

PATIENT UPDATE FORM

PATIENT'S NAME: (Print) _____ **DOB:** _____

REASON FOR TODAY'S VISIT: _____ **DATE OF VISIT** _____

CURRENT MEDICATIONS:

Name _____ Strength _____ Dose _____

Name _____ Strength _____ Dose _____

Name _____ Strength _____ Dose _____

Name _____ Strength _____ Dose _____

Name _____ Strength _____ Dose _____

ALLERGIES:

Name _____ Reaction _____

Name _____ Reaction _____

MEDICAL DOCTOR (PCP): _____

PHARMACY: _____ **LOCATION** _____

EMERGENCY CONTACT: _____ **PHONE #:** _____

Relationship: _____

DATE OF LAST MENSTRUAL PERIOD: _____ Postmenopausal Hysterectomy

PERIODS COME EVERY _____ **days.** **PERIODS LAST** _____ **days.** **FLOW: (CIRCLE)** Light Moderate Heavy

BIRTH CONTROL: _____ Tubal Ligation Partner w/ Vasectomy

TOBACCO USE: Never Former Current; Packs/Day _____

RECENT PERSONAL HISTORY:

Have you been recently hurt or threatened emotionally or physically? No Yes

Has anyone, including your partner, recently forced you to have sex? No Yes

Are you afraid of your partner? No Yes

HISTORY of BREAST or OVARIAN CANCER in YOURSELF or RELATIVES? No Yes

(INCLUDE MATERNAL AND PATERNAL SIDE; PARENTS, SIBLINGS, CHILDREN, AUNTS/UNCLES, GRANDPARENTS)

Type of cancer: _____ Relative: _____ Age when diagnosed: _____

Outcome: _____ Comments: _____

If you like to be contacted for any of the following aesthetic services, please check below:

- SculpSure – Body Contouring Skinceuticals Products or Peels Pelleve Wrinkle Reduction Laser Hair Removal

Patient's Name: _____

DOB: _____

Please fill out obstetrical history section if you have had a pregnancy in the last five years.

OBSTETRICAL HISTORY:

Date of Delivery	Weeks of gest	Type of Delivery	Physician	Sex	Wt.	Abortion (Elective)	Miscarriage	List other problems/complications and outcome
TOTALS: Enter totals below:								
Total Pregnancies	# of Full Term	# of Premature	Elective Abortions	Miscarriages	Ectopics	Live Children		

This section MUST be completed prior to being seen by your provider in order for your medical record to be updated and accurate.

Any update to your Medical History/Surgeries/Hospitalizations: _ (This section MUST be completed.)

Any updates to your Family History:

Do you currently drink alcohol or use drugs: (If yes, how much and how often):

PATIENT REGISTRATION FORM

Last Name (Print) (First) (MI) (Previous/Maiden)

DOB Marital Status: Single Married Divorced Sep. Widow

Address City State Zip

Home# Work# Ext Cell#

Circle best way to reach you

E-Mail Employer Occupation

Race: ()White ()Black/African American ()Hispanic ()Other:

Ethnicity: ()Hispanic or Latino ()Not Hispanic or Latino ()Decline Language: ()English ()Spanish ()Other:

ARE YOU CURRENTLY PREGNANT: Yes No

I have been seen by Annapolis OB-GYN within the past 12 months Yes No
NOTE: If you checked "Yes", do NOT complete the rest of the form unless your information has changed. If you checked "No", please continue to complete the rest of the form below this box. YOU MUST SIGN AT THE BOTTOM.

PRIMARY CARE DOCTOR(Other than at this practice) Phone

PHARMACY LOCATION Pharm Phone:

EMERGENCY CONTACT Relationship

Emergency Contact's Home # Work# Cell#

YOUR PARTNER'S INFORMATION (SPOUSE /PARTNER/BABY'S OTHER PARENT) (Please circle one)

Name (Last) (First) (MI) DOB SS#

Address City State Zip

Home# Work# Cell#

PRIMARY INSURANCE: Insurance Co. Phone#

Name of Insured Patient Relationship to Insured DOB

Insurance Address Employer

Subscriber ID# Group ID# Co-Pay Amount

SECONDARY INSURANCE: Insurance Co. Phone#

Name of Insured Patient Relationship to Insured DOB

Insurance Address Employer

Subscriber ID# Group ID# Co-Pay Amount

I declare I have listed all the medical/health insurance plans from which I may receive benefits. I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I also understand that I am responsible for contacting AAMG Annapolis Ob-Gyn, in a timely manner, with any future changes in the above information, especially those that may affect the processing of my insurance claims.

