111 E. Loomis St, Thomasville, GA 31792

Phone: 850-999-2651/ eFax 877-378-3390 / Fax 850-765-2020

Adanna Amanze, MD, FACOG

PATIENT INFORMATION

Date: _____

Name: _____

Last First Middle

Date of Birth: _____ Age: _____ Primary Language: _____

Patient's Social Security #: _____

Home address: _____

City, State, Zip Code: _____

Primary phone: _____ Alternate Phone: _____

Email address: _____

Ethnicity/Race: _____

Marital Status: _____ Single _____ Married _____Widowed _____Divorced _____Separated

Employer: _____ Occupation: _____

Partner/Father of baby: _____ Phone: _____

Partner/Father of baby's age: _____ Partner/Father of baby's Race/Ethnicity: _____

Partner/Father of baby's Employer/Occupation: _____

Emergency Contact: _____ Phone: _____

Referring OB: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

ID#: _____ Group #: _____

Secondary Insurance Company: _____

ID#: _____ Group #: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

I authorize the practice to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial insurance and billing information with those listed below. I understand that my or my child's healthcare provider will use their judgement in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed HIPPA-complaint authorization. This permission will be considered on-going until I indicate otherwise in writing.

PHI may be released to the following individuals:

1. _____
2. _____
3. _____

The practice staff have my permission to leave messages concerning treatment (i.e., lab results) on my: (Please check all boxes that apply)

□ Home voice mail Home phone number: _____

□ Cell phone Cell phone number: _____

□ Work Voice Mail Work phone number: _____

□ NO INFORMATION: I do not authorize the release of any verbal information (other than appointment reminders to the number (s) that I have provided).

_____ _____

Print Name of Patient *Print Name of Authorized Representative

_____ _____

Patient/Authorized Representative Signature Date Signed

Authorized Representative's authority* to act on the Patient's behalf:

*Parent/legal guardian *Power of Attorney

*Evidence of authority must be provided and on file with the practice.

Privacy Notice and Patient Rights

I confirm that I have read or received a copy of the notice of Privacy Practices. I know that I can get more information about uses of my medical record from that notice.

I confirm that I have read or received a copy of the Patient Rights and Responsibilities.

I give permission to Tallahassee Perinatal Consultants, LLC to release information to other health care providers that may be treating me as well.

Duration of Consent and Agreement

I understand that this agreement will need to be signed once per year for treatment at Tallahassee Perinatal Consultants, LLC.

I have read and understand the office policy of Tallahassee Perinatal Consultants, LLC and have no further questions or concerns. I agree to abide by its guidelines.

Signature of patient or responsible party Date

Sonogram Image Release Form

I hereby grant Tallahassee Perinatal Consultants, LLC permission to my sonogram images in a photograph, or digital media in all its publications, including web-based publications without payment or other consideration. No personal patient information will be displayed or mentioned.

I hereby irrevocably authorize Tallahassee Perinatal Consultants, LLC to edit, alter, copy, exhibit, publish, or distribute these sonogram images for any lawful purpose. In addition, I waive the right to inspect or approve the finished product wherein my sonogram images appear. Additionally, I waive any right to royalties or other compensation arising or related to the use of the sonogram.

I hereby hold harmless, release, and forever discharge Tallahassee Perinatal Consultants, LLC from all claims, demands, and causes action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have because of this authorization.

I HAVE READ AND UNDERSTAND THE ABOVE SONOGRAM RELEASE FORM. I AFFIRM THAT I AM AT LEAST 18 YEARS OF AGE, OR, IF I AM UNDER 18 YEARS OF AGE, I HAVE OBTAINED THE REQUIRED CONSENT OF MY PARENTS/GUARDIANS AS EVIDENCED BY THEIR SIGNATURES BELOW.

☐ **I ACCEPT** ☐ **I DECLINE**

_____ _____

Printed Name Date

_____

Patient/Guardian's Signature

MEDICAL APPOINTMENT NO CALL/NO SHOW POLICY

Thank you for trusting your medical care to Tallahassee Perinatal Consultants, LLC. When you schedule an appointment with TPC we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule another mom the opportunity to receive the highest quality care and see her little one. Please see our Appointment No Call/No Show Policy below:

- **Effective June 22, 2018,** any established patient who fails to show for a scheduled appointment or cancels an appointment without at least a **24-hour notice** will be considered a **No Call/No Show** and will be **charged a $50.00 fee. This fee is not billable to your insurance company.**
- Any established patient who fails to show a second time for a scheduled appointment or cancels without a 24-hour notice will be charged a $75.00 fee.
- If an established patient fails to show a third time for a scheduled appointment, then they will be dismissed from Tallahassee Perinatal Consultants, LLC and a letter will be sent to their Obstetrician stating the patient has been dismissed due to No Call/No Show.
- Any new patient who fails to show for their first scheduled appointment and does not contact the office to cancel/reschedule will not be rescheduled.
- As a courtesy, we make reminder calls and send text messages to the mobile number that the patient provided for all appointments. If you did not receive the reminder call or message, the above Policy will remain in effect.

