ObGyn Associates

Kelly Jago, MD | Laila Needham, MD | Eric Pulsfus, MD | Thomas Searle, MD | Karen Toppi, MD | Susan Yarian, MD
Elizabeth Arnett, CNM | Barbara Dembek, CNM | Amy Loughlin, CNM | Elizabeth Meadows, CNM | Michele Rogero, CNM | Lisa Salt, PA-C
300 Health Park Blvd., Ste. 3002, St. Augustine, FL 32086 | phone.904.819.1500 | fax.904.810.1023

# Patient Registration and Insurance Information

Name: _____ D.O.B. _____/_____/_____ SS# _____-_____-_____
Address: _____
City: _____ State:_____ Zip: _____
Home Phone: _____ Cell Phone: _____ Consent to Text: Y/N
Work Phone: _____ext:_____
Email Address:_____ ☐decline to report

Marital Status: ☐ married ☐ domestic partner ☐ single ☐ divorced ☐ separated ☐ widowed ☐ unknown

How do you prefer to be contacted? ☐Home phone ☐Cell phone ☐Patient Portal ☐standard mail

In which language do you communicate? _____
In case of an EMERGENCY we have permission to contact Name:_____
Number: _____

We are required by law to ask which RACE and what ETHNICITY best describes you (you may decline to report). Please choose one in each of the following categories

**RACE:**
☐American Indian or Alaska Native
☐Asian
☐Black or African American
☐Native Hawaiian or Pacific Islander
☐White
☐Other _____
☐Decline to report

**ETHNICITY**
☐Hispanic or Latina
☐Not Hispanic or Latina
☐ Other _____
☐ Decline to report

**PLEASE COMPLETE ALL INSURANCE INFORMATION**

If you do NOT have insurance, check here _____

Insurance Co._____ Name of insured_____

Policy holder's date of birth:_____ Relationship _____

Primary Pharmacy: _____ Primary Lab(circle one) LABCORP/QUEST/Other

Primary Imaging Facility:_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical or medical benefits to OBGYN ASSOCIATES for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

I hereby authorize OBGYN ASSOCIATES to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

I understand I may revoke this consent at any time by notifying OBGYN ASSOCIATES in writing. OBGYN ASSOCIATES has the right to refuse treatment should I revoke or refuse this consent.

Patient Signature _____ Date _____

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## Privacy Issues for Patients

I have read and understand the "Notice of Privacy Practices" which is available at the front desk. A printed copy is available upon request.

Signature: _____ Date: _____

**Please list the following people that you give OB/GYN ASSOC. OF ST. AUGUSTINE permission to release your detailed medical information to. IF you choose not to release your medical information, please write NONE below.**

(Please print)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

## Office Policies

1. Your co-pay is due at the time of service. You are responsible for any deductible insurance amounts.

2. If your insurance requires a referral or authorization, it is your responsibility to get it.

3. Your insurance company has contracted with a lab for any blood work, PAP smears or biopsies. You should know which lab to visit for blood work. We will make every attempt to send any specimens to the correct lab. Our office does not bill for lab work; the lab company will bill you for any labs, PAP smears or biopsies.

4. . Our office has a $50.00 NO SHOW fee and requires a 24 hour notice of any cancellations.

Signature: _____ Date: _____

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**WELCOME TO OUR PRACTICE!**

4/3/17

Name:_____ DOB : _____ Date:_____

**How can we help you today**? Check-up _____ Problem ____ (Briefly describe. If you would prefer to leave this blank, that's fine) _____

Are you allergic to any medications? _____

_____

Current medications (Please include birth control and herbal supplements _____

_____

_____

Who is your primary care provider? _____

What is your primary pharmacy? _____

**GYNECOLOGIC HISTORY**

Date of last menstrual period ____/____/_____

Date of last mammogram ___/___/___ Date of last colonoscopy ___/___/___ Date of last bone scan ___/___/___

Date of last Pap smear ____/____/_____ Abnormal Pap ☐Y ☐N If yes, when? ____/____/_____

