

**Please Fill out all Paperwork Before
You come in for your appointment.
Please bring first morning urine in a
small container and put the container
in a plastic bag.**

**All prenatal patients with Aetna Insurance
Must call 800-272-3531 to register with the
Mom's to Babies Program**

Patients Name
Address
City, State, Zip

Women's Healthcare
Medical-Surgical Specialty Group
135 Newton Sparta Road Suite 201
Newton, New Jersey

Provider
Appt Date, Time

PATIENT INFORMATION

Patient Name _____ SS# _____ - _____ - _____
Address _____ Date of Birth _____
Address _____ Age _____
City, State, Zip _____ First Day of Your Last Period _____
Email _____
Home Phone _____ Cell Phone _____
Work Phone _____ Ext _____
Marital Status (circle one) Widowed Married Single Divorce

SIGNIFICANT OTHER/ EMERGENCY CONTACT PERSON

Name _____ Phone _____
Address _____ Relation to Patient _____
_____ Date of Birth _____

INSURANCE INFORMATION

Primary Insurance _____
Policy # _____ Group # _____
Subscriber's Name _____
Subscriber's SS # _____
Subscriber's Date of Birth _____ SS# _____
Subscriber's Address _____
Relationship to Patient Self Spouse Child

Secondary Insurance _____
Policy # _____ Group # _____
Subscriber's Name _____
Subscriber's SS # _____
Subscriber's Date of Birth _____ SS# _____
Subscriber's Address _____
Relationship to Patient Self Spouse Child

OUTSIDE LABS

Outside labs maybe used for testing the following procedures: lab work, cultures and pap smears. If we participate with your insurance carrier we will send it to the lab they direct us to, otherwise we will send the specimens to labs which we use for the quality of service. Please specify if there is a lab your carrier has an agreement with:

Lab (circle one) Quest Labcorp LabOne Newton Memorial Hospital

Pharmacy _____ Pharmacy Phone _____

Primary Care Physicain _____ Phone Number _____

Name: _____ Date: _____

PAST MEDICAL HISTORY

Please check if you have had any of the following conditions or diseases, indicating date and treatment.

<u>Yes</u>	<u>No</u>	<u>Condition/ Disease</u>	<u>Date</u>	<u>Treatment</u>
___	___	Anemia	_____	_____
___	___	Asthma	_____	_____
___	___	Blood Transfusion	_____	_____
___	___	Blood in Urine or Stool	_____	_____
___	___	Cancer	_____	_____
___	___	Diabetes	_____	_____
___	___	Emotional Disorder	_____	_____
___	___	German Measles (Rubella)	_____	_____
___	___	Heart Problems	_____	_____
___	___	High Blood Pressure	_____	_____
___	___	Infertility	_____	_____
___	___	Kidney/Bladder Problems	_____	_____
___	___	Liver Problems/Hepatitis	_____	_____
___	___	Lung Disease	_____	_____
___	___	Migraine Headaches	_____	_____
___	___	Phlebitis/Blood clots	_____	_____
___	___	Psychiatric Condition	_____	_____
___	___	Rheumatic Fever	_____	_____
___	___	Seizures	_____	_____
___	___	Syphilis/Gonorrhea(STD)	_____	_____
___	___	Thyroid disease	_____	_____
___	___	Tuberculosis	_____	_____
___	___	Other	_____	_____

Do you Smoke? Yes No If Yes, How many cigarettes per day? _____

Do you Drink? Yes No If Yes, How many drinks per Day? _____

What MEDICATION are you taking? Please list _____

Do you have ALLERGIES? _____

Please list any OPERATION / SURGERIES you have had

	<u>DATE</u>	<u>HOSPITAL</u>
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____

WOMEN'S HEALTHCARE

Medical Surgical Specialty Group

Patient Name _____ Patient # _____ Date _____

- | | | | |
|---|--|---|---|
| 1 | Will you be 35 years or older when the baby is due? | Y | N |
| 2 | Have you, the baby's father, or anyone in either of your families ever had any of the following Disorders? | | |
| | Down Syndrome (Mongolism) | Y | N |
| | Other Chromosomal Abnormality | Y | N |
| | Neural Tube Defect i.e. Spina Bifida (open Spine) Anencephaly | Y | N |
| | Hemophilia | Y | N |
| | Muscular Dystrophy | Y | N |
| | Cystic Dystrophy | Y | N |

If yes, indicate the relationship of the affected person to you or to the baby's father: _____

- | | | | |
|---|---|---|---|
| 3 | Do you or the baby's father have a birth defect? | Y | N |
| 4 | In any previous marriages, have you or the baby's father had a child born dead or alive, with a birth Defect not listed in question #2 above? | Y | N |
| | If yes, what was the defect and who had it? _____ | | |
| 5 | Do you or the baby's father have any close relatives with mental retardation ? | Y | N |
| | If yes, indicate the relationship of the affected person to you or to the baby's father: _____ | | |

- | | | | |
|---|---|---|---|
| 6 | Do you, the baby's father or a close relative in either of your families have a birth defect, and familial Disorder, or a chromosomal abnormality not listed above? | Y | N |
| 7 | In any previous marriage have you or the baby's father had a stillborn child? | Y | N |
| 8 | Are you or the baby's father of Jewish Ancestry? | Y | N |
| | If yes, indicate the condition and the relationship of the affected person to you or to the baby's father _____ | | |

