Fetal Echocardiogram Registration

Patient Information

First Name – M I – Last Name	Nick Name	Birth Date		Age

Patient's Full Name (First M. Last)	Profession	Date of Birth	
Home Address	City	State	Zip
Employer Name & Address	Work Phone Number ( )		
Home Phone Number	Cell Phone Number	Mother's Home E-mail	

Referring Physician – (OB/Gyn & Perinatologist) — Contact Info

Physician Name: Reason for Today's Visit:	

Primary Insurance Information

Policy Holder's Name (As it appears on card)		Social Security Number of Subscriber	
Primary Insurance Company / Health Plan Name	Sex of Policy Holder [] M [] F	Policy Holder Date of Birth	Effective Date
Policy Holder's Employer	Employer Health Plan? [] Yes [] No	Identification/Policy Number	
Insurance Address	Insurance Network		Group Number
City	State	Zip	Insurance Phone Number for Eligibility/Verification ( )

Secondary Insurance Information

Policy Holder's Name (As it appears on card)		Social Security Number of Subscriber	
Primary Insurance Company / Health Plan Name	Sex of Policy Holder [] M [] F	Policy Holder Date of Birth	Effective Date
Policy Holder's Employer	Employer Health Plan? [] Yes [] No	Identification/Policy Number	
Insurance Address	Insurance Network		Group Number
City	State	Zip	Insurance Phone Number for Eligibility/Verification ( )

I certify that the information I have reported above is correct and that as the Patient/Guardian/Guarantor I have read, understand and fully accept the Patient's Financial Payment Policy conditions of Registration.

Signature of Guarantor/Patient/Guardian	Print Name	Date

Pediatric Cardiology: Maternal – Fetal History Form

Patient's Name (Mother): _________________________________Today's Date:______________

Patient's Birth Date: _____________ Age:_________ Email Address: ______________________

Referring Ob/GYN:____

Referring Perinatologist (High Risk Ob/Gyn):____

Reason for today's fetal echocardiogram____

Total # of Pregnancies________ # of Full term births_________ # of Preterm Births _________
Total # of Miscarriages / Abortions____________ Total # of live Children___________________
How many weeks pregnant are you today? ____
When is your due date? ____
What is the date of your last menstrual period (LMP)? _________________________________
How many times have you been pregnant (including this pregnancy)? _____________________
If previous miscarriages, Why?____

Are you taking any medications (now or at any time during your pregnancy)? Yes ❒ No ❒ Please list:
____

Which Hospital do you plan to deliver at?____

Have you smoked during this pregnancy? Yes ❒ No ❒
Have you used recreational drugs or alcohol during this pregnancy? Yes ❒ No ❒

If yes, please list____

Do you have any other children? Yes ❒ No ❒ If yes, please complete.

Male / Female Age Health

____
____
____

Patient Name:____

Do you or any blood relatives to your baby have any of the following medical problems?

Congenital Heart Disease	**Yes ❐ No ❐**	**If yes, which relative?**________
Cardiomyopathy	**Yes ❐ No ❐**	**If yes, which relative?**________
Heart Murmur	**Yes ❐ No ❐**	**If yes, which relative?**________
High Blood Pressure	**Yes ❐ No ❐**	**If yes, which relative?**________
Arrhythmia	**Yes ❐ No ❐**	**If yes, which relative?**________
Stroke	**Yes ❐ No ❐**	**If yes, which relative?**________
Rheumatic Fever	**Yes ❐ No ❐**	**If yes, which relative?**________
Diabetes (sugar)	**Yes ❐ No ❐**	**If yes, which relative?**________
Seizures	**Yes ❐ No ❐**	**If yes, which relative?**________
Lung Problems	**Yes ❐ No ❐**	**If yes, which relative?**________
Immune Disorders (Lupus)	**Yes ❐ No ❐**	**If yes, which relative?**________
Other medical problems	**Yes ❐ No ❐**	**If yes, which relative?**________

Other physicians/nurses to receive our report:

1. ____

2. ____

3. ____

Patient's Signature: _____________________________________

Patient Authorization for Use and Disclosure of Protected Health Information

I authorize Pediatric Cardiology of Maryland 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 his/her judgment in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed HIPAA-compliant authorization. This permission will be considered on-going until I indicate otherwise in writing.

Protected Health Information may be released to the following individuals:

1. ___________________________________

2. ___________________________________

3. ___________________________________

Pediatric Cardiology of Maryland has my permission to leave voicemail messages concerning treatment on my:
(Please check all boxes that apply)

- o Home Voice Mail or Answering Machine
- o Cell phone
- o Work Voice Mail

________________________________ ________________________________
Print Name of Patient Print Name of Authorized Representative

________________________________ ________________________________
Patient/Authorized Representative Signature Date

I do **NOT** authorize the release of any verbal information (Other than appointment reminders).

________________________________ ________________________________
Print Name of Patient Print Name of Authorized Representative

________________________________ ________________________________
Patient/Authorized Representative Signature Date

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of Pediatric Cardiology of Maryland Notice of Privacy Practices, 2014 Revision. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

____
Patient Name (print)

____
Responsible Party Name (print)

____ ________________________
Responsible Party Signature Date

Office Use Only

The following attempts to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices have been made:

Date:______________ Date:______________ Date:______________

Attempt Description:____

____

Staff Name:____________________________________

____
Staff Signature

Financial Policies Acknowledgment

I acknowledge that I have received, or had the opportunity to receive a copy of the Financial Policies of Pediatric Cardiology of Maryland, LLC while in the office, or on the Pediatric Cardiology of Maryland website (www.PediatricCardiologyMD.com). I understand that the practice has the right to change its Financial Policies, and that I may contact the practice at any time to obtain a current copy of the Financial Policies.

I have read and understand the financial policies of Pediatric Cardiology of Maryland LLC, and agree to comply and accept the responsibility for any payment that becomes due as outlined in the policy.

Patient Name____

Responsible Party Name ______________________________ Relationship ________________

Responsible Party Signature_________________________________ Date____________________