Have you received the HPV vaccine? ☐Y ☐N If yes, was the three shot series completed? ☐Y ☐N

Are you interested in receiving information on the HPV vaccine for you or a family member? ☐Y ☐N

Do you identify as ☐Heterosexual ☐Homosexual ☐Bisexual ☐Transgender Are you sexually active?☐Y ☐N

How long have you been with your partner? _____

Are you currently using a birth control method? ☐Y ☐N Type: _____

Do you have any history of sexually transmitted diseases? ☐Y ☐N _____

Age at onset of period _____ If menopausal, age at time of last period_____

Any significant GYN history? _____

_____

**OBSTETRIC HISTORY**

How many pregnancies have you had total (including miscarriages)? _____How many deliveries? _____

**Delivery History:**

| | Date of Birth | Full Term? | CS or Vaginal | Length of Labor | Weight | Sex | Complications? |
|---|---|---|---|---|---|---|---|
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 7 | | | | | | | |

## FAMILY HISTORY

| | Year of Birth | Diseases/Complications | Deceased? Y/N |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Sister(s) | | | |
| Brother(s) | | | |
| Maternal Grandmother | | | |
| Maternal Grandfather | | | |
| Paternal Grandmother | | | |
| Paternal Grandfather | | | |
| Other | | | |

## SOCIAL HISTORY

Are you a cigarette/cigar smoker? ☐Y ☐N Cig/day_____ Years of use _____ Are you ready to quit? ☐Y ☐N

Are you blind or have difficulty seeing? ☐Y ☐N Are you deaf or have difficulty hearing? ☐Y ☐N

Alcohol intake: (check one) ☐never ☐occasionally ☐daily

How many days in the past year have you had heavy drinking consumption (4+drinks) _____

Are you in recovery from drug or alcohol dependency? ☐Y ☐N Type_____

Do you have a current or past history of drug use (including misuse of prescription medications)? ☐Y ☐N

Caffeine: ☐Y ☐N amount/day: _____

Exercise level: (check one) ☐never ☐occasionally ☐moderate ☐heavy

Diet: (check one) ☐Vegan ☐Vegetarian ☐Gluten Free ☐Diabetic ☐No Restrictions

Marital Status: ☐ married ☐ domestic partner ☐ single ☐ divorced ☐ separated ☐ widowed ☐ unknown

Have you ever felt threatened or unsafe in a relationship? ☐Y ☐N ☐ Past relationship ☐ Current relationship

Education Level: (check one) ☐ High School ☐ 2yr College ☐ 4yr College ☐ Post Graduate

Occupation: _____

Religion: _____

Have you (or your partner) traveled to a zika-affected area in the past 12 months? ☐Y ☐N

Do you routinely use seat belts? ☐Y ☐N

Is a blood transfusion acceptable in an emergency? ☐Y ☐N

## SURGICAL HISTORY

| Name of Surgery | Date of Surgery |
|---|---|
| | |
| | |
| | |
| | |
| | |

## MEDICAL HISTORY (Please describe any medical conditions that apply to you)

☐Y ☐N Cancer_____
☐Y ☐N Heart Disease_____
☐Y ☐N Hypertension_____
☐Y ☐N Dermatology_____
☐Y ☐N Diabetes/Gestational Diabetes_____
☐Y ☐N Thyroid Problems_____
☐Y ☐N Abdominal Digestive Problems_____
☐Y ☐N Liver Disease _____
☐Y ☐N Blood Clots/Bleeding Disorder _____
☐Y ☐N History of Chicken Pox
☐Y ☐N Migraines_____
☐Y ☐N Seizures/Epilepsy_____
☐Y ☐N Bone Fractures as an Adult_____
☐Y ☐N Depression/Anxiety/Psychiatric Disorder
☐Y ☐N Asthma_____
☐Y ☐N Autoimmune Disorder_____
☐Y ☐N Urology_____
☐Y ☐N Weight Management_____

Other :

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Name:_____

# REVIEW OF SYSTEMS

In the past 6 months have you experienced any of the following?
Please use the back to explain any "yes" answers.

