Name _____ Date of Birth_____ MR # _____

Cole Family Practice, LLC - Registration Form**- PREGNANCY**

Patient Information

First: _____ Middle: _____ Last: _____

□ Male □ Female

Date of Birth: _____/_____/_____ Marital Status: M S D W SS#:_____/_____/_____

Address: _____

City: _____ State:_____ Zip: _____

Phone: (H)_____(C)_____ (W)_____

Email address: _____

Emergency Contact: _____ Phone: _____

Employer Information:

Patient's Employer: _____ Occupation: _____

Address: _____

City: _____ State:_____ Zip: _____

Parent or Financially Responsible Party (if different than patient)

First: _____ Middle: _____ Last: _____

□ Male □ Female

Date of Birth: _____/_____/_____ SS#: _____/_____/_____

Address: _____

City: _____ State:_____ Zip: _____

Phone: (H)_____ (C)_____ (W)_____

Relationship to Patient:_____

Primary Insurance

Insurance Name: _____Cardholder's Relationship to Patient:_____

ID #: _____ Co-Pay Amount: _____

Secondary Insurance

Insurance Name: _____ Cardholder's Relationship to Patient: _____

ID #: _____ Co-Pay Amount: _____

Please Present Insurance Cards and Picture ID at Reception Desk

Name _____ Date of Birth_____ MR # _____

Who referred you to Cole Family Practice? _____

Have you received prenatal care prior to this appointment for this pregnancy □ No □ Yes, please specify.
_____

Father of the baby
Name: _____ Contact Number: _____

If married, how long: _____ FOB occupation/employer: _____

Patient Medical, Surgical, Social & Family History

List Medication Allergies: _____

List all Current Medications (prescriptions, OTC, hormones, or herbal remedies) _____

_____

Pharmacy (Please list name and Street):_____

Patient Surgical History (List year of surgery) □ No History of Surgeries

□ Appendix Removed
□ C-Section
□ D & C
□ Ear Tubes
□ Gall Bladder Removed
□ Hernia
□ Artificial Joints_____
□ Pins or Plates inserted (location:_____)
□ Spleen Removed
□ Thyroid Removed
□ Tonsils Removed
□ Pace Maker
Other:_____

Height: _____ Weight: _____ Pre-Pregnancy Weight: _____

Patient Health History □ No History of Illness

□ ADHD □ Autism □ Hearing Loss
□ Allergies (Seasonal) □ Heart Attack
□ Arthritis □ Heart Burn (acid reflux)
□ Asthma □ High Blood Pressure
□ Bipolar □ High Cholesterol
□ Cancer (location?_____)
□ Congestive Heart Failure □ Interstitial Cystitis
□ COPD / Emphysema □ Kidney Stones
□ Crohn's
□ Hypothyroid □Hyperthyroid
□ Depression / Anxiety □ Migraine Headaches
□ Diabetes □ Seizures
□ Diverticulitis □ Stomach Ulcers
□ Stroke □Fibromyalgia

Health Maintenance:

Date of last Complete Physical:_____
Date of last EKG:_____
Date of last cholesterol screen:_____
Date of last Bone Density:_____
Date of last Tetanus Injection:_____
Date of last Colonoscopy:_____
Date of last dental exam:_____
Date of last Mammogram: _____

GYN Last Period:_____ Sure □ No □ Yes
Periods regular every 28-30 days? □ No □ Yes
Date of last Pap:_____ Normal: □ No □ Yes
How was your pregnancy Confirmed?
□ Home Pregnancy test □ Doctor's Office
#of Pregnancies:____ # Vaginal deliveries:_____
C-sec:____ # Miscarriages:____ # Abortions:___

How do you feel about this pregnancy? □ Happy □ Sad □ Unsure

How do you want to feed your baby? □ Breast □ Bottle □ Both □ unsure

If your baby is a boy, do you want him circumcised? □ No □ Yes

When you deliver your baby, what type of pain medicine do you want? □ Epidural □ IV Medication □ Nitrous Oxide □ None

