Patient Information Form

NAME Last: _____ First: _____ MI:_____

Preferred Name: _____ SSN:_____

DOB: _____ Age _____ Married____ Single____ Divorced____ Separated____ Widowed____

Address _____ City _____ ST _____ Zip _____

Home phone:_____Cell:_____ Email:_____

How do you prefer to be contacted? Home____Cell____Email_____
Would you like to receive information via email regarding access to our Patient Portal? Yes____ No____

Employer: _____ Work Ph: _____

Pharmacy: _____ Location _____ Phone: _____

Spouse/Parent: _____ DOB: _____ SSN: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Allergies:

Previous Medical/Surgical History:

Advanced Directives
Do you have an Advanced Directive (DNR)? Y N

For Office Use Only

Date	Problems	Date	Surgeries/Deliveries

Marion Women's Health Center
Insurance Information and Payment Authorization

Patient Name: _____

Primary Coverage Insurance Company: _____

Policy ID# _____ Group # _____

Effective Date: _____ Copay amount* $ _____

Subscriber Name _____

Subscriber SSN: _____ Subscriber Date of Birth: _____

Subscriber Address (if different from patient) _____

Subscriber relationship to patient _____

Subscriber Employer _____

Secondary Coverage Insurance Company (if applicable): _____

Policy ID# _____ Group # _____

Effective Date: _____ Copay amount* $ _____

Subscriber Name _____

Subscriber SSN: _____ Subscriber Date of Birth: _____

Subscriber Address (if different from patient) _____

Subscriber relationship to patient _____

Subscriber Employer _____

PAYMENT AUTHORIZATION

I, _____, hereby authorize Marion Women's Health Center to furnish information concerning my care. I direct the insurer to pay, without equivocation directly to the physician, all benefits due to him as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. A photostatic copy of authorization will be as valid as the original.

Signature of Patient or Guardian: _____ Date: _____

*If your insurance requires a Co-payment, this Co-pay must be paid at each visit for which they are required. If you are unable to make your Co-payment at the time of service, your visit will be rescheduled.

Jay Moodley M.D.
Brenda Gatchel CNM/CRNP

960 South Prospect Street
Marion, OH 43302

740.383.2776 voice
877.678.2776 toll free
740.383.2978 fax

Marion Women's Health Center

To ensure confidentiality and comply with HIPAA regulations, it is the policy of our office to release information regarding our patients only to the patient. By signing this, you are giving our office staff permission to release information to your referring physician, insurance companies and any necessary treating physicians, therapists or hospitals.

If you wish for others to receive information regarding your care, please list their name, telephone number and relationship to you below. If you are a minor, parents/guardians are not automatically authorized to be given information. You must list each parent/guardian you give permission for our staff to speak to.

I give my permission to Dr. Moodley, Brenda Gatchel, and their staff to speak to the following people regarding my care in addition to those listed in the first paragraph above:

Name	**Telephone Number**	**Relationship.**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALL REQUESTED MEDICAL RECORDS require a release filled out and signed by the patient.

When calling our office, our staff will need to speak with you directly.
When we are trying to reach you by telephone, do we have your permission to leave a message on your answering machine or voice mail?

YES NO (Circle One)

_____
Patient Name (please print)

_____
Patient Signature

_____
Date

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NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

I acknowledge that I have been offered a copy of Marion Women's Health Center's Notice of Privacy Practices, but decline to take a copy.

_____ _____

Patient or Personal Representative Signature date

I acknowledge that I have received a copy of Marion Women's Health Center's Notice of Privacy Practices.

_____ _____

Patient or Personal Representative Signature date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to patient: _____

At your initial visit, a family medical history will be completed. To aid this process, please answer the following questions. Include immediate family only – yourself, baby's father, parents, siblings and grandparents.

Illness	**Yes**	**No**	**If yes, explain**
Heart disease			
High Blood Pressure			
Cancer			
Lung Disease (TB, Asthma)			
Kidney Disease			
Neurological Disease (Epilepsy)			
Metabolic/Endocrine (Thyroid)			
Anemia/Blood Disorders			
Psychiatric Illness (Depression)			
Diabetes			
Have you ever had			
Rheumatic Fever			
Stomach problems (ulcers)			
Kidney Infection (bladder)			
Infertility			
Surgeries			
Accidents (major)			
Blood Transfusion			
Allergies to medications			

How old were you when you had your first menstrual period? _____ years

Within the last year, how often were your periods? _____ How long did they last? _____

Have you had any of the following since your last menstrual period: (circle)

spotting or vaginal bleeding abdominal cramping headaches nausea or vomiting fever

NAME:_____ **DOB:**_____

Marion General Hospital
OhioHealth

In an effort to simplify your admission to the Center for New Beginnings at Marion General Hospital we are asking you to complete the following information. This information will be reviewed again upon admission to verify accuracy and will allow us to speed up the admission process. Please contact us at 740-383-8461 to answer your questions. Once again, thank you for taking the time to complete this information.

