CENTER FOR MATERNAL-FETAL CARE

KENNETH HIGBY, M.D.

Welcome to the Center for Maternal-Fetal Care

Enclosed is our New-Patient Packet. Please be sure to fill out your paperwork in its entirety before your appointment. Also, be sure to bring your Photo ID and Insurance card/s to your appointment.

Please note our Office Policies:

- We do **not** allow children under the age of 13 in our office or in the waiting room.
- We do **not** allow food or beverages in our office.
- We have a **15-minute** late policy. If you are more than 15 minutes late to your appointment we may ask to re-schedule or work you back into the schedule, if time permits.

Please advise if you are unable to attend this appointment. Our office number is 210-354-2229.

We are located at the corner of Medical Drive and Ewing Halsell, next to the PVA Building. Our address is 4330 Medical Drive Ste. 225 San Antonio, Texas 78229.

Please feel free to call with any questions. We look forward to meeting you!

"Our mission is to provide the highest quality of obstetrical care in a pleasant surrounding."

4330 MEDICAL DRIVE. SUITE 225 SAN ANTONIO, TEXAS 78229

Phone (210) 354-2229 FAX (210)-354-9973

THANK YOU FOR CHOOSING OUR OFFICE
IN ORDER TO SERVE YOU PROPERLY WE WILL NEED THE FOLLOWING INFORMATION.

Last Name:_____ First Name:_____ MI:____

Maiden:_____

DOB:_____ /_____ /_____ SS#_____-_____-_____

Street Address:_____

City:_____ State:_____ Zip:_____

Phone:(_____)_____ Marital Status: Single Married Student: (Y/N)

The information below is requested by CMS guidelines but is not mandatory

Race : _____

Ethnicity:
(Circle One Below)

Hispanic or Latino
Not Hispanic or Latino
Unknown

Preferred Language:_____

Whom may we thank for referring you:

Doctors Name:_____

Address:_____

_____

Phone:(_____)_____

Fax:(_____)_____

Employer:_____ Work Phone:(_____)_____ Ext:_____

Employer Address:_____

Cell Phone:(_____)_____ Email Address:_____

Alt. Contact Name:_____ Phone:(_____)_____ Relationship:_____

Responsible Party (fill out only if other than the patient)

Last Name:_____ First Name:_____ MI:____

Street Address:_____ Zip:_____

City:_____ State:_____ DOB:_____/_____/_____ SS#_____-____-_____

Employer:_____ Work Phone:(_____)_____ Ext:_____

Employer Address:_____

How do you speak English? Very Well _____ Well _____ Not Well _____ Not At All _____

CONSENT FOR TREATMENT:

I hereby authorize the provider for the Pediatrix Medical Group, to treat myself for anything deemed medically necessary. I can refuse treatment at anytime.

POST PARTUM DEPRESSION AND PARENTS OF NEWBORN CHILDREN PACKETS:

I hereby state that I have received the Pregnancy, Parenting and Depression Resource List as required by law through House Bill 341. Furthermore I have received the information packet regarding Parents of Newborn Children as required by law through Senate Bill 316.

Patient's Signature:_____ Date:_____

Financial Policy

Thank you for choosing the Center For Maternal-Fetal Care as your health care specialist. We are committed to providing you the best medical care. Our personnel will be pleased to discuss our fees and policies with you at any time.

All patients are financially responsible for payment of charges related to the professional services rendered by Center For Maternal-Fetal Care Payment for professional services, is expected at the time of the services are rendered.

Center For Maternal-Fetal Care has entered into a number of contractual relationships with various Managed Care Organizations. The practice will use its best efforts to fully comply with all the rules and regulations covering physician, Managed Care Organization and patients responsibilities related to these plans. In adherence to these responsibilities, patients are expected to pay co-payments and deductibles at the time services are rendered; and to pay any remaining account balances as allowed under plan guidelines.

In the event that the practice provide services in cases involving non contracted insurance plans, patients acknowledge their responsibility for the timely and complete payment of charges for professional services rendered. The office will assist in providing the necessary information for patients to obtain reimbursement from the third party, however; the patient expressly agrees that this assistance in no way shifts the reimbursement responsibility from the patient.

Statement of Financial Responsibility

I understand and affirm that I am financially responsible for the payment for all charges related to the professional services rendered by Pediatrix Medical Group on my behalf.

Patients Signature_____ Date_____

Release of Information

I hereby authorize Pediatrix Medical Group to release any information including diagnosis and records of any treatments or examinations rendered to my insurance as necessary to have my insurance claim paid.

A xerographic copy of this authorization shall be considered as effective and valid as the original.

Patients Signature_____ Date_____

General Information Regarding Ultrasound and Amniocentesis

Diagnostic ultrasound uses high frequency, but low power sound waves. Unlike X-ray, there is no radiation involved.

Ultrasound can provide your physician with useful data about your baby and its anatomy. While many defects can be seen on ultrasound, it is important to understand not all problems or defects will be identified. Fetal position, gestational age, maternal size, placental location, the amount of amniotic fluid, and prior maternal surgeries limit ultrasound studies. These factors can result in either incomplete, or non-visualization of fetal anatomical structures. Please be aware that a normal ultrasound does not guarantee the absence of a birth defect or a chromosomal abnormality.

Center For Maternal-Fetal Care welcomes up to two family members to share in your ultrasound experience. Their members will be allowed in the exam room to watch your ultrasound procedure.

If you are having an amniocentesis you will need to avoid strenuous work or physical activity for the remainder of the day on which the procedure is performed. You will be able to resume normal activity the following day.

