Med Center Health®
Women's Health Specialists

NEW OB PATIENT PACKET

Congratulations on your pregnancy, and "Thank You" for choosing Women's Health Specialists to provide quality care to you and your unborn child.

At your first prenatal appointment, we set aside plenty of time to devote our attention totally to you and to understanding your needs and concerns. We view good health as a partnership, which requires close involvement and good communication between you and your provider. Please understand that this first appointment usually takes at least an hour to complete as a complete health history will be reviewed for the mother and father of the baby, as well as a full physical of the mother, usual lab work, and in some cases an Ultrasound.

Early detection of any disease or illness usually means early treatment and a higher success rate. Thus, appointments that are not kept pose an increased risk to your health as well as the health of your unborn child. If you are unable to keep an appointment, please notify us as soon as possible. It is important you arrive on time for your scheduled appointment(s). Arriving late causes us to get behind schedule, which in turn makes all other patients' appointments run late. Therefore, **if you are late, we will require you to reschedule your appointment.** Because of our concern with closely monitoring the health of all our patients, patients who fail to show up for an appointment or fail to call and reschedule more than two times may be discharged from the practice.

We also ask that you be patient with us and understand that we are an obstetrical practice, so unexpected delays may occur. While we try to keep these delays from interrupting your scheduled appointment, it is a natural occurrence that is beyond our control. If your provider has to leave the office, we may have to reschedule your appointment or ask you to see another provider during your routine prenatal appointment.

Please complete the attached paperwork and bring it with you to your appointment along with your Insurance Card(s) and a Picture ID. Completing all paperwork will expedite your appointment. If you are unable to complete the enclosed paperwork, please arrive earlier than requested to receive assistance in completion / processing. If you have any questions or concerns, always feel free to contact our office.

It is a pleasure to serve you, and we look forward to seeing you in our office soon!

Appointment Date: _____

Time: _____

Provider: _____

Office Location: _____

Please plan to arrive 30 minutes early for processing of all paperwork!

Thank You

523 Park Street • Bowling Green, KY 42101 • 270.781.0075
Toll Free: 1.866.997.5784 • Fax: 270.781.0143 • MedCenterHealth.org

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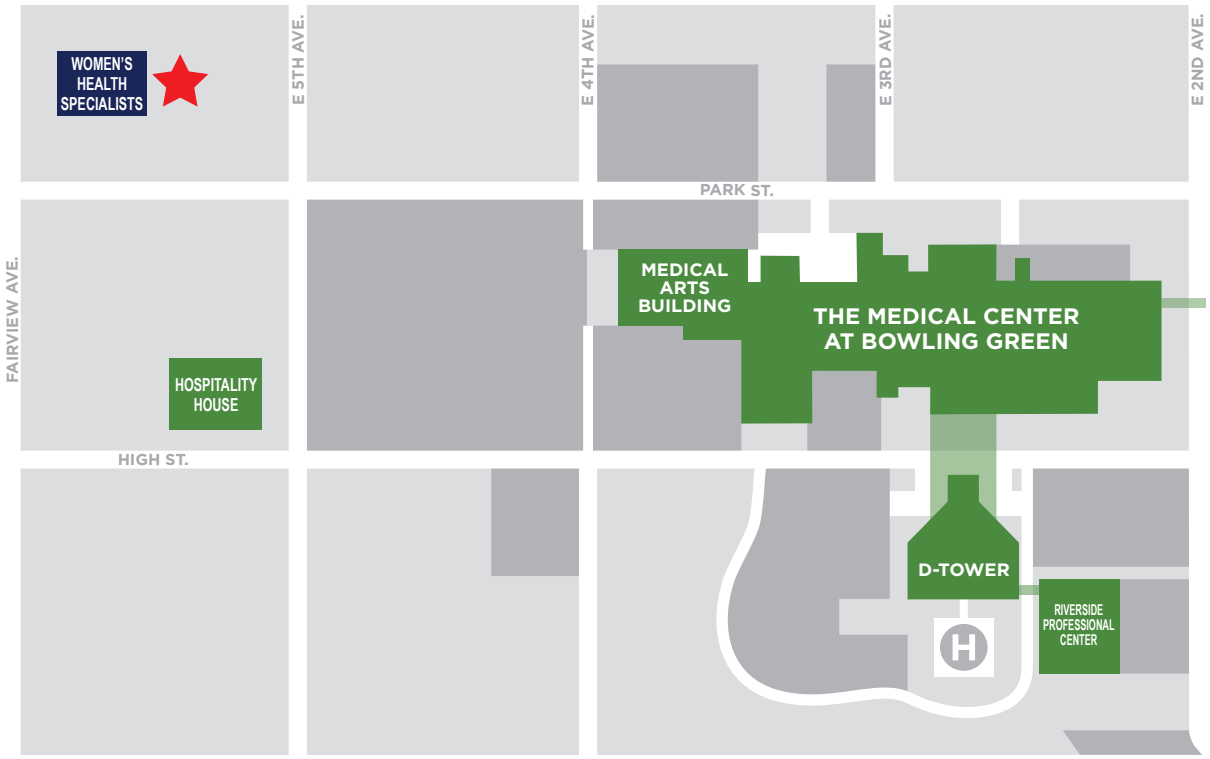
PARKING & ENTRANCE



