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Phone 516-498-2300 Fax 516-498-2301

Date: _____

Mother:

First Name: _____

Middle: _____

Last: _____

Suffix: _____

Preferred Name: _____

DOB: _____

SSN: _____

Marital Status: _____

Occupation: _____

Date of return: _____

Babies:

#1 First Name: _____

Middle: _____

Last: _____

Preferred Name: _____

DOB: _____

Sex: _____

#2 First Name: _____

Middle: _____

Last: _____

Preferred Name: _____

DOB: _____

Sex: _____

Spouse/Other Parent:

First Name: _____ Last Name: _____ DOB: _____

Contact Information:

Address: _____ Apt. _____

City, State and Zip Code: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

_____ Phone: (_____) _____ Email: _____

Insurance Information:

Mother's Ins Plan: _____

Holder Name: _____

Relationship to Holder: _____

Holder SSN#: _____ - _____ - _____

Holder DOB: _____ / _____ / _____

Baby's Ins Plan: _____

Holder Name: _____

Relationship to Holder: _____

Holder SSN#: _____ - _____ - _____

Holder DOB: _____ / _____ / _____

Pediatrician:

Name: _____

City/State/Zip: _____

Phone: (_____) _____

Fax: (_____) _____

Ob/ Gyn/ Midwife:

Name: _____

City/State/Zip: _____

Phone: (_____) _____

Fax: (_____) _____

What's the reason for your visit today:

Who referred you to our office or how did you find us:

Mother Review of Systems:

Please ONLY put a check mark next to any symptom you've had recently otherwise leave blank.

General Symptoms:

- Fever
- Chills
- Recent infection

Breasts:

- Pain: Right Left
- Redness: Right Left
- Swelling: Right Left
- Warmth: Right Left

Nipples:

- Soreness: Right Left
- Bleeding: Right Left
- Cracks: Right Left

Lactation:

Fullness, milk in, if yes when:

- Expressing breastmilk
- Using hand expression
- Using manual breastpump, if yes, which one: _____
- Using electric breastpump, if yes, which one: _____

If pumping or expressing how frequently: _____

For how long per session: _____

General amount of breastmilk expressed per pumping session: Right: _____ Left: _____

Head, Eyes, Ears, Mouth, Nose and Throat:

- Vision changes
- Nose bleeding
- Sore throat
- Ear pain
- Hearing changes
- Unusual sneezing
- Swallowing difficulties
- Facial pain

Genitourinary:

- Pain with urination
- Urinary frequency
- Urinary urgency
- Dark urine

Bones, Joints, Extremities:

- Joint pain
- Back pain
- Muscle pain
- Joint stiffness
- Muscle cramps

Lungs:

- Cough
- Wheezing
- Shortness of breath

Abdomen:

- Pain
- Vomiting
- Constipation
- Flatulence
- Nausea
- Diarrhea
- Dark or bloody stools

Heart:

- Palpitations
- Chest pain

Neurological, Psychiatric:

- Depression
- Memory loss
- Fainting
- Suicidal ideation
- Disorientation
- Dizziness

Skin:

- Rash
- Sweatiness
- Itchiness
- Skin lesions
- Bruising

Neck:

- Neck pain
- Neck stiffness
- Neck swelling

Baby Review of Systems:

Please ONLY put a check mark next to any symptom the baby had recently otherwise leave blank.

Baby #1 Name: _____

Baby #2 Name: _____

General Symptoms:

- Crying more than usual
- Sleeping poorly
- Difficult to awaken
- Fever

General Symptoms:

- Crying more than usual
- Sleeping poorly
- Difficult to awaken
- Fever

Head, Eyes, Ears, Mouth, Nose and Throat:

- Tongue tie
- Abnormal palate

Head, Eyes, Ears, Mouth, Nose and Throat:

- Tongue tie
- Abnormal palate

Neck:

- Limited motion

Neck:

- Limited motion

Lungs:

- Cough
- Congestion

Lungs:

- Cough
- Congestion

Heart:

- Murmur

Heart:

- Murmur

Genitourinary:

- Diaper rash

Genitourinary:

- Diaper rash

Musculoskeletal:

- Torticollis
- Developmental dysplasia hip

Musculoskeletal:

- Torticollis
- Developmental dysplasia hip

Abdomen/Gastrointestinal:

- Vomiting
- Diarrhea
- Constipation

Abdomen/Gastrointestinal:

- Vomiting
- Diarrhea
- Constipation

Skin:

- Jaundice
- Rash

Skin:

- Jaundice
- Rash

Pregnancy History:

Number of pregnancies: _____ Number of living children: _____ Number of miscarriages: _____

Delivery weeks gestation (At what # week did you give birth): _____ weeks.

Medical/Social History:

- | | | |
|--|---|---|
| <input type="checkbox"/> Breast Surgery | <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Polycystic Ovarian Disease |
| <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Currently Pregnant |
| <input type="checkbox"/> Breast Implants | <input type="checkbox"/> Infection | <input type="checkbox"/> Contraception |
| <input type="checkbox"/> Breast Trauma | <input type="checkbox"/> Raynaud’s Phenomenon | <input type="checkbox"/> Drug Use |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Depression | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Alcohol Use |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Abuse | <input type="checkbox"/> Special Diet |

Mothers Family History:

Please list any medical conditions that your relatives have/had.