What type of birth control do you want to use after your baby is born? □ Oral Contraceptive □ Patch □ Nuva Ring □ Condoms
□ Depo Provera □ IUD □ Tubal Ligation □ Unsure □ Implant □ Natural Family Planning

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Pregnancy History

Please include ALL pregnancies including any miscarriages, abortions, or preterm

Pregnancy	Month/Year	Gestational Age	Gender	Infant weight	Vaginal or Cesarean	Pain Management	Feeding Breast or Bottole	Infant's Name	Hours in Labor	Details or Complications
# 1	/	____weeks	M F		Vag Csec		Breast Bottle			
#2	/	____weeks	M F		Vag Csec		Breast Bottle			
#3	/	____weeks	M F		Vag Csec		Breast Bottle			
#4	/	____weeks	M F		Vag Csec		Breast Bottle			
#5	/	____weeks	M F		Vag Csec		Breast Bottle			

Patient and Family Medical History

Please check any of the following that relate to **YOU** or **YOUR FAMILY**

- ☐ Multiple births (twins, triplets)
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Operations/Accidents _____ _____ _____
- ☐ Lung Disease
- ☐ Gastrointestinal problems
- ☐ Breast Disease
- ☐ Urinary Tract Problems
- ☐ Endocrine/Metabolic (Diabetes/Thyroid)
- ☐ GYN Problems (abnormal pap smears)
- ☐ Hematologic
- ☐ Infertility & recurrent miscarriages
- ☐ History of sexual /physical abuse/trauma
- ☐ Neurological
- ☐ STD, HPV, or Group B Strep
- ☐ Phlebitis/varicosities
- ☐ Psychiatric/Mental Illness
- ☐ Immunological/Infectious disease
- ☐ Other _____

Please check any of the following that relate to **YOU, FATHER of BABY and BOTH FAMILIES**

☐ Patient's age > 34 at delivery ☐ Recurrent pregnancy loss (>2) and/or still birth
☐ Other inherited or chromosomal disorder _____
☐ Thalessemia
☐ Other structural birth defect _____
☐ Neural Tube Defect ☐ Congenital Heart Defect
☐ Maternal metabolic/endocrine disorder (Diabetes, PKU)
☐ Down syndrome ☐ Autism
☐ Tay Sachs ☐ Canavan Disease, Gauchers
☐ Hemophilia or other blood disorders
☐ Cystic Fibrosis ☐ Huntingtons Chorea
☐ You or baby's father had a child with a birth defect not listed above

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Patient's Family Health History

Father
List any health problems:_____

□ No Known Health Problems □ Has Died – Age and Cause of Death:_____

Mother
List any health problems:_____

□ No Known Health Problems □ Has Died – Age and Cause of Death:_____

Brothers
How many _____ □ No Known Health Problems List any health problems:_____

□ Has Died – Age and Cause of Death:_____

Sisters
How many _____ □ No Known Health Problems List any health problems:_____

□ Has Died – Age and Cause of Death:_____

Social History

Marital Status: □Married □Single □ Divorced □ Widowed Patient's occupation _____

Highest level of education completed: _____

Did you have any special needs in school? □ No □ Yes

How do you learn best? □ Listening/Watching □ Demonstration □ Reading

Are you enrolled in any of the following programs? □ WIC □ Social Security □ AFDC □ Food Stamps

Alcohol use? □ No Yes- □ Beer □ Liquor □ Wine Average amount - _____/ Day Week Month Year

Smoke or Tobacco use? □ No □ Yes How many Packs per Day_____ Smokeless Tobacco? □ Yes □ No

Recreation Drug Use? □ No □ Yes, please list _____

Caffeine (soda, tea, coffee)? □ No □ Yes Average amount _____ / Day Week Month Year

Religious Preference: _____

Any spiritual/cultural needs that would affect how we care for you? □ No □ Yes Any objection to receiving blood products? □ No □ Yes

Do you live in a/an? □ House □ Apartment/Condo Where you live do you have: □ Electricity □ Water □ Cooking Facilities □ Stairs

Form of transportation: □ Own a car □ Public □ Family/Friends □ TennCare

Do you have a living will, durable power of attorney, or advanced directives? □ No □ Yes
If No, would you like information? □ No □ Yes

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OFFICE POLICY

I authorize Cole Family Practice, LLC to furnish information to insurance carriers concerning my care. I agree to pay Cole Family Practice, LLC for all services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance.

