Thomasville OB-GYN Associates, PA
1302 Lexington Avenue
Thomasville, NC 27360
Phone (336) 475-6139

Registration Form

Date_____ Account #_____ Pharmacy_____

Patient Name:

First_____ Middle_____ Last_____

Address_____ City_____ State_____ Zip_____

Home Telephone_____ Age_____ Birth date_____

Cell Phone_____ Work Phone_____ Marital Status: ☐ Married ☐ Single ☐ Widowed

Employer: _____ Social Security #_____

Email Address:_____ Primary Care Physician _____ Phone_____

If Patient is under 18 or is a student (Please check which applies and complete the following:)

☐ K-12 ☐ College ☐ Other

Mother's Name_____ Mother's Employer_____

Social Security #_____ Work #_____ Birth date_____

Father's Name_____ Father's Employer_____

Social Security #_____ Work #_____ Birth date_____

Spouse's Information

Spouse's Name_____ Birth date_____

Social Security #_____ Employer_____

Employer's Address_____ Work #_____

Emergency Contact (Please list two)

Name_____ Relationship_____ Home Ph:_____ Work Ph:_____

Name_____ Relationship_____ Home Ph:_____ Work Ph:_____

I authorize the release of my medical records from Thomasville OB-GYN Associates in order to process any claims or for appropriate medical treatment. I authorize payment directly to this professional association for the medical care and /or surgical benefits that is entitled under my insurance plans. I understand that as the patient (or the patient's guardian), I am responsible for any unpaid balance on my account. I also understand that if any charges are not covered by my insurance, workers compensation, or other third-party payers, I am responsible for full payment. I understand that fees for visits, examinations, or treatments are payable at the time of service unless covered by insurance or arrangements have been made in advance. I have read the notice of privacy practices and authorize Thomasville OB-GYN to use and disclose my Protected Health information to carry out my treatment, payment, or healthcare operations.

Signature_____ **Date**_____

Novant Health Thomasville Medical Center

Pregnancy /Toddler newsletter

NOVANT HEALTH

Name* _____

Email * _____

Baby's Due Date* Month: _____ Day: _____ Year: _____

Zip code _____

Please circle relationship to baby:

Mom - *Dad* - *Grandparent* – *Friend/Family* – Care provider

As you prepare for childbirth and caring for your new baby, we want to touch base with you by email each week to make sure you have additional support on your journey into parenthood. We think this is the best way for us both to connect regularly.

This program is **free**, includes customized information, news and resources tailored to your specific stage of pregnancy and/or your child's age—as well as announcements from our staff and access to support information—all conveniently delivered right to you! This program is powered by UbiCare, a product of TPR Media LLC.

YOUR RIGHTS:

- You may refuse to sign this authorization.
- Refusal will not affect your ability to obtain treatment or your eligibility for benefits through your care provider.
- You may revoke this authorization at any time. Revocation will take effect immediately.
- You have a right to receive a copy of this authorization.

REMUNERATION:

By submitting, you acknowledge that your care provider will not disclose nor directly receive any money for the use of your health information provided for this program.

***required information please**

Pre-Admission Information

Please fill out completely and return to the pre-visit services department or fax to 336-277-9985
You can also complete this form on our website at NovantHealth.org/maternity.

Personal Information

Last Name: First: Middle (Full name or Initials) Maiden (if applicable)

Social Security #: Date of Birth:

Marital Status: (Check one) ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Street Address:

City: State: Zip code:

Home Phone: Work Phone: Cell/other:

Race ☐ White ☐ Black/African-Amer ☐ Hispanic/Latino ☐ Asian ☐ American Indian ☐ Alaska Native ☐ Other

Religious Preference: Primary Language: Country of Birth:

Advanced Directives/Living Will: ☐ Yes ☐ No Power of Attorney: ☐ Yes ☐ No

Patient Employer: ☐ Employed: ☐ Retired: ☐ Student: ☐ Unemployed/Disabled

Employer Name: Employer Address:

Employer Phone: Occupation:

Spouse or Primary Emergency Contact: (Please list 1) Phone: Relationship to Patient:

Insurance Information

Include a copy of card if possible. Be sure to obtain a pre-admission certification number if required

Insurance Name: Group #:

Policy/Subscriber #: Benefit Phone # Certification Phone #

Primary Insurance Provider/Policy Holder Name DOB:

Social Security #: Employer:

Secondary Insurance Name: Group #:

Policy/Subscriber #: Benefit Phone # Certification Phone #

Primary Insurance Provider/Policy Holder Name DOB:

Social Security #: Employer:

Obstetrician (Physician Name or Practice): C-section Planned: ☐ Yes ☐ No

Sterilization Planned: ☐ Yes ☐ No

Primary Care Physician(Physician name or Practice): Due Date:

OBSTETRICAL QUESTIONAIRE

Date _____

NAME _____ AGE _____

ADDRESS _____ HOME PHONE _____

EMPLOYMENT _____ WORK PHONE _____

RACE: CAUCASIAN BLACK JEWISH HISPANIC OTHER BLOOD TYPE _____

MARITAL STATUS: MARRIED SINGLE DIVORCED SEPARATED YEARS OF EDUCATION _____

WAS PREGNANCY WANTED? ____YES ____NO

BABY'S FATHER'S AGE _____ BABY'S FATHER'S BLOOD TYPE _____

BABY'S FATHER'S RACE: CAUCASIAN BLACK JEWISH HISPANIC OTHER

BABY'S FATHER'S YEARS OF EDUCATION _____

HISTORY OF PREVIOUS PREGNANCIES

NUMBER OF TIMES PREGNANT _____
NUMBER OF PRETERM (EARLY) DELIVERIES _____
NUMBER OF ABORTIONS _____
NUMBER OF MISCARRIAGES _____

SINCE YOUR LAST PERIOD HAVE YOU BEEN EXPOSED TO ANY OF THE FOLLOWING?

	YES	NO
CATS	___	___
DRUGS	___	___
ALCOHOL	___	___
FUMES AT HOME OR WORK	___	___
PESTICIDES	___	___
RADIATION	___	___
SMOKING	___	___
OTHER _____	___	___

COMPLICATIONS OF PREVIOUS PREGNANCIES

	YES	NO
CESAREAN SECTION	___	___
STILLBORN	___	___
EARLY INFANT DEATH	___	___
HYDATIDIFORM MOLE	___	___
MALFORMED BABY	___	___
HIGH BLOOD PRESSURE	___	___
BIRTH DEFECTS	___	___
TOXEMIA	___	___
CEREBAL PALSY	___	___
NEUROLOGICAL DEFECTS	___	___
LOW BIRTH WEIGHT	___	___
PREMATURE BIRTH	___	___
ECTOPIC (TUBAL) PREGNANCY	___	___
OTHER _____	___	___

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO
HERPES	___	___
PKU (ON SPECIAL DIET AS A CHILD)	___	___
DIABETES	___	___
CHRONIC ILLNESS	___	___
SICKLE CELL	___	___
OTHER _____	___	___

HAS BABY'S FATHER EVER HAD ANY OF THE FOLLOWING?

	YES	NO
HERPES	___	___
PKU (ON SPECIAL DIET AS A CHILD)	___	___
DIABETES	___	___
CHRONIC ILLNESS	___	___
SICKLE CELL	___	___
OTHER _____	___	___

HAVE YOU BEEN EXPOSED TO ANYONE WHO HAS AIDS OR IS AT HIGH RISK FOR AIDS? _____
(IV DRUG USER, HOMOSEXUAL, BISEXUAL, MULTIPLE SEX PARTNERS, BLOOD TRANSFUSIONS OR BLOOD PRODUCTS BETWEEN 1978-1985.)

(Over)

DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF ANY OF THE FOLLOWING?