Patient Signature Date

Parent or Guardian Relationship Date

For office use only
FD CL

PRENATAL QUESTIONNAIRE

DATE: _____

NAME: _____ DOB: _____ AGE: _____

1. When was your last menstrual period? _____ Was it normal? Yes No
2. How many total pregnancies have you had? _____ (including this pregnancy)
3. How many pregnancies ended in miscarriage, ectopic or therapeutic abortions?
Therapeutic abortions _____ Miscarriages _____ Ectopic _____
4. How many pregnancies were full term? _____ How many living children do you have? _____
5. Please check any of the following problems that you are currently experiencing:
Nausea _____ Vomiting _____ Bleeding _____ Breast tenderness _____ Frequent urination _____
Bladder pressure _____ Cramping _____
6. Have you had an X-ray since you have been pregnant? Yes No
If yes, what did you have X-rayed? _____
7. Have you taken any prescribed or over-the-counter medications since you have been pregnant? Yes No
If yes, what were the medications? _____
8. Have either you or the baby's father had herpes? Yes No
If yes, circle: Mother of baby Father of baby
9. Do you or the baby's father use drugs? Yes No
If yes, circle: Mother of baby Father of baby
10. Have you been treated for an eating disorder? Yes No
11. Do you have a history of diabetes? Yes No
If yes, circle one: while pregnant while not pregnant
12. Have you ever tested positive for Hepatitis B? Yes No
13. Have either you or the baby's father ever tested positive for HIV (AIDS)? Yes No
If yes, circle: Mother of baby Father of baby
14. Is there a history of twins or other multiple births in your family? Yes No
If yes, circle: Mother of baby Father of baby
15. Have you or the baby's father in a previous pregnancy had a stillborn child or three or more first trimester spontaneous pregnancy losses? Yes No
If yes, circle: Mother of baby Father of baby
16. What is your ethnicity? _____ Father of the baby's ethnicity? _____
17. Are you or the baby's father black? Yes No
If yes, circle one or both: Mother of baby Father of baby
Was this person or persons tested for sickle cell trait? Yes No
Mother's results _____ Father's results _____
18. Are you or the baby's father of Jewish ancestry? Yes No
If yes, circle one or both: Mother of baby Father of baby
19. Have you been tested for Tay Sachs? Yes No
Mother's results _____ Father's results _____

PATIENT'S NAME: _____

DOB: _____

20. Are you or the father of Italian, Greek or Mediterranean background? Yes No
 If so, have either of you been tested for B-Thalassemia? Yes No
 If yes, circle one or both: Mother of baby Father of baby
 and indicate the results _____
21. Are you or the baby's father of Filipino or Southeast Asian ancestry? Yes No
 If yes, have either of you been tested for A-Thalassemia?
 If yes, circle one or both: Mother of baby Father of baby
 and indicate the results _____
22. Was anyone in your family or the baby's father's family live born or stillborn with birth defects, mental retardation or any disease which you think might be inherited? Yes No
 If yes, please circle the disease or problem below and state the family relation.

DISORDER

FAMILY RELATION

- | | |
|--|-------|
| Any mental retardation | _____ |
| Down Syndrome or other chromosomal defect | _____ |
| Hemophilia | _____ |
| Hydrocephalus | _____ |
| Huntington's Chorea | _____ |
| Neural Tube Defect (Spina Bifida, Anencephaly) | _____ |
| Muscular Dystrophy | _____ |
| Duchenne's Muscular Dystrophy | _____ |
| Cystic Fibrosis | _____ |
| Congenital Heart Disease | _____ |
| Cleft Lip/Cleft Palate | _____ |
| Adult onset Polycystic Disease | _____ |
| Other _____ | _____ |

23. Do you have any medical conditions that may affect your pregnancy? Yes No
 If yes, please state: _____
24. Do you have a child with Autism, Asperger's or a related Syndrome? Yes No
25. If "yes" would you be interested in being tested for Fragile X Syndrome? Yes No
26. Are you interested in genetic testing? Yes No
27. Do you have a history of hypertension? Yes No

Place a check in the box to indicate your answer:

Over the last 2 weeks, how often have you been Bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on the edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

28. Do you have any physical, emotional or sexual abuse in your life? Yes No

AAMG ANNAPOLIS OB-GYN

Information for Obstetrical Patients

We offer complete obstetrical care including prenatal, delivery, and post- partum care.