PATIENT NAME: LAST	FIRST	MIDDLE		MAIDEN
ADDRESS	CITY	STATE		ZIP
PHONE: HOME WORK BEST TIME TO CONTACT: MORNING		MAY WE CONTACT YOU AT HOME: Y N MAY WE CONTACT YOU AT WORK: Y N AFTERNOON		EVENING
SS#	BIRTHDATE (MM/DD/YY)		MARITAL STATUS	
CHURCH EMPLOYER	CITY	STATE		ZIP
SPOUSE NAME	SS#	BIRTHDATE (MM/DD/YY)		
SPOUSE'S EMPLOYER	CITY	STATE		ZIP
PRIMARY INSURANCE	POLICY/PLAN CODE POLICY #			
SUBSCRIBER NAME				
ADDRESS OF INSURANCE CO.	CITY	STATE		ZIP
SECONDARY INSURANCE	POLICY/PLAN CODE POLICY#			
SUBSCRIBER NAME				
ADDRESS OF INSURANCE CO.	CITY	STATE		ZIP
SMOKER: Y N	ALLERGIES			
OB PHYSICIAN'S NAME	DUE DATE	PEDIATRICIAN'S NAME		
LAST HOSPITAL ADMISSION DATE	NAME LAST ADMITTED UNDER			
LAST MENSTRUAL PERIOD_____ # OF PREGNANCIES_____ # OF BABIES DELIVERED____ ARE YOU PLANNING A VAGINAL OR C-SECTION DELIVERY? _____				
ALTERNATIVE CONTACT/NEXT OF KIN	ADDRESS	PHONE		RELATIONSHIP

the center for
AT MARION GENERAL HOSPITAL

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Marion Women's Health Center

Smoking and Pregnancy

Statement of Understanding

Maternal smoking affects the outcome of both the pregnancy and the child. I have been informed that smoking during pregnancy increases the risk of:

1. Abruption of the placenta (Early separation of the placenta from the uterus).
2. Bleeding during pregnancy.
3. Lower birth weight, which may have cause my child to have long term physical and intellectual deficits.
4. Miscarriage.
5. Placenta previa.
6. Premature rupture of membranes (bag of water breaks before contractions begin).
7. Premature labor and delivery.
8. SIDS (Sudden Infant Death Syndrome).
9. Stillbirth.

I understand the adverse effects of smoking. I have been advised to stop smoking and/or not to start.

Signature _____ Date _____

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OBSTETRICAL ULTRASOUND

I, _____, hereby request the performance of **Obstetrical Ultrasound.** This procedure will be performed by Sharon Hostetler RDMS.

Recent recommendations from the American College of Obstetricians and Gynecologists (ACOG) suggest that specific fetal structures be examined during your ultrasound examination. While every effort will be made to identify birth defects of the brain, chest, heart, abdomen, kidneys and extremities, not all birth defects will necessarily be detected.

This ultrasound test is not a treatment for any condition but is done for diagnostic purposes. The information obtained may be used to confirm the presence of a fetal heart beat, evaluate the baby's growth, estimate the size of the baby, detect the presence of multiple fetuses and to detect **some but not all birth defects.** It is possible that fetal birth defects may not be seen on the ultrasound or that normal anatomy could falsely appear abnormal. Therefore, neither a normal ultrasound nor the results of any other prenatal test guarantee a normal, healthy baby.

_____ I agree to the ultrasound examination and do not wish to be referred to a specialist for a more detailed evaluation

_____ I prefer to be referred to a specialist who may have a higher detection rate for serious birth defects.

Currently, there are no known health risks to the mother or fetus during an ultrasound examination. I understand that alternatives to this examination may be available to me.

I acknowledge that I have had an opportunity to discuss with Dr. Moodley/Brenda Gatchel CNM/CRNP (provider) and they have explained to my satisfaction the purpose and nature of this obstetrical ultrasound, as well as reasonable risks. I understand that medicine is not an exact science, that it may involve the making of medical judgments based upon the facts known to the physician at the time, and that it is not reasonable to expect the physician to be able to anticipate nor explain all possible risks and complications, and further, that an undesirable result does not necessarily indicate an error in judgment. I understand no guarantee as to the results has been made to me. I expressly wish the physician to exercise his/her best judgment during the course of the procedure and to inform me of the findings of the obstetrical ultrasound.

I understand that this obstetrical ultrasound may or may not be paid for by my insurance company. Many insurance companies will not pay for an ultrasound unless medical indications are present. I understand and agree that if the procedure is not paid for by my insurance, I will be responsible for the payment.

All of my questions have been answered and I do hereby consent to the performance of obstetrical ultrasound.

_____ _____
Patient Signature Patient Name (printed)

_____ _____
Physician/Provider Date

First Peek Ultrasound

for

Gender determination

Marion Women's Health Center is pleased to announce the addition of "**First Peek**" ultrasound to identify the gender (sex) of your baby. "**First Peek**"ultrasound does not replace diagnostic examinations that your doctor may perform, it is an enhancement to the healthy bonding during pregnancy.

"**First Peek**" ultrasound is scheduled no earlier than fourteen weeks of pregnancy. This is offered as a non-diagnostic enhancement to pregnancy. **Insurance considers this optional and is not covered. Payment is required at the time of the ultrasound and is accepted in cash or credit card only. You are required to bring proof of your due date, either a note from your physician or an ultrasound picture with dating of your pregnancy. If you are a patient of Marion Women's Health Center, no verification is required. If this is something that you would like to experience, please schedule an appointment after fourteen weeks of pregnancy.**

Cost of the "**First Peek**" ultrasound is **$65.00**. This includes a 10 minute session to identify the gender (sex) of your baby and two printed black and white pictures. If your baby does not cooperate the day of the "First Peek" ultrasound you will be rescheduled approximately three weeks later.