	YES	NO
SUDDEN DEATH	___	___
BIRTH DEFECTS	___	___
TAY-SACHS	___	___
BLOOD DISORDER	___	___
HYDROCEPHALIC (LARGE HEAD)	___	___
OTHER _____		

	YES	NO
GENETIC DISORDERS	___	___
SPINA BIFIDA (SPINAL CORD DEFECT)	___	___
SICKLE CELL	___	___
DOWNS SYNDROME (MONGOLOID)	___	___
MENTAL RETARDATION	___	___

SIGNATURE _____ DATE _____

WITNESS _____ DATE _____

THOMASVILLE OB-GYN ASSOCIATES, PA
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CYSTIC FIBROSIS TESTING

The American College of Obstetrics and Gynecology recommends that screening should be offered to those at higher risk of having children with Cystic Fibrosis (Caucasians, including Ashkenazi Jews) and in whom the testing is most sensitive in identifying carriers of a Cystic Fibrosis mutation. It is further recommended that screening should be made available to couples in other racial and ethnic groups who are at lower risk and in whom the test may be less sensitive. It is recommended that this be done when the patient seeks preconception counseling or infertility care, or during the first and early second trimester of pregnancy.

The cost of the CF test is determined by the lab and the amount that your insurance company pays will, of course, greatly affect what your financial responsibility will be. It is not always necessary that both parents of the unborn child be tested; however, this should be discussed with your physician. We will arrange for the testing to be done by LabCorp if you so choose.

I have read the above and wish to have Cystic Fibrosis testing done .

Signature_____

I have read the above and decline CF testing.

Signature_____

Date_____

Screening for Down Syndrome, Trisomy 18, and Neural Tube Defects (spina bifida or defects on spine)

Patient Informed Consent

- First trimester screening consists of an ultrasound measurement of the thickness of skin at the back of the baby's neck called the nuchal translucency, and the measurement of a hormone called free beta hCG and a protein called Pregnancy Associated Plasma Protein- A that are present in a pregnant woman's bloodstream. This screening can be performed from 11 weeks 1 day to 13 weeks 6 days of pregnancy.

- First trimester screening is performed to determine if your baby is at an increased risk for Down syndrome and trisomy 18. It does not tell you that your baby does or does not have these conditions.

- If results of the screening test reveal an increased risk for Down syndrome or trisomy 18, then a diagnostic test such as chorionic villus sampling (CVS) or amniocentesis will be offered to you. There is about a 1 out of 250 chance of a miscarriage associated with CVS and amniocentesis. Genetic counseling will also be offered to you. If you would not consider having a chorionic villus sampling or an amniocentesis under any circumstance, then you may not wish to proceed with first trimester screening.

- Studies suggest that first trimester screening detects between 80 and 90 percent of babies who have Down syndrome and 90 to 98 percent of babies with trisomy 18.

- If results of the screening test are normal, this does not guarantee that your baby is not affected with Down syndrome or trisomy 18, or another chromosome problem. Additionally, this does not eliminate the possibility of other birth defects, mental retardation or inherited conditions. In addition, all pregnancies have a 3-5% chance for having a birth defect and a normal first trimester screen does not change this risk.

- If the results of the screening test are normal, but the nuchal translucency measurement is significantly increased, a follow-up ultrasound will be suggested the second trimester.

- Screening for neural tube defects (spina bifida or defects on spine) cannot be done until between 14 and 20 weeks of pregnancy by alphafetoprotein (AFP) testing. AFP is a protein normally found in a pregnant woman's blood. If the results are abnormal, you will be offered a diagnostic test (amniocentesis).

- If you present for care after the time for first trimester screening and you are less than 20 weeks gestation, you will be offered a "quadruple" test for Down syndrome and spina bifida. This is a blood test that measures hormones that are present in a pregnant woman's bloodstream.

- These tests are voluntary. These tests are offered to all pregnant women. However, it is still recommended that all women who are 35 years or older at delivery be offered chorionic villus sampling or amniocentesis because these screening tests do not detect all babies who are affected with chromosome abnormalities or neural tube defects. You will be responsible for any costs of the screening tests that are not covered by your insurance plan.

I understand the benefits and limitations of first trimester screening and screening for neural tube defects.

I request screening.

_____

Patient Date

I decline screening.

_____

Patient Date

_____

Witness Date