We rotate our delivery room coverage and feel it is important for you to meet each of us during your pregnancy. This will occur through scheduling of your prenatal visits. On some of these visits you may schedule with our obstetricians: Drs. Claudia Hays, Frederick Guckes, Suleika Michel, Ifeyinwa Stitt, Benjamin Solomon, Laura Merkel, Victoria Moore, Julia Lubsky and Janelle Cooper, along with our advanced practice providers - Rene Smit, CNM, Tara Pomponio, PA-C, Wenda Collien, CRNP, Julie Viera, PA-C, Marianne Eggerl, WHNP-BC/CNM and Aileen Landis, CRNP. We encourage scheduling visits with our advanced practice providers; however, they do not deliver.

We do not practice general medicine, but we wish to be informed of any problems occurring during your pregnancy. We will work with your family doctor, internist, surgeon, etc., for problems outside the obstetrical bounds.

We encourage full participation of the baby's father or your support person in your prenatal care, childbirth classes, labor, delivery, and subsequent care of your infant. We do encourage and support the philosophy of prepared childbirth classes. We feel this is a most helpful and extremely beneficial way for you to prepare for your pregnancy, labor and delivery.

Our fee includes your initial complete physical examination, all routine prenatal visits, the management of labor and vaginal delivery, post-partum visits during your hospital stay, and your six week post-partum checkup in the office.

When you come into the office for your initial visit and registration, blood will be drawn and sent to the appropriate laboratory for your insurance. You may receive a bill from the lab for their service. Special medications, i.e. injections and medicines which must be obtained from a pharmacy, are not included in our fee. It is important to have insurance identification information with you at all times in case we are able to bill insurance directly for certain tests or procedures.

Should a cesarean section be required for delivery, there will be an additional charge. This procedure requires a surgical assistant. Since AAMC is not a teaching hospital, the assistant will be a licensed surgeon in private practice and you will receive a bill from his/her office. A vaginal birth after cesarean section (VBAC) may also involve an additional fee.

The hospital has no staff anesthesiologists, therefore, you will be billed separately for his/her service should you either desire or require anesthesia.

It is up to you to make arrangements for a Pediatrician to take care of your new baby. If you do not already have one and are not sure who to contact, ask one of us to recommend one or more for you to consider. Again, you will be billed separately for his/her service.

Sometimes during a pregnancy we may deem it necessary to order a sonogram or non-stress test. If this is the case, those procedures will be scheduled for you in our office. The charges for these tests are not included in your obstetrical fee. As soon as you receive notice from your insurance company that they have paid their portion, you are responsible for remitting the balance. Please carefully read our Advanced Beneficiary Notice (ABN) regarding your financial responsibility on certain tests that may not be covered by your insurance. There will be additional charges for the management of unlikely, but possible complications.

DANGER SIGNS DURING PREGNANCY:

Throughout your pregnancy, we will be discussing many of the common complaints and possible complications that occur. In the meantime, we would like you to familiarize yourself with the following danger signs:

- Vaginal bleeding
- Severe swelling in your face, hands or feet
- Pain, redness, swelling or heat in the calf of your leg
- Shortness of breath or difficulty breathing
- Blurring of vision or spots before your eyes
- Severe or constant headaches
- Fever and chills
- Burning and pain during urination
- Sharp, constant abdominal pain

Call us at (410)573-9530 should you notice any of these symptoms.

PAYMENT:

Upon confirmation of pregnancy, our billing department will confirm the level of benefits available for Global Maternity Care with your insurance company.

For patients whose plans involve deductible and/or coinsurance amounts, an Explanation of Delivery Fees will be sent to you specifically outlining your maternity benefits, including the amount estimated to be the portion of patient responsibility collectible during the prenatal months of care. Each Explanation of Delivery Fees acts as a contract between you and our office with balances payable in accordance with your payment plan selection. Specific questions regarding information contained in an Explanation of Delivery Fees should be directed to our OB billing coordinator at the number listed below.