Father: _____

Mother: _____

Brothers: _____

Sisters: _____

Children: _____

Prenatal History:

Pre-eclampsia Eclampsia Gestational Diabetes Bleeding Preterm Labor

Any other Complications? _____

Increased breast size Areola Darkening Veins more prominent

Any other Prenatal Breast Changes? _____

Birth History For THIS PREGNANCY:

Delivery Location: _____ Home or _____ Hospital Name of hospital: _____

Vaginal delivery Vaginal birth after c-section (VBAC)

C-section planned C-section unplanned # Days in Hospital: _____

Breech Anesthesia: _____ Apgars: 1 min. _____ 5 min. _____

Postpartum Complications:

Bleeding Infection Severe Engorgement
 Fever Retained Placenta Depression

Birth Complications:

#1 #2 Jaundice #1 #2 Low temperature #1 #2 Difficulty Breathing
#1 #2 Low Blood Sugar #1 #2 Feeding Difficulties #1 #2 NICU Stay

Feeding History:

Present Feeding: Breastfeeding: Formula:
Breastfeeding Goals: Exclusive: Partial:
Perception of Milk Supply: Too Much: Adequate: Too Low:

Breastfeeding History:

#1 Birth Weight: _____ lbs _____ oz #1 Discharge Weight: _____ lbs _____ oz
#2 Birth Weight: _____ lbs _____ oz #2 Discharge Weight: _____ lbs _____ oz
#1 Discharge Date: _____ #1 Additional Weights: _____
#2 Discharge Date: _____ #2 Additional Weights: _____

Hospital Course:

Breast Fed Formula Supplementation: _____
Supplementation given via: Bottle Spoon Finger Feeder Syringe SNS
When did you first breastfeed your baby?: _____ When did your milk come in?: _____

Are you experiencing:

Sore Nipples Vaginal Bleeding from Pregnancy
 Engorgement Supplementing
 Let Down When Nursing Return of Menses
 Uterine Cramps When Nursing Use of Nipple Shield

Medication Information: Please list your medications (including vitamins and over-the-counter meds)

<u>Medication Name</u>	<u>Dosage (mg)</u>	<u>How many times a day/week/month do you take it?</u>
_____	_____	_____
_____	_____	_____

Allergy Information: Please list your allergies (including food, medication and environmental)



OFFICE AND FINANCIAL POLICY

Note to All Patients

Thank you for choosing our practice. We are committed to providing the best medical care possible. To help our patients manage their medical care expenses, we accept most insurance plans.

We provide outpatient physician breastfeeding medicine office visits. If you call your insurance company to verify coverage, make sure that you state you are seeing a physician. We are not a lactation consulting business. If you say the word, "lactation", you might be told erroneously that the visit is not covered or covered in full with no co-pays.

Breastfeeding involves both mom and baby. To provide the best breastfeeding care possible we usually need to see both of you. We take a history of both mom and baby, examine each of you as needed, and observe a feeding. Then together we develop a plan for you and your baby. We complete two patient encounters, thus if your insurance company requires co-pays for physician visits, we collect two co-pays. Insurance plans vary and change frequently, we charge the primary care co-pays and adjust if insurance states otherwise after the visit

Patient Financial Responsibilities

- You **will be responsible** for all treatments and charges not covered by your insurance policy.
- You are required to provide us with **the most updated information** about your insurance.
- According to your insurance plan, **you are responsible** for any and all co-payments, deductibles, and coinsurances. We are obligated by contract with your plan to collect these charges.
- Since there are so many insurance companies providing health insurance and so many different insurance plans associated with each insurance company, it is your responsibility to **understand your coverage**.

Patient Office Visit

- Upon arrival, please sign in at the front desk and present **your current insurance card** at every visit. If the insurance company that you designate is incorrect you will be responsible for payment of the visit.
- It is your responsibility to understand **your benefit plan** and what services are covered.
- Copayments are due at the time of service. A **processing fee** of \$15 may be charged in addition to your copayment if the copayment is not paid at the time of service or by the end of the next business day.
- Returned checks will incur a \$30 fee.
- **Appointments:** before scheduling any service, please check with your insurance company to ensure it will be covered.
- If services are provided and your coverage is not in effect or you have failed to provide us with the correct information to submit the insurance claim in a timely manner, any fees submitted and denied will become **your financial responsibility**.

Consent to Treat:

- By my signature below, I authorize Allied Physicians Group personnel to **contact me** by mail, answering machine message, text message and/or email according to the information I have provided in my patient registration information.
- By my signature below, I authorize Allied Physicians Group **to securely store my credit card information if I have met the requirements above** and only charge it should I have an outstanding balance or any leftover balance from a processed claim in the future. I may also choose to have my credit card on file for my convenience. I am aware that the storage system used is fully compliant to the highest level of credit card storage security regulations. Once stored, I am aware that only the last 5 digits of my card are viewable by Allied Physicians Group personnel. I understand that I am responsible for all charges for services that I receive from Allied Physicians Group and that if the patient responsibility portion of my charges (including charges applied to my deductible and/or coinsurance) is not paid in full within thirty (30) days following the receipt of the patient financial responsibility statement mailed from the Allied Physicians Group Billing Office, Allied Physicians Group will bill my stored credit card for the outstanding balance due. Payment plans will be offered.
- I consent to the **use and/or disclosure of my protected health information** by Allied Physicians Group, PLLC, for purposes of diagnosis or providing treatment of me (or my child) or obtaining payment for my health care bills. I consent to treatment. I understand and agree that diagnosis or treatment of me (or my child) may be conditioned upon my consent as evidenced by my signature on this document. **By signing below, I state that I have read and understood the office and financial policy and the attached Allied Physicians Group HIPPA Policy.**

Print Name _____

Signature _____

Date _____