We understand there are times when unforeseen circumstances occur, and you may not be able to keep your appointment. If this happens, please contact our office manager, who may be able to waive the No Call/No Show fee. You may contact Tallahassee Perinatal Consultants, LLC by phone during regularly scheduled business hours or by e-mail.

Tallahassee Perinatal Consultants, LLC 850-999-2651

or e-mail: info@tpcmfm.com

I have read and understand the Medical Appointment No Call/No Show Policy and agree to its terms.

_____ _____

Printed Name Date

_____

Patient/Guardian's Signature

MEDICAL HEALTH HISTORY

Name: _____

Age _____Date of birth _____Due Date _____

Height _____ feet _____inches Current weight _____ Pre-pregnancy weight _____

Pharmacy _____ Rx phone & Address _____

PREGNANCY HISTORY (Live birth, miscarriages, terminations)

MM/YR	Weeks at delivery	Baby Weight	Vaginal or C-section	Sex	Preterm Labor	Gestational diabetes	Birth defects	High blood pressure	Complications
					Y / N	Y / N	Y / N	Y / N	
					Y / N	Y / N	Y / N	Y / N	
					Y / N	Y / N	Y / N	Y / N	
					Y / N	Y / N	Y / N	Y / N	
					Y / N	Y / N	Y / N	Y / N	
					Y / N	Y / N	Y / N	Y / N	

MM/YR	
	□Miscarriage □Termination □Ectopic _____ Wks Pregnant D&C Y / N
	□Miscarriage □Termination □Ectopic _____ Wks Pregnant D&C Y / N
	□Miscarriage □Termination □Ectopic _____ Wks Pregnant D&C Y / N

GYNECOLOGICAL HISTORY

1st Day of Last Period _____ Regular cycles Y /N

History of Sexually Transmitted Infection: Y / N

Circle applicable: HIV/ Chlamydia/ Gonorrhea/ Syphilis/ Herpes/ HPV/ Trichomonas

Use of fertility treatment this pregnancy? Y / N

Circle applicable: Clomid/ IVF/ IUI or ovulation induction/ ICSI

MEDICATIONS/DRUGS/ALLERGIES

Are you taking any medications (prescriptions, vitamins, herbs, alternative medications, over the counter)? Y /N.

If so, please list all with dosages: _____

_____

_____

_____

Do you have any medication, latex, or drug allergies? Y /N. If so, please list below with reactions:

_____

_____

FAMILY AND GENETIC HISTORY

Do you, your partner, or close relative have any of the following? If yes, please explain:

	Self	Family	No	Who & Explain
Anemia/Thalassemia				
Spina bifida (open spine)				
Heart problems from birth				
Down Syndrome/Fragile X				
Tay-Sachs disease (Jewish)				
Sickle cell disease or trait				
Clotting/bleeding disorders (hemophilia)				
Muscular dystrophy				
Spinal muscular atrophy				
Cystic fibrosis				
Three or more miscarriages				
Canavan disease (Jewish)				
Mental delay/autism/learning disorder				
Hydrocephalus (water on the brain)				
Hearing loss or deafness from childhood				
Cancer				
Polycystic kidneys				
Diabetes				
Hypertension/stroke				
Blood clots in lungs or legs				
Stillbirth or infant death				
Cleft lip or palate				
Blindness from childhood				
Clubbed feet				
Other birth defects				

Do you have any other health concerns in your family or the baby's father's family? Y /N

If yes, please explain: _____

Are you interested in obtaining information on cystic fibrosis? It is a chronic disease that is more common in individuals of European ancestry that affects the respiratory, digestive, and reproductive systems. Y / N.

Are you interested in obtaining information on fragile X syndrome? It is a disease that causes developmental and mental delay, autism, and hyperactivity. Y / N.

Are you interested in obtaining information on spinal muscular atrophy? It is a rare disease that causes infants or children to lose muscle control over their body. Y / N.

You may be a carrier of the above diseases and not be aware of it. We have information regarding the above medical conditions and screening. **Please check with your individual insurance company to see if they will cover screening for the above medical conditions.**

SOCIAL HISTORY

Please check if any of the following apply

	No	Current	Past	How long quit	How much/often
Tobacco					
Alcohol					
Street drugs					
Other					

Medical History

	Self	Family	No	Who & Explain
Vision/hearing				
Asthma				
Tuberculosis or close contact				
Heart problems (murmurs, palpitations, circulation)				
Pulmonary embolus or deep venous thrombosis				
Hypertension				
Nausea/vomiting/diarrhea/constipation				
Intestinal problems/Colitis/Ulcers				
Hepatitis				
Liver problems				
Bladder/kidney/urinary infections				
Diabetes				
Seizure/Migraines				
Depression/anxiety				
Thyroid problems				
Joint pain/arthritis				
Lupus/anti-phospholipid syndrome				
Blood transfusion				

Surgical History:

Year: _____ Type of surgery: _____

Year: _____ Type of surgery: _____

Explain any surgical complications: _____

_____

_____