abnormalities that have occurred in children of your family or the baby's father's family (eg. mental disabilities, birth defects, early infant death, deformities, or inherited diseases such as hemophilia, muscular dystrophy, or cystic fibrosis): _____

4. Are there any additional genetic or medical conditions in your family that I need to be aware of? *(eg. pregnancy related conditions, sudden death, or early heart disease, bleeding, or blood clotting disorder)*

_____

_____

5. Does your mother or sister have a history of pre-eclampsia (toxemia of pregnancy)? ☐ Yes ☐ No
6. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if you are, or the baby's father is, of one of these backgrounds:

☐Yes☐No Eastern European Jewish (Ashkenazi) ancestry
- If yes, have you had Tay-Sachs screening tests? ☐ Yes☐ No
- If yes, have you had a Canavan screening test? ☐ Yes☐ No
- If yes, have you had a cystic fibrosis screening? ☐ Yes☐ No
- If yes, have you had a familial dysautonomia screening? ☐ Yes☐ No
- Date: _____ Result: _____

☐Yes☐No African American
- If yes, have you had sickle cell screening? ☐ Yes☐ No
- Date: _____ Result: _____

☐Yes☐No European ancestry and Eastern European Jewish (Ashkenazi) ancestry
- If yes, have you had cystic fibrosis screening? ☐ Yes☐ No
- Date: _____ Result: _____

☐Yes☐No Mediterranean ancestry or Southeast Asian ancestry
- If yes, have you had a screening for inherited forms of anemia such as thalassemia? ☐Yes☐No
- Date: _____ Result: _____

PSYCHOSOCIAL SCREENING

1. ☐Yes☐ No Do you have any problems (job, transportation, etc.) that prevent you from keeping your health care appointments?
2. ☐Yes☐ No Do you feel unsafe where you live?
3. ☐Yes☐ No Are you exposed to second-hand smoke?
4. ☐Yes☐ No In the past 2 months, have you used drugs or alcohol (including beer, wine, or mixed drinks)?
5. ☐Yes☐ No In the past year, have you been threatened, hit, slapped, or kicked by anyone you know?
6. ☐Yes☐ No Has anyone forced you to perform any sexual act that you did not want to do?
7. On a 1-5 scale, how do you rate your current stress level? Low 1 2 3 4 5 High
8. How many times have you moved in the past 12 months? _____

Physician's Signature _____