- | | | | |
|----|--|---|---|
| 9 | Are you or the baby's father black? | Y | N |
| 10 | Are you or the baby's father of Italian, Greek or Mediterranean background? | Y | N |
| | Have either of you been tested for B-Thalassemia? | Y | N |
| | If yes, indicate who and the results: _____ | | |
| 11 | Are you or the baby's father of Philippine or Southeast Asian ancestry? | Y | N |
| | Have either of you been tested for A-Thalassemia? | Y | N |
| | If yes, indicate who and the results _____ | | |
| 12 | Excluding iron and vitamins, have you taken any medications or recreational drugs since pregnant or since your last menstrual period? (including non- prescription drug) | Y | N |
| | If yes, give the name of the medication and time taken during pregnancy: _____ | | |

- | | | | |
|----|---|---|---|
| 13 | Have you ever used intravenous drugs? | Y | N |
| 14 | Have you ever had a blood transfusion? Hepatitis? Liver Disease? | Y | N |
| | If yes, Explain: _____ | | |
| 15 | Have you ever worked as a lab technician, dental assistant, or nurse? | Y | N |
| | If yes, have you ever received the Hepatitis Vaccine? | Y | N |
| 16 | Do you have a cat? | Y | N |

Patient Sign _____ Witness _____ Date _____

GENETICS

CYSTIC FIBROSIS SCREENING QUESTIONNAIRE

This form should be filled out when routine cystic fibrosis DNA screening for 31 common mutations is ordered (test 480553). The form should be completed by the ordering physician's office must accompany sample. Please call 800-345-4363 with any questions.

Patient Name _____ Patient's DOB _____

Name of person completing form: _____

Physician's Signature _____

Indication for testing:

- _____ Routine carrier screening
- _____ Screening for partner of a previously identified carrier
- _____ Routine screening of fetus (either on CVS or amniotic fluid)
- _____ Suspected diagnosis of fetus/symptomatic individual
- _____ Known diagnosis of symptomatic individual

Patient History:

Is this patient/ this patient's partner currently pregnant? Yes No

If so, what is current gestational age? _____

Has anyone in the patient's family been diagnosed with cystic fibrosis or been identified as a carrier for a cystic fibrosis mutation? Yes No

If this patient is suspected to have cystic fibrosis, what clinical symptoms/ ultrasound findings are present? _____

Has the individual been sweat tested? _____

Patient Ethnicity:

- | | |
|---|--|
| _____ Caucasian, Northern European
(Poland, Germany, etc...) | _____ American Indian |
| _____ Caucasian, Southern European
(Italy, Greece, etc...) | _____ Ashkenazi Jewish |
| _____ Hispanic
(Puerto Rican, Mexican, etc...) | _____ African American/Black |
| _____ Asian | _____ Other _____
(please indicate) |
| | _____ Unknown Race/Ethnicity |

Note: This form should be photocopied as necessary and submitted (with specimens) to the laboratory.

Women's Healthcare
Medical Surgical Specialty Group
135 Newton-Sparta Road
Newton, New Jersey 07860
973-383-8555

Donald J Rubino, MD, FACOG
Raquel Dardik MD, FACOG
Melissa Sotillo DO, FACOG
Andria Pennant MD, FACOG
Vendy Wagner MD, FACOG

Barbo Noren, CNM
Gail Ludwig, CNM

Cystic Fibrosis Carrier Testing
Informed Consent/Decline

You should be certain you understand the six items listed below. If you are not certain about any of them, please ask your health care provider to explain them further before signing this form accepting or declining Cystic Fibrosis carrier testing.

1. I understand that the decision to be tested for CF carrier status is completely mine,
2. I understand that the test does not detect all CF Carriers
3. I understand that if I am a carrier, testing the baby's father will help me learn more about the chance that my baby could have CF.
4. I understand that if one parent is a carrier and the other is not, it is still possible that the baby will have CF, but the chance of this is very small.
5. I understand that if both parents are carriers, additional testing can be done in order to know whether or not the baby will have CF.
6. I understand that if the baby has inherited a changed CF gene from each parent, the only way to avoid the birth of a baby with CF is by terminating the pregnancy.

I have read and understand the information and:

I do NOT want CF carrier testing

I WANT CF carrier testing

Signed: _____ Date: _____

Witness _____

Women's Healthcare
Medical Surgical Specialty Group
135 Newton-Sparta Road
Newton, New Jersey 07860
973-383-8555
Fax 973-383-8034

FAX

TO: NMH/Admission

FROM: _____

ATTN Evelyn / Shannon

Pages: _____

FAX: 973-383-1641

Date: _____

Phone: 973-579-8867

RE: Maternity Admission

URGENT FOR REVIEW PLEASE COMMENT PLEASE REPLY PLEASE RECYCLE

Patient Name _____

Patients Address _____

S.S. # _____

DOB: _____

EDC: _____

Phone # _____

Insurance # and Name _____

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Preauthorization for prenatal care and delivery global package will be obtained by the business office, unless otherwise discussed. Please contact the business office or your insurance company before testing to ensure all preauthorization requirements have been fulfilled.

Prepayment on the uncovered portion of our fee is expected before delivery. If necessary, a monthly payment plan can be arranged. *You are responsible for any unpaid balance*, including deductible or fees for additional services needed during the pregnancy.

Please be sure to notify the business office if your insurance coverage changes

Remember, your contract is between you and your insurance company. Any confusion or delay in payment is to be settled by you with your insurance company. Your payment on any balance is due within 30 days of settlement with insurance company.

Thank you for your cooperation. Please feel free to call us or stop by anytime. The business office is open Monday through Friday from 8am-4pm. The phone number is (973) 383-6738.

Patricia Ferrer
Practice Manager

Payment Agreement

I have read the above fee schedule and agree to prepay \$ _____, which is not covered by my insurance company, or is applicable to my deductible. I will also be responsible for the balance after insurance for any additional charges as explained above.

Signature

Print Name

Date

******PLEASE SIGN BOTH COPIES AND KEEP ONE FOR YOUR RECORDS******