Ancient City MIDWIVES

Delivering the Newest Generation
In the Oldest City.

Patient Registration and Insurance Information

[PLEASE PRINT]

Name _____ Date _____

Mailing Address _____

City _____ State _____ Zip _____

Employer _____

Work Phone _____ Cell Phone _____

Home Phone _____ Email Address _____

Date of Birth_____ SS# _____

Alternate contact

Name _____ Relationship _____

Home Phone _____ Cell Phone _____

Insurance Information

If you do not have insurance, check here [ ]

Insurance Company _____ Name of Insured _____

If the insured party is not you, please provide the following information regarding the insured:

Relationship _____ SSN _____ Date of Birth _____

Assignment of Insurance Benefits

I hereby authorize direct payment of medical or surgical benefits to Ancient City Midwives for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

I hereby authorize Ancient City Midwives to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand that I may revoke this consent at any time by notifying Ancient City Midwives in writing. Ancient City Midwives has the right to refuse treatment should I revoke or refuse this consent.

Patient Signature _____ Date _____

Parent or Guardian Signature _____ Relationship _____

1301 Plantation Island Drive, Unit 105 B Saint Augustine, Florida 32080

T: 904-826-1007 F: 904-826-1073 E: AncientCityMidwives@yahoo.com W: AncientCityMidwives.com

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Welcome To Our Practice!

Name_____ Date _____ Age _____

Are you allergic to any medications? _____

Who is your primary physician? _____

Which pharmacy do you use? Mail order? _____

Current medications _____

_____

Gynecologic History

First day of last menstrual period _____

Are your menstrual cycles regular? [YES] [NO]

Birth History

BIRTH DATE	VAGINAL/ C-SECTION	SEX	FULL TERM?	WEIGHT	LENGTH OF LABOR	COMPLICATIONS

Medical History

Depression/Anxiety _____ Abdominal/Digestive _____

Thyroid _____ Urinary _____

Lung _____ Cancer _____

Heart _____ Other _____

High Blood Pressure _____

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Medical History [CONTINUED]

Operation and Year

Family History

	AGE IF LIVING	AGE AT DEATH IF DECEASED	MEDICAL PROBLEMS
Mother			
Father			
Sister(s)			
Brother(s)			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Other			

Social History

Are you: married ____ single ____ divorced ____ separated ____ widowed ____

Sexually active? _____ If so, do you use contraception? _____ Type _____

Do you smoke? _____ If so, how many packs per day? _____

Alcohol consumption: None ____ Occasional ____ 1-2/day ____ 3-5/day _____

Are you experiencing any of the following? [PLEASE CIRCLE]

Weight loss	Nausea or vomiting	Leakage of urine	Shortness of breath
Skin problems	Change in bowel function	Painful urination	Abdominal bloating
Cough or cold symptoms	Blood in stool	Depression	Suicidal thoughts
Chest pain	Violence in your home		

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HIV Testing

The following information regarding HIV testing has been discussed with me by a certified-nurse midwife or nurse at Ancient City Midwives:

- The benefits of HIV testing during pregnancy
- The meaning of a positive test
- Risk factors associated with having a positive test
- HIV testing is voluntary
- State requirements of reporting patients with positive HIV tests

If you have any further questions, please ask one of our staff.

I UNDERSTAND THE ABOVE INFORMATION AND DECLINE THE HIV TEST.

Patient signature _____ Date _____

I UNDERSTAND THE ABOVE INFORMATION AND AGREE TO HIV TESTING.

Patient signature _____ Date _____

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Notice of Privacy Practices

Ancient City Midwives are committed to protecting the privacy of your medical information. We are required by law to maintain the confidentiality of information that identifies you and the care you receive. We are required to give you this Notice of our legal duties, our privacy practices and your rights, and we must follow the terms of this Notice. When we disclose information to other persons and companies to perform services for us, we require them to protect your privacy too. There are other laws that provide additional protections for medical information related to treatment for mental health, alcohol and other substance abuse and HIV/AIDS. We will follow the requirements of these laws.

I, _____ have read a copy of Ancient City Midwives Notice of Privacy Practices.

Patient signature _____ Date _____

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Our Financial Policy

Dear patient,

Thank you for choosing Ancient City Midwives for your health care provider. The cost of your visit is your responsibility. As a courtesy, we will file with participating insurance companies. Any lab work (pap smear, blood work) that may be associated with your exam will be billed by the laboratory directly. If you have health insurance that we will be billing for you today, and you do not have a benefit for this exam, you will be responsible for this fee today. The laboratory will bill you separately for their charges.

By signing this form, you are confirming your agreement to assume financial responsibility for payment of these charges should your insurance company find them not medically necessary or non-covered.

Required payment is due at time of service. We accept : cash, check, Visa, Mastercard, and Discover.

Patient signature _____ Date _____

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