## Constitutional

| | |
|---|---|
| Unexplained fever? | ☐Y ☐N |
| Night sweats? | ☐Y ☐N |
| Unexplained weight gain? | ☐Y ☐N |
| Unexplained weight loss? | ☐Y ☐N |

## Ear/Nose/Throat

| | |
|---|---|
| Visual changes? | ☐Y ☐N |
| Difficulty hearing? | ☐Y ☐N |
| Frequent nose bleeds? | ☐Y ☐N |
| Sore throat? | ☐Y ☐N |
| Do you snore? | ☐Y ☐N |

## Cardiovascular

| | |
|---|---|
| Chest pain? | ☐Y ☐N |
| Shortness of breath when at rest? | ☐Y ☐N |
| Shortness of breath when walking? | ☐Y ☐N |

## Respiratory

| | |
|---|---|
| Persistent cough lasting >4weeks | ☐Y ☐N |
| Seasonal allergies? | ☐Y ☐N |
| Wheezing? | ☐Y ☐N |
| Coughing up blood | ☐Y ☐N |

## Gastrointestinal

| | |
|---|---|
| Abdominal pain? | ☐Y ☐N |
| Bloating? | ☐Y ☐N |
| Change in appetite? | ☐Y ☐N |
| Nausea or vomiting? | ☐Y ☐N |
| Change in bowel pattern? | ☐Y ☐N |

## Genitourinary

| | |
|---|---|
| Leaking of urine (incontinence)? | ☐Y ☐N |
| Frequent nighttime urination (nocturia)? | ☐Y ☐N |
| Difficulty urinating? | ☐Y ☐N |
| Painful urination? | ☐Y ☐N |
| Increased frequency of urination? | ☐Y ☐N |

## Musculoskeletal

| | |
|---|---|
| Muscle aches? | ☐Y ☐N |
| Muscle weakness? | ☐Y ☐N |
| Joint pain? | ☐Y ☐N |
| Back/neck pain? | ☐Y ☐N |

## Integumentary

| | |
|---|---|
| Skin changes? | ☐Y ☐N |
| Abnormal mole? | ☐Y ☐N |

## Neurologic

| | |
|---|---|
| Change in headache pattern? | ☐Y ☐N |
| Loss of consciousness? | ☐Y ☐N |

## Psychiatric

| | |
|---|---|
| Felt/feeling depressed or sad? | ☐Y ☐N |
| Felt anxious? | ☐Y ☐N |
| Sleep disturbances? | ☐Y ☐N |
| Felt/feeling unsafe in a relationship? | ☐Y ☐N |
| Dealt/dealing with an eating disorder? | ☐Y ☐N |

## Endocrine

| | |
|---|---|
| Heat/cold intolerance? | ☐Y ☐N |
| Excessive hair growth? | ☐Y ☐N |
| Increased thirst/hunger? | ☐Y ☐N |

## Other

| | |
|---|---|
| Bruise easily? | ☐Y ☐N |
| Seasonal allergies? | ☐Y ☐N |

If you answered “yes” to any of the questions please explain:

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Drs. Yarian, Pulsfus, Searle, Jago, Needham and certified nurse-midwives Amy Loughlin, Elizabeth Meadows, Michelle Rogero and Elizabeth Arnett have furnished information prepared by the Florida Birth-Related Neurological Injury Compensation Association. I understand that the practitioners of OBGYN Associates of St. Augustine participate in this program, which provides certain limited compensation in the event neurological injuries occur during the birth of your infant.

For specifics on the program, I understand I can contact the Florida Birth Related Neurological Injury Compensation Association (NICA) at the following address and phone number:

Lynn Dickinson, Executive Director
P.O. Box 14567
Tallahassee, Fl 32317-4567
(904)488-8191 or 800-398-2129

I further acknowledge I have received a copy of the brochure prepared by NICA.

Date: _____

Signature: _____

Print your name: _____

Nurse or Physician: _____Date:_____

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## Options for Prenatal Screening

Three prenatal lab tests, HIV, Drug Testing and Cystic Fibrosis screening are recommended but voluntary during pregnancy. Your provider encourages you to have all of these tests done so that we can ensure the best outcome for your pregnancy.