Women's Health Specialists is located at 523 Park Street. If you have problems locating us, please feel free to call our office for directions.

Patients are also seen in Franklin and Scottsville on select days.

The Medical Center at Franklin
Physician Specialty Clinics
Franklin Medical Pavilion
1100 Brookhaven Road
Suite 103
Franklin, KY 42134

The Medical Center at Scottsville
Physician Specialty Clinics
456 Burnley Road
Scottsville, KY 42164

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PATIENT INFORMATION (Please Print)

Patient Name _____
(Last, First, Middle Initial)

Date of Birth _____ Age _____ Social Security # _____

Marital Status (Please Circle) Single Married Widowed Divorced Separated

Mailing Address _____

_____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

E-mail Address: _____

Preferred Method to Confirm Appointments (Please Circle One) Text Home Phone Cell Phone Work Phone

Employer _____ Occupation (Indicate if a Student) _____

Name of Insured or Parent_____ Date of Birth_____
(Last, First, Middle Initial)

Social Security # _____ Relationship to Patient _____

Insured's Employer _____

Emergency Contact Name _____ Phone # _____

Relationship to Patient _____

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite Insurance Carrier payments. The patient is responsible for all fees, regardless of Insurance Coverage. Payment is due at the time services are rendered unless other arrangements have been made in advance. KRS 194A.505 requires every person to disclose all sources of Insurance Coverage, at each visit. Failure to do so is fraudulent. Our office is required and will report all such misrepresentations.

INSURANCE AUTHORIZATION (Please Read & Sign)
I HEREBY AUTHORIZE WOMEN'S HEALTH SPECIALISTS TO FURNISH TO INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONCERNING MY (MY DEPENDENT'S) ILLNESS AND TREATMENT AND I HEREBY ASSIGN TO WOMEN'S HEALTH SPECIALISTS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

_____ _____
Signature of Patient or Parent Date

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GYNECOLOGICAL / OBSTETRICAL HISTORY

Baby's Father Name _____ Phone # _____Age_____Race_____

Baby's Father's Occupation / Employer _____

Emergency Contact Name _____Phone #_____Relationship_____

GENERAL HISTORY – SELF & FAMILY

Please mark if you or your family member (children, sisters, brothers, grandparents, aunts, uncles) have had any of the following conditions. **IF YOU ARE UNSURE OF A CONDITION PLEASE CIRCLE IT.**