Patients whose insurance plan issues benefits at a level that indicates limited patient responsibility will NOT be issued an Explanation of Delivery Fees. ALL balances assessed to your account are payable upon receipt of statements.

It is extremely important to advise our office immediately of any insurance changes to ensure appropriate billing.

If you have any questions regarding our obstetrical payment policies, please contact our OB billing coordinator. She can be reached at 443-837-1226, Monday thru Friday from 8:00 am to 4:00 pm

**AAMG Annapolis OB-GYN Advanced Beneficiary Notice (Signature required by ALL OB Patients)
Managed Care Organization Enrollment**

The information contained in this document applies to the following patient demographic:

- Any obstetrics patient applying for insurance through the Maryland Health Exchange whose eligibility qualifies them for enrollment in the Maryland Medical Assistance Program.
- Any obstetrics patient applying for Maryland Medical Assistance to help offset the cost of maternity care due to the large deductibles and/or co-insurance amounts of their current commercial insurance policies.
- Dependant children who either do not have maternity coverage under their parents' insurance plan or those who are looking to ensure automatic coverage for the baby from date of birth.

This document stands as notification that Annapolis OB-GYN only participates with Priority Partners, University Healthplan (Riverside), United Healthcare MCO (including AmeriChoice)

Important Information you need to know:

Who can apply?

- Uninsured patients (NOTE: In some instances, having health insurance will not prevent eligibility for MCHP. *Even if you have health insurance, it's best to apply and let the case manager assigned to your application determine whether your health insurance will affect your eligibility for MCHP.*)
- Dependant children with or without maternity coverage under their parents' policy.
- Children under age 19, who are not eligible for Medicaid, and whose countable income is at or below 200% of the federal poverty level (FPL).
- Pregnant women of any age, whose countable income is at or below 250% FPL.

Selecting Priority Partners, University Healthplan (Riverside), United Healthcare MCO (including AmeriChoice) as your MCO:

Upon approval for the Maryland Medical Assistance Program (MA), **you are required to select the MCO in which you wish to be enrolled...PLEASE NOTE: SELECTING YOUR MCO IS A TIME SENSITIVE PROCESS.** Failure to comply with the enrollment process will result in you being auto enrolled in an MCO picked for you by the state of Maryland.

There are two ways to enroll for an MCO:

- Upon approval for Medical Assistance (MA), immediately contact your local County Health Department with your Medical Assistance number. Advise them that you have recently been approved for Medical Assistance, and need to enroll in one of the above plans. Request the effective date of coverage for your records. Usually 7-10 days from calling. **(RECOMMENDED)**
- Within 7 to 10 days from being approved for Medical Assistance, you will be sent a packet of information by mail describing all available MCO's. Phone numbers are provided for you to call to enroll in the MCO with which we participate. (THIS PROCESS CAN TAKE UP TO 3 WEEKS LONGER...and exposes you to auto enrollment if you miss the deadline.)

IMPORTANT NOTICE: At the present time, Priority Partners is open to **new** enrollment for all Maryland residents. If at some point they close enrollment to a county, you can enroll under one of the following conditions:

- If you were previously enrolled in Priority Partners within the last 180 days, your enrollment is reinstated.
- If you have a dependant or are the sibling of a dependant who is currently enrolled with Priority Partners, you can enroll under the Family Unity Program

BE ADVISED: Patients who do not comply with enrollment procedures and end up enrolled in an MCO with which we do not participate, may be subject to the following:

- **Transfer of care.** Obstetrics services may no longer be rendered to you by AAMG Annapolis OB/GYN. You will need to find a provider that participates with your current MCO insurance, and facilitate a transfer of care immediately.
- **Financial responsibility.** Services rendered to you while you were covered by an insurance this office DOES NOT participate with will be reduced to our office cash pay fee schedule and become your patient responsibility.

******I have read the above information, and understand that should I have need to enroll in a Managed Care Organization (MCO), I must enroll with one of the plans listed above to maintain status as an obstetric patient at AAMG Annapolis OB-GYN. Additionally, I accept financial responsibility for any services rendered to me while I am covered by an MCO with whom AAMG Annapolis OB-GYN does NOT participate.**