STONERIDGE OBSTETRICS & GYNECOLOGY

NEW PRENATAL APPOINTMENT

Please be sure to complete the following forms.

Attach a front and back copy of your insurance card and mail to:

Stoneridge Ob/Gyn
670 Lawn Avenue
Suite 4
Sellersville, PA 18960

We recommend that you please arrive 15 minutes prior to your appointment with your insurance Card.

Thank You

STONERIDGE OBSTETRICS & GYNECOLOGY

STONERIDGE PROFESSIONAL CENTER
670 LAWN AVENUE, SUITE 4
SELLERSVILLE, PA 18960
TEL: 215-257-0414
FAX: 215-257-1740

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SUSAN SCHWARZ, PA-C

PATIENT'S NAME: ______________________________ DATE OF 1ST APPOINTMENT: __________

Congratulations! We look forward to caring for you and your baby during your pregnancy. To better facilitate your visits with us, we ask that you take the time to read and complete the enclosed forms.

- Please fill in the enclosed "PATIENT INFORMATION" sheet, and, if possible, include a copy of ***both sides*** of your insurance card(s). Should you have insurance through your employer ***AND*** through your husband's employer, please include copies of both.

- Prior to your visit with us, you may experience the common cold, viral symptoms, headaches, etc. It is always preferable to avoid all medications during pregnancy, especially during the first three months, but should it become necessary to medicate, please refer to the enclosed **"MEDICATIONS FOR THE PRENATAL PATIENT"**. We also ask that you call your primary care physician for those illnesses not related to the pregnancy.

- We do recommend that you start taking a daily prenatal vitamin as soon as possible. We have listed several brands on the Medication List that you may choose from. (If you are experiencing the common early pregnancy symptoms of nausea and vomiting, it is sometimes helpful to take your prenatal vitamin at bedtime to avoid the further upset that a prenatal vitamin can cause in some women.)

- In order to obtain the most accurate medical information for your pregnancy, we ask that you complete the **"MEDICAL HISTORY"** questionnaire ***prior*** to your first visit. This will allow you time to contact family members, a family physician and/or a previous obstetrician, if necessary, to obtain any information. Once you have completed this questionnaire, please send it back in the enclosed, self-addressed envelope ***at your earliest convenience and before your first prenatal appointment.*** We will review your answers with you at that time.

If questions arise as you work on these forms, it is requested that you **DO NOT** call our office. We ask that you fill out the forms ***to the best of your ability.*** If you are unsure about a word or question, you may put an (*) by it. We can then discuss any of these questions in detail at your first prenatal visit.

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Medications for the Prenatal Patient

Listed below are frequently recommended medications used in treating the common cold, as well as the normal aches, pains and discomforts of pregnancy. The doctors in this practice consider these medications to be safe in pregnancy. It is of utmost importance that you should NOT use any of these medications if you are allergic to them or any of the components in the medications. We request that you contact your primary care physician for any illness not directly related to the pregnany, such as the flu, a cold or viral infections. If you are currently taking prescription drugs, contact your prescribing physician to inform him/her of your pregnancy and to review your current medications.

HEADACHES/PAIN
Use only regular or extra-strength Tylenol.

MIGRAINE HEADACHES
Tylenol #3 (this is a prescription drug and may be obtained through your primary care physician.)

COUGHS/COLDS
Over-the-counter products are acceptable that contain only acetaminophen, pseudoephedrine, guaifensin, or diphenhydramine/ such as Tylenol Cold, Tylenol Flu, Tylenol Sinus, Tylenol Allergy Sinus, Robitussin CF, DM, PE and Sudafed, Sudafed Sinus and Cold, Sudafed Sinus and Allergy and Sudafed Severe Cold. Do not use cough preparations that contain alcohol. All cough drops are okay. Saline Nasal Spray may be used to help congestion. Do not take Phenylephrine, some Tylenol preparations contain these.

SEASONAL ALLERGIES
Over-the-counter products are acceptable that contain only acetaminophen, Benadryl (diphenhydramine) or chlorpheniramine, such as Chlor-Trimenton. Claritin & Zyrtec -- These are prescription medications.

FLU SHOT
This is recommended at any time during pregnancy.

CONSTIPATION
Increase liquids, fresh fruits, vegetables and bran cereal. Increase daily walking. Metamucil, Senekot, Surfak, Colace, Phillips' Milk of Magnesia, glycerin suppositories.