**HIV:** Federal law requires we tell you the following:

* Most pregnant women who are HIV positive have no symptoms
* If you are HIV positive, treatment during pregnancy greatly reduces the risk that your baby will be HIV positive.
* Early detection of HIV greatly increases your chance of a healthy life.
* The initial screening test has rare false positive results; there are additional tests that can confirm the diagnosis.
* If you test positive for HIV, we must report your name to the Florida Health Department.
* Everyone in our office is committed to complete confidentiality and professionalism.

□ **Consent** □ **Decline**

**Cystic Fibrosis:**

* This is a serious genetic disease in which children are unable to clear secretions in the lungs and other organs.
* Most pregnant women who carry the gene for cystic fibrosis have no family history and no symptoms.
* Early detection in infants improves medical care for children with cystic fibrosis.
* The test does not identify every carrier, but does identify the vast majority of women who may be carriers of the genes associated with cystic fibrosis.
* The test may not be covered by your insurance or may be applied to your deductible.

□ **Consent** □ **Decline** □ **Tested in previous pregnancy (circle one) POSITIVE/NEGATIVE**

**Drug Screen:**

* When you are pregnant, it is important that you watch what you put into your body. Consumption of certain drugs, both legal and illegal, can be harmful to your unborn baby.
* Pregnancy is a unique time to address health issues and for this reason we screen all pregnant women for the presence of drugs that could adversely affect yours and or the baby's health.
* A positive screen will initiate a conversation with your provider about how the substance effects your pregnancy and potentially a referral for counseling services. This is not a punitive test but rather a chance to identify those who need help during pregnancy.

□ **Consent** □ **Decline**

I understand the information above, have asked the nurse or physician if I have any questions regarding the information above, and I (please check below). I understand that some tests may not be covered by my insurance and or the cost may go towards my deductible.

Print Name _____ Date _____

Signature _____ DOB:_____

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**Congratulations on your pregnancy and welcome to our practice!**

Our goal is to provide excellent obstetric care. Everyone on our staff remembers the joy and the fear, the emotional and physical changes during pregnancy. We hope to reassure you, to challenge you to be your best and to ensure the health of our two patients -- you and your baby.

One important point:

There are NO dumb questions.

Due Date and Timing in Pregnancy

Your due date is determined as 40 completed weeks from your last period. If you are unsure of your last period or have irregular intervals between menstrual cycles, let us know. Ultrasound is often used to confirm or change a due date. It is normal for your baby to arrive anywhere from 37 to 42 weeks.

We will talk about your pregnancy in weeks. Every 13 weeks marks a trimester.

Routine visits are scheduled as follows:

* Every 4 weeks from 10 to 30 weeks
* Every 2 weeks from 30 to 36 weeks
* Every week from 36 weeks to delivery

Prenatal Care

We will discuss all of the following at your office visits; however, it is nice to have something to refer to when questions come up.

1. Nutrition/Health Habits

   A good rule during pregnancy is to be yourself, but better. Substitute cottage cheese for that doughnut. Eat your greens. A low-fat, low-sugar diet is best. Stop smoking. We recommend gaining five to ten pounds in the first twenty weeks, then a pound per week for the next twenty weeks. Listen to your body. Eat when you are hungry. If you have a limited diet; for example, vegetarianism, make sure you get enough folic acid, protein and iron.

2. Medications

   After the first trimester, you may take Tylenol or Sudafed (dose on package) if you have a cold (or you may choose to simply blow your nose). Call us regarding any other medications. In general, keep medications to a minimum.

3. Ultrasound

   We generally do an ultrasound in the office in the first trimester to confirm your due date. A second ultrasound is done at 21 weeks to look at the baby's anatomy. You can choose to do a GENDER ultrasound at 16-18 weeks and/or a 3-D ultrasound in the third trimester which gives you a sneak peek at what your baby looks like. These two optional ultrasounds are not covered by insurance.