SELF-PAY PATIENTS will be required to pay for your office visit before you are seen. However, you are responsible for any additional cost related to the visit. Federal Law requires that we bill every patient the same amount. We are not allowed to change billing based on whether or not patients have insurance.

INSURANCE PATIENTS – IT IS YOUR RESPONSBILITY TO:

- Provide us with updated and current insurance information at each visit.
- Provide us with updated contact information including phone numbers and address.
- Pay your deductible and/or copay at the time of service
- Pay for any services not covered by your insurance
- Make sure you have a current referral if your insurance requires one.

As a courtesy to our patients we will file all claims with your insurance carrier and provide them with any information necessary to process the claim.

YOU ARE RESPONSBILE FOR ALL SERVICES RENDERED – IF (FOR ANY REASON) YOUR INSURANCE DOES NOT PAY- THE BALANCE IS YOUR RESPONSIBILITY.

Unpaid Bills – A collection agency will be chosen to manage delinquent accounts. Once referred to collections, no assistance will be provided by our office. If your account is placed with a collection agency, you will be responsible for all collections and attorney's fees necessary to collect this debt.

CONSENT TO TREAT & MEDICAL RECORDS RELEASE AUTHORIZATION:

I authorize Cole Family Practice practitioners to provide treatment that they may deem advisable for my dependents and me. I understand that these services are voluntary and I have the right to refuse these services. In the event of a life-threatening emergency, I consent for the provider to administer emergency treatment. I authorize Cole Family Practice to conduct urine drug screens as part of my assessment per the office policy. I authorize Cole Family Practice to obtain any previous medical records, for my dependents or myself, including lab and imaging results, if my providers feel it is necessary for the care of my dependents or me.

I have read and understand the above items regarding insurance, finance, responsibility, authorization of charges, consent, and medical records and agree to the terms and conditions related to each item.

_____ _____

Patient or Responsible Party Signature **Date**

Name _____ Date of Birth_____ MR # _____

Cole Family Practice, LLC – HIPAA/Permission From

The Health Insurance Portability and Accountability Act (HIPAA) require Cole Family Practice to notify patients regarding how their Protected Health Information is handled. Our HIPAA policy is posted in the Lobby. You have the right to review policy and take a copy of the policy. With your permission, we may disclose your Protected Health Information to a family member, close friend, or any other person that you identify.

I, _____, authorize Cole Family Practice to

release any personal information relating to my health care

☐ To No One

To: _____ Relationship to patient: _____

To: _____ Relationship to patient: _____

To: _____ Relationship to patient: _____

To: _____ Relationship to patient: _____

I have reviewed the HIPAA Notice of Privacy Practices for Cole Family Practice. I hereby acknowledge that I am familiar with and understand the terms of this policy.

Print Patient Name: _____

Patients / Guardian Signature: _____ Date: _____

Name _____ Date of Birth_____ MR # _____

Release of Medical Records Authorization

Patient Name:_____

DOB:_____

Release records From: Cole Family Practice

Release records to: West End Women's Health Center
Main 615-936-5858
Fax 615-936-2600
AND/OR
Vanderbilt Medical Center Labor & Delivery
Main 615-332-2255
Fax 615-322-1170

I understand and give consent to release my prenatal record including but not limited to medical history, visit notes, medication lists, laboratory results, imaging reports, etc. I understand that my medical record may also include information on diagnosis/treatment related to **psychiatric or psychological conditions, drug and/or alcohol abuse, acquired immune deficiency syndrome (AIDS), and/or HIV status, and/or sexually transmitted infections.**

I do_____ do not_____ authorize this information to be released. (Please initial)

I understand no information may be disclosed by either agency to any individual or agency unless by written consent. I give my consent freely and voluntarily.

Patient Signature_____ Date_____

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 60 days after delivery.