CALCIUM
Recommended dosage for the prenatal patient is 1500-2000mg daily. This may be obtained through diet (milk contains 300 mg per 8 oz glass) or supplements such as Tums, Tums EX, Viactiv, Os-Cal.

HEMORRHOIDS
Tucks, Anusol-HC, Preparation-H.
Warm tub soaks for 15-20 minutes three times a day.

PRESCRIPTION ANTIBIOTICS (if not allergic, any Penicillin or Cephalosporin is okay)
Ampicillin, Keflex, Erythromycin, Augmentin, Penicillin, Zithromax, Macrodantin, Amoxicillin.
For any questions, please contact prescribing physician and advise them of your pregnancy status.

INDIGESTION/HEARTBURN
Tums, Rolaids, Mylanta, Maalox, Zantac (75mg), Pepcid-AC.
Avoid Alka Seltzer. Lactose pills okay for those with a lactose intolerance.

COLD SORE
Lysine

MUSCLE ACHES
Mineral Ice, BenGay Avoid hot tubs. A heating pad may be used for 10 minutes at a time, but avoid the 'hot' setting and do not apply directly to the abdomen.

RASH
Hydrocortisone cream 1%, Benadryl, Calamine lotion, Eucerin.

DENTAL
Lidocaine or another local anesthetic is acceptable if you are not allergic to it. X-rays are acceptable if necessary to determine treatment options if the abdomen is shielded.

INSOMNIA (Sleep Problems)
Warm milk, Benadryl (25 or 50 mg) used sparingly, Unisom SleepTabs (1/2 tablet, 12.5 mg)

YEAST INFECTIONS
Terazol (prescription)
Any over-the-counter anti-fungal preparation; do not use the applicator after 36 weeks of pregnancy.

DIARRHEA
Kaopectate, low dose Imodium.

PRENATAL VITAMINS
Any prenatal vitamin, prescription or over-the-counter. Avoid extra dose of vitamins.

MEDICAL HISTORY

Patient's Name: ___________________________Race: _______________ Last Grade Completed: ___________

Patient's blood type and rH: _________________Father of baby's blood type and rH:____________________
If you know that the father of the baby's blood type is rH negative, we request that you obtain a photo-copy of that result for our records. Please attach it to this medical history and return to our office.

Emergency Contact: ____ Phone: ___________________________

Since your last menstrual period, have you had:
Yes No any vaginal bleeding
Yes No vomiting
Yes No low back pain/cramps
Yes No pain or burning when urinating
Yes No headache
Yes No exposure to German measles
Yes No exposure to radiation
Yes No viral symptoms
Yes No more than 5 alcoholic drinks at a time
Yes No medication since last menstrual period, If yes, list: ____________________________________
Yes No multi-vitamins/folic acid since last menstrual period. If yes, list: _________________________

MENSTRUAL HISTORY:

1. How old were you when you got your first period? _______________
2. How frequently do you get your period? every____________days
3. When was the first day of your last period? ___________________
4. Was it normal in amount and duration?____
5. When was the first day of your previous period?____
6. Were you on birth control pills at the time of conception? Yes No
7. Did you have a home pregnancy test or blood pregnancy test? No If blood test, where?
____

PREGNANCY HISTORY:

1. How many times have you been pregnant? (This number includes all miscarriages and abortions.) _______
2. How many pregnancies were full-term deliveries (delivered between 37 and 40+ weeks)? ______________
3. How many pregnancies were premature deliveries (delivered before 37 weeks)? ______________________
4. How many abortions were voluntarily induced? ____
5. How many miscarriages were spontaneous (occurring naturally)? _______________________________
6. How many pregnancies were ectopic (occurring in the tube)? _________________________________
7. How many pregnancies resulted in multiple births? ____
8. How many pregnancies resulted in a live birth?____
9. How many pregnancies resulted in still birth? ____
10. How many children are currently alive? ____

Please fill in the grid below regarding your previous pregnancies, including information about miscarriages and abortions.

EXPLANATION OF PREGNANCY GRID BELOW

A. Month and year of delivery
B. How many weeks of gestation were you at the time of delivery/miscarriage? (A full-term pregnancy is 40 weeks.)
C. How many hours were you in labor?
D. What was the weight of the baby?
E. What was the sex of the baby?
F. What type of delivery did you have, i.e..vaginal, induced, vacuum extraction, Cesarean section, breech, forceps. VBAC (vaginal birth after Cesarean)? If miscarriage, indicate if D&E was done.
G. What type of anesthesia did you have, i.e., spinal, general, epidural?
H. At what hospital did you deliver/miscarry? If out of the area, please include city and state.