Self	Family	Condition	Self	Family	Condition
		Cancer			Twins
		High Blood Pressure			Infertility
		Heart / Valve Disease			Blood Clots / Varicose Veins
		Rheumatic Fever			Blood Transfusions
		Lung Disease	*Sexually Transmitted Disease:*		
		Stomach / Bowel Problems			Genital Herpes
		Kidney Disease			Condylomata (Genital Warts)
		Urinary Problems			Chlamydia
		(including infections/malformations)	*Infectious Disease:*		
		Diabetes Mellitus			Hepatitis
		Anemia / Blood Disorders			Tuberculosis
		Other Endocrine / Hormone Disorders	*Other Diseases or Illnesses:*		
		Nervous / Mental Disorders			PKU
		Convulsive Disorders / Epilepsy			DES Exposure
		Abnormal Babies			Other _____
		Genetic Diseases			

Does the baby's father or his family, have any history of abnormal babies or genetic disease? Yes No

Are you ever around cats? Yes No

Do you have a hot tub? Yes No

Do you exercise regularly? Yes No

Do you, or have you, used drugs (marijuana, cocaine, etc)? Yes No

TOBACCO & CAFFEINE

Coffee/Tea_____cups a day

Cola or other caffeinated drinks____a day

Cigarettes - Now____a day____years

Cigarettes - Ever____a day____years

When stopped:_____

ALCOHOL

Do you drink Alcohol?

Yes No

____Drinks a day

____Drinks a week

ALLERGIES/SENSITIVITIES

Antibiotics:_____

Pain Medication:_____

Anesthesia:_____

Other:_____

Please list all the times you've been hospitalized, operated on, or seriously injured

Year **Operation, Illness, or Injury** **Hospital & City**

_____

_____

_____

Pregnancy History				Grav		Term	Preterm	Abortion	Living	C.Section
No. of Preg	Mo/Day/Yr	Baby's Sex	Birth Wgt.	Wks Gestat.	Hrs. Labor	Delivery Type	Detail Complications - Maternal/Newborn/Anesthesia if a C.Section, list incision type			
1										
2										
3										
4										
5										
6										

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HEALTH PROFILE

Patient Name _____ **Today's Date** _____
(Last, First, Middle Initial)

Date of Birth _____ Age _____ Social Security # _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Why are you seeing the Doctor? _____

When was the first day of your last menstrual period? _____

How often do you get your period? _____ How long does the bleeding last? _____

How severe is the cramping with your period (none / mild / severe)? _____

Are you doing anything for Birth Control right now? Yes No If yes, what? _____

When was your last PAP smear? _____ Ever had an abnormal PAP? Yes No When?_____

When was your last Mammogram? _____ Ever had an abnormal mammogram? Yes No When? _____

What medications are you currently taking (name & dose)? _____

_____

Primary Pharmacy _____ Location (City, State) _____

Do you smoke? Yes No If yes, how many packs of cigarettes per day? _____

Do you use alcohol (beer, wine, etc.)? Yes No If yes, what kind? _____

How many times have you been pregnant? _____ How many babies have you delivered? _____

How many miscarriages have you had? _____How many abortions have you had? _____

Have you ever had a Cesarean Section? Yes No

What surgeries have you had? (Please list all & year) _____

_____

Do you have any medical problems (i.e. diabetes, thyroid disease, high blood pressure, heart disease, asthma, joint problems, etc.)? Please list any _____

_____

Do you have a history of seizures? _____

Has anyone in your family had any of the following problems?

Cancer _____ Who_____ What kind/location (i.e. breast, colon, etc.) _____

Diabetes _____ Who _____ High Blood Pressure _____ Who _____

Heart Disease _____ Who _____ Asthma _____Who _____

Any other major medical problems to note? Please list _____

Latex Allergy Screening Tool

1. Do you have a confirmed latex sensitivity, or do you have spina bifida? Yes No
2. Have you ever had a reaction after handling/using poinsettia plants, balloons, rubber products or spandex? Yes No
3. Have you ever had one of the following after a medical/dental appointment: itching, tearing, fatigue, sneezing or running nose? Yes No
4. Have you ever reacted after eating bananas, avocados, kiwi, or chestnuts? Yes No

For patients who have responded in the affirmative to most of these questions, latex precautions will be utilized, unless otherwise stipulated by the physician. The suspected allergy will be documented in the patient's chart and the referring physician will be contacted.

_____ _____ _____
Date Employee Signature Patient Signature

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