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Allied Physicians Group, PLLC
1575 Hillside Avenue, Suite LL#1
New Hyde Park, NY 11040
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:_____

BABY:
First Name:_____
Middle:_____
Last:_____
Suffix:_____ Sex:_____
Preferred Name:_____
DOB:_____

SPOUSE/OTHER PARENT:
First Name:_____
Last:_____
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: _____
Address: _____
City/State/Zip: _____
Phone: (_____)_____
Fax: (_____)_____

Ob/ Gyn/ Midwife:
Name: _____
Address: _____
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: ___ Left ___ Right
Redness: ___ Left ___ Right
Swelling: ___ Left ___ Right
Warmth: ___ Left ___ Right

Nipples:
Soreness: ___ Left ___ Right
Bleeding: ___ Left ___ Right
Cracks: ___ Left ___ Right

Lactation:
If you are expressing breastmilk check off all that apply:
___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

Lungs:
___Cough
___Wheezing
___Shortness of breath

Heart:
___Palpitations
___Chest pain

Skin:
___Rash
___Sweatiness
___Itchiness
___Skin lesions
___Bruising

Neck:
___Neck pain
___Neck stiffness
___Neck swelling

Genitourinary:
___Pain with urination
___Urinary frequency
___Urinary urgency
___Dark urine

Bones, Joints, Extremities:
___Joint pain
___Back pain
___Muscle pain
___Joint stiffness
___Muscle cramps

Abdomen:
___Pain
___Vomiting
___Constipation
___Flatulence
___Nausea
___Diarrhea
___Dark or bloody stools

Neurological, Psychiatric:
___Depression
___Memory loss
___Fainting
___Suicidal ideation
___Disorientation
___Dizziness

Baby Review of Systems:

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

General Symptoms:
___Crying more than usual
___Sleeping poorly
___Difficult to awaken
___Fever

Head, Eyes, Ears, Mouth, Nose and Throat:
___Tongue tie
___Abnormal palate

Neck:
___Limited motion

Lungs:
___Cough
___Congestion

Heart:
___Murmur

Genitourinary:
___Diaper rash

Musculoskeletal:
___Torticollis
___Developmental dysplasia hip

Abdomen/Gastrointestinal:
___Vomiting
___Diarrhea
___Constipation

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:

___Breast Surgery
___Breast Reduction
___Breast Implants
___Breast Trauma
___Breast Cancer
___Diabetes
___High Blood Pressure
___Hyperthyroid
___Hypothyroid
___Infection
___Raynaud's Phenomenon
___Depression
___Anxiety
___Abuse
___Polycystic Ovarian Disease
___Currently Pregnant
___Contraception
___Drug Use
___Tobacco Use
___Alcohol Use
___Special Diet

Mothers Family History:

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

Father: _____

Mother: _____

Brothers: _____

Sisters: _____

Children: _____

Prenatal History Of This Pregnancy:

___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 Of This Pregnancy:

___Home Birth

___Hospital - Hospital Name_____ # Days in Hospital:_____

___Vaginal delivery ___Vaginal birth after C-section (VBAC)

___C-section planned ___C-section unplanned

___Breech Anesthesia:_____ Apgars: 1 min.___ 5 min.___

Postpartum Complications:

___Bleeding ___Infection ___ Severe Engorgement

___Fever ___Retained Placenta ___ Depression

Birth Complications:

___Jaundice ___Low temperature ___Difficulty Breathing

___Low Blood Sugar ___Feeding Difficulties ___NICU Stay

Breastfeeding History:

Birth Weight:_____lbs_____oz Discharge Date:_____

Discharge Weight:_____lbs_____oz Additional Weights:_____

Hospital Course:

___Breast Fed ___ Formula ___Supplementation:_____

Supplementation given via: ___Bottle ___Spoon ___Finder 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

Feeding History:

Check off all that apply

Present Feeding: Breastfeeding:___ Formula:___

Breastfeeding Goals: Exclusive:___ Partial:___

Perception of Milk Supply: Too Much:___ Adequate:___ Too Low:___

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

Medication Name	**Dosage (mg)**	**How many times a day/week/month do you take it?**

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 evidence 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_____