A	B	C	D	E	F	G	H
Month/year	Gestational weeks	Hours in labor	Birth weight	Male or female	Type of delivery	Type of anesthesia	Place of delivery
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

Identifying your pregnancies by the number assigned them on the above grid, which of them have been complicated by:

Breech presentation __________

Preterm labor __________

—Did this require cerclage? __________

Placental abruption __________

Placenta previa __________

High blood pressure while pregnant __________

Gestational diabetes __________

Excessive vomiting requiring hydration __________

Eclampsia/pre-eclampsia __________

Post-partum hemorrhage __________

Other complications or comments: __________

PAST MEDICAL HISTORY

Indicate positive history with a "+" and a negative history with "0" If positive, describe briefly, including date of onset, medication, and the doctor who treats you.

1. ____anemia
2. ____gastro-intestinal
3. ____diabetes
4. ____high blood pressure
5. ____heart disease/heart murmur
6. ____auto immune disease, i.e., lupus
7. ____kidney disease
8. ____urinary tract/bladder infection
9. ____asymptomatic bacteruria
10. ___pyelonephritis/kidney infections
11. ___neurologic
12. ___epilepsy
13. ___psychiatric
14. ___hepatitis/liver disease
15. ___varicose veins
16. ___phlebitis
17. ___thyroid dysfunction
18. ___trauma/violence
19. ___history of blood transfusion
20. ___tobacco use: How many per day/week before pregnancy? ________per __________
    How many per day/week now? ________per __________
    How many years used? ________
21. ___alcohol use: How many per day/week before pregnancy? ________per __________
    How many per day/week now? ________per __________
    How many years used? ________
22. ___street drugs: What type? ____
    How much per day/week before pregnancy? ________per __________
    How much per day/week now? ________per __________
    How many years used? ________
23. ___unusual blood disorder
24. ___cancer
25. ___lung (TB & asthma)
26. ___allergies to medications: ____
    What is the reaction when this drug is used?________________________________
    ____
27. ___breast
28. ___gynecologic surgery, such as D&C, D&E, cone biopsy, cerclage, removal of myoma, diagnostic laparoscopy, exploratory laparotomy, cystectomy, etc. (Include year and doctor)
    ____
    ____
29. ___other surgeries (Include year and doctor)
    ____
    ____
30. ___anesthetic complications. Explain:____
31. ___abnormal pap (Include year, doctor, and treatment)

____
32. ___abnormality of the uterus, such as fibroids, or DES exposure
33. ___infertility (Include length of treatment and doctor) ___________________________
34. ___Multiple birth
35. ___Other

Stoneridge Obstetrics and Gynecology

Patient Information: PLEASE PRINT

Name:____SS#:____________________
LAST NAME FIRST NAME

Address: ____Date of Birth__________________

City: ____ State: ______________ Zip: ___________

Home#:(_____)_______________ Cell#:(_____)_______________ Work#: (_____)______________Ext:_____

Employer: ____Occupation:_______________________________

Marital Status: S M W D Sep. Family MD ____

Allergies to medication: ____

Spouse's Name: ____ Work #: ______________________________

Please note: Without the policy holder's Date of Birth we will not process your medical claim.

Primary Insurance:

Policy#: _______________________________ Name of Insurance Company:____________________________

Group# _________________________Relationship to patient: Parent_____Spouse _____ Other _____ Self _____

Policy Holder Name: ____ SS#: ___________________
LAST NAME FIRST NAME

Address: ____Date of Birth:__________________

City: ____ State: __________________________ Zip: ___________

Home#:(_____)_______________ Cell#:(_____)_______________ Work#: (_____)______________Ext:_____

Policy Holder Employer: ____

Secondary Insurance:

Policy#: _______________________________ Name of Insurance Company:____________________________

Group# _________________________Relationship to patient: Parent_____Spouse _____ Other _____ Self _____

Policy Holder Name: ____ SS#: ___________________
LAST NAME FIRST NAME

Address: ____DOB:____________________

City: ____ State: __________________________ Zip: ___________

Home#:(_____)_______________ Cell#:(_____)_______________ Work#: (_____)______________Ext:_____

Policy Holder Employer: ____

I request that payment of authorized Medicare and/or all other Insurance benefits be made either to me or on my behalf to Stoneridge Obstetrics and Gynecology for any services furnished to me by that physician/supplier. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits payable for related services. I understand I am financially responsible for any non-covered services and unpaid balances. In addition, I understand that there will be a monthly added fee of fifteen dollars for all outstanding balances over 30 days. As part of this organization's treatment, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for this permitted use, including disclosures via fax.