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4. When to call the office: (Call 904-819-1500 day or night)

- Temperature higher than 101 degrees and/or chills
- Nausea and vomiting such that you haven't been able to keep fluids down for 24 hours or more
- Vaginal bleeding
- Marked decrease in the baby's movements (after 24 weeks)
- Severe abdominal pain
- Burning with urination
- Any time you are unsure or have questions

If you have a non-acute problem or question, please avoid Monday mornings as the phone lines are very busy then.

5. Insurance

As you may know, there are two types of insurance plans. PPO plans allow you to see a physician without a referral from a primary care physician. HMOs usually require a referral. You are responsible to know whether your plan requires that you see your primary care physician first and if you must pay a co-pay.

If we are a participating practice in your insurance plan (PPO or HMO), we will be happy to file insurance claims for you as a courtesy. The front office can tell you if we participate with your insurance plan.

If you have any billing questions, call Tracy or Lawanda directly at 904-819-1500.

For more information about our practice and other helpful medical information, please visit our websites at www.obgynstaugustine.com or www.staugustinemidwife.com

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## APPROVED OVER THE COUNTER MEDICATIONS IN PREGNANCY

In general, the fewer medications in pregnancy, the better. However these medications have not been found to have any fetal effects if taken **after** 13 weeks gestation. Store brand versions of these medications are fine.

Headache, body ache, low-grade fever – Tylenol or Extra-Strength Tylenol

Allergies – Benadryl, Claritin, Zyrtec, Flonase

Colds – Sudafed, Tylenol Cold & Sinus, Dimetapp

Cough – Robitussin or Robitussin DM (use sugar-free if diabetic)

Constipation – Increase fluid intake, use glycerin suppositories and stool softeners such as Colace or Miralax regularly. If you are less than 20 weeks pregnant, an enema is safe for severe constipation. Increase fiber through diet or a supplement such as Benefiber or Metamucil.

Diarrhea – Imodium AD or Kaopectate

Gas – Maalox Plus, Mylanta II, Mylicon

Heartburn – Maalox, Mylanta, Zantac, Pepcid AC, Tums, Rolaids

Hemorrhoids – Anusol, Preparation-H, witch hazel pads, Tucks, ice packs

Nausea – Emetrol, ginger, peppermint or lemon

Sore Throat – Chloraseptic spray or lozenges, Cepacol lozenges, warm salt water gargle

Tooth pain – Extra-Strength Tylenol

Yeast infections – Monistat 7 day (suppositories or cream)

Vaccinations – **Flu shots** in pregnancy are allowed and encouraged as this is not a live virus. **PPD testing** for tuberculosis (TB test), **Hepatitis vaccinations,** and **D-TAP vaccine** are also allowed.

Hair color and perms are safe.

**Do not take Ibuprofen, Aleve, Advil, Motrin or any medication with the description NSAID**

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# 3/D FETAL PORTRAITS

**Our doctors and midwives are proud to offer state-of-the-art, 3D/4D ultrasound services to our obstetric patients. This scan does NOT replace your regular prenatal medically indicated ultrasound.**

**3D/4D ultrasound imaging provides expectant parents the opportunity to see their baby for the first time like no other ultrasound technology allows. Expectant parents can share the photos with family and friends at baby showers and other family gatherings. The photos make great additions to your baby book, and images on a DVD and CD can easily be shared via e-mail or the internet. In addition to images captured for you to keep, we provide you the opportunity to see your baby in real-time 4D.**

**The package includes a full motion DVD, CD, and multiple still images both in black and white and color for $200.00. This ultrasound is strictly a NON-CLINICAL ultrasound scan and is not reimbursed by insurance companies. Unlike medically indicated ultrasounds, no fetal measurements or clinical evaluations are performed during this examination. The preferred gestational age for the 3D/4D pictures is between 28-32 weeks. At this stage of your pregnancy, amniotic fluid levels are optimal and the fetus has adequate body fat and tissue.**

**Our sonographer is ARDMS certified. She also performs all of our obstetrical and gynecological ultrasounds and will, therefore, be familiar with you. These ultrasounds are performed only at our St. Augustine office.**