Ultrasound Authorization

I have read the information presented above and give my permission for an ultrasound exam to be performed on me. I understand that this procedure may have limitations due to the above variables, and thus cannot guarantee the absence of fetal defects or abnormalities.

Patients Signature_____ Date_____

Patient's name:_____ Birth date:_____ Today's date:_____
At which hospital will you deliver?_____ Your doctor's name:_____

PLEASE RECORD THE NUMBER OF EACH THAT APPLIES TO YOU:

Pregnancies (including this one): ____ Elective Abortions: ____ Miscarriages: ____
Premature births (less than 37 weeks): ____ Live Births: ____ Living children: ____

FOR EACH PAST PREGNANCY PLEASE COMPLETE THE FOLLOWING INFORMATION:

	Birth date	Weeks Pregnant	Baby's Weight	Male or Female	Type of Delivery Vaginal or C-Section	Medications and/or Epidural	Preterm Labor Y/N	Complications such as diabetes, high blood pressure, preeclampsia etc
1								
2								
3								
4								
5								
6								
7								
8								

Dr's Comments:

_____
_____
_____
_____

Have you been immunized for Hepatitis B? (series of 3 injections) YES NO

Have you been exposed to someone with Tuberculosis? YES NO

Do you or your partner have a history of genital herpes? YES NO

Have you had a rash or viral illness during this pregnancy? YES NO

Have you ever had a Sexually Transmitted Disease? YES NO

If yes, please identify: Gonorrhea Syphilis HPV/Venereal Warts Chlamydia Herpes Other:_____

Patient's name:	Today's date:

DOB:

Please list all medications you are currently taking:

Medication name please include vitamins, inhalers, suppositories	**Dose:** (example- 1mg)	**How often:** (example- twice a day)

Patient's name:_____ Birth date:_____ Today's date:_____

Please circle if any of the following symptoms apply to you now or since adulthood,
If none are applicable, please circle NONE

1. Constitutional weight loss, weight gain, fatigue, none
2. Eyes double vision, spots before eyes, vision changes, glasses/contacts, none
3. Ear, Nose, Throat earaches, ringing in ears, hearing problems, sinus problems, sore throat, mouth sores, dental problems, none
4. Cardiovascular chest pain or pressure, difficulty breathing on exertion, swelling of legs, rapid or irregular heartbeat, none
5. Respiratory painful breathing, wheezing, spitting up blood, shortness of breath, chronic cough, none
6. Gastrointestinal frequent diarrhea, bloody stools, nausea/vomiting/indigestion, constipation, involuntary loss of gas or stool, none
7. Genitourinary involuntary/unintended urine loss, urine loss when coughing or lifting, abnormal bleeding, painful periods, PMS, painful intercourse, abnormal vaginal discharge, none
8. Musculoskeletal **9.** muscle weakness, muscle or joint pain, none
10. Skin rash, sores, dry skin, moles (growth or changes), none
11. Breasts pain in breast, nipple discharge, lumps, none
12. Neurologic dizziness, seizures, numbness, trouble walking, memory problems, frequent headaches, none
13. Psychiatric depression or frequent crying, anxiety, none
14. Endocrine hair loss, heat/cold intolerance, abnormal thirst, hot flashes, none
15. Hematologic/lymphatic frequent bruises cuts that do not stop bleeding, enlarged lymph nodes (glands), none

Dr's comments:

_____

_____

_____

_____

_____

_____

_____

Patient's name: _____ Birth date: _____ Today's date: _____

Medical allergies? (please circle) NO YES if yes, please state name of medication and reaction:
_____
_____

Your blood type: _____ If negative, have you received Rhogam in this pregnancy? _____

Operations in lifetime (please list dates and procedures):
_____
_____

Problems with Anesthesia? NO YES (if yes, please explain):
_____
_____

YOUR MEDICAL HISTORY: (if nothing applies you may leave it blank)

Problem	YES	Date Diagnosed	Treatment including meds	Who in your family has this diagnosis?
Infertility				
Diabetes				
High blood pressure				
Heart disease				
Autoimmune disorder				
Kidney disease				
Urinary tract infections				
Neurologic/epilepsy				
Mental illness/depression				
Blood clots in lungs or legs				
Varicose Veins				
Thyroid dysfunction				
Trauma or domestic abuse				
Hepatitis/liver disease				
Breast surgeries/cancer				
Uterine surgeries				
History of abnormal pap smear				
Respiratory disease, asthma, TB				

Tobacco use:_____ How many cigarettes per day?_____ How many years?_____

Alcohol use:_____ How many drinks per day?_____ How many years?_____

Street drug use:_____ Name of drug(s):_____ How many years?_____

GENETIC SCREENING / COUNSELING

Patient's name:_____ Birth date:_____ Today's date:_____
Patient's **AGE** as of today:_____

HAS ANYONE IN EITHER FAMILY OF BABY'S MOTHER OR FATHER EVER BEEN BORN WITH ANY OF THE FOLLOWING CONDITIONS?

CONDITION	YES	SPECIFY AND STATE RELATIONSHIP
Neural Tube Defect such as anencephaly, meningomyelocele or Spina bifida		
Congenital HEART defect		
Any other birth defect		
Any other chromosomal birth defects		
Down's Syndrome		
Sickle Cell disease or trait		
Hemophilia / blood disorders		
Muscular Dystrophy		
Cystic Fibrosis		
Mental Retardation / Autism		
Are you of Jewish, French Canadian, Cajun or Mediterranean decent?		
Has the mother or father of this baby ever had a child with a birth defect not listed above?		