Also, as a result of the many insurance contracts with various laboratories, my specimen(s) will be sent to the lab determined by my insurance carrier. Should the insurance information I provide to Stoneridge Obstetrics and Gynecology be incorrect, I understand that my signature below indicates I assume responsibilities for any charges.

Patient Signature: ____Date: ______________

Stoneridge Obstetrics and Gynecology

Patient Name:____**Date of Birth:**______________________

COMMUNICATION PERMISSION

To preserve your privacy, we would like you to indicate how to communicate information to you. Without your permission, we will not release any of your medical or billing information to another person.

Please Initial:

_____ I give permission for Stoneridge Ob/Gyn personnel **to leave appointment confirmation and medical information on an answering machine.**
Home ( )_______________ Cell ( )_______________ Work ( )_______________

_____ I give my permission for Stoneridge Ob/Gyn personnel **to mail any information pertaining to my care to the address I have provided.**

_____ I give permission for Stoneridge Ob/Gyn personnel **to leave or discuss any and all medical information pertaining to me to the individual(s) listed below:**

Name:______________________________Relationship:_______________Telephone#:___________________

Name:______________________________Relationship:_______________Telephone#:___________________

_____ I give permission for Stoneridge Ob/Gyn personnel **to leave or discuss any and all billing and insurance information to the individual(s) listed below:**

Name:______________________________Relationship:_______________Telephone#:___________________

Name:______________________________Relationship:_______________Telephone#:___________________

I assume responsiblity to inform the practice of any changes in regards to the above items.

Patient Signature:____ **Date:** ____________________

STONERIDGE OB/GYN
SELLERSVILLE, PA 18960
Effective Date: April 14, 2003

NOTICE OF PRIVACY PRACTICES

This Notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can access your individual identifiable health information. Please read carefully .

A. WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION IN THE FOLLOWING WAYS:

1. **Treatment:** Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory test and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.
2. **Payment:** Your health information may be used to seek payment from your health plan from other sources or coverage such as automobile insurer or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated. You are required to provide this practice with all insurance coverage information; health, auto, and worker's compensation (if applicable), or discuss and provide an alternative method for providing payment for services to this practice.
3. **Health Care Operations:** Your Health Information may be used as necessary to support the day-to-day activities and management of this practice. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality or to contact and remind you that you have an appointment.
4. **Law Enforcement:** Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.
5. **Public Health Reporting:** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable disease to the state's health department.
6. **Other Uses and Disclosures:** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services (such as a billing service) if the information is necessary. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement. Your Health Information may also be used or released for coroners, Medical examiners and Funeral Directors. Any other disclosure of your Health Information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.
7. **Information about Treatment:** Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health related goods and services that we believe may interest or be of benefit to you.

B. YOUR RIGHTS UNDER THE FEDERAL PRIVACY STANDARDS:

- The right to request restrictions on the use and disclosure of your Health Information. However, we are not required to agree to your request.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and purchase a copy of your protected information.
- The right to request an amendment or submit corrections of your Health Information. However, we are not required to agree to your request.
- The right to receive an accounting of how and to whom your Health Information has been disclosed.
- The right to file a complaint. If you would like to submit a comment or complaint about our privacy practices or suspect violation, you may do so by a letter, outlining your concerns. Please address this correspondence to our Privacy officer, Debby Konstantakis, Office Manager or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

C. CHANGES TO THIS NOTICE:

- We reserve the right to change this notice and make the new notice apply. We will post a copy of our current notice at our office with the effective date.

ACKNOWLEDGEMENT OF NOTICE

I acknowledge that I am aware of the Privacy Practices for Stoneridge OB/GYN.

________ Yes

________ No

Name of patient:____

Patient's Signature:____ Date: ________________

Name of personal representative (if applicable):____

Signature: ____ Date: ________________

Relationship to patient (or other authority):____

FOR OFFICE USE ONLY

_______ Consent received by__________________________________ on _______________________________

_______ Consent refused by patient. Received by_________________ on _______________________________