

**IN UTERO PATIENT REGISTRATION FORM**

Patient Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

D.O.B \_\_\_\_\_ Social Security # \_\_\_\_\_ Sex: (M) (F)

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

If the need arises, where may we contact you? \_\_\_ Home \_\_\_ Cellular

Emergency Contact Person \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**\*\*\*\* PLEASE FILL OUT THIS PORTION COMPLETELY \*\*\*\***

Fetal Diagnosis: \_\_\_\_\_

Projected Due Date: \_\_\_\_\_ Date of Last Menstrual Period: \_\_\_\_\_

What current problems are you having (what are we seeing you for)?

\_\_\_\_\_

Check if you now have or have had the following illness or problems:

- |  |  |
|--|--|
| <input type="checkbox"/> Trauma (broken bones, loss of consciousness, etc) | <input type="checkbox"/> Anemia or blood disorder      |
| <input type="checkbox"/> Stomach or intestinal problems                    | <input type="checkbox"/> Diabetes                      |
| <input type="checkbox"/> Growth problems                                   | <input type="checkbox"/> Asthma                        |
| <input type="checkbox"/> Seizures  | <input type="checkbox"/> Heart problems                |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Emotional/behavioral problems |
| <input type="checkbox"/> Neurological problems                             | <input type="checkbox"/> Past surgeries                |

Please explain: \_\_\_\_\_

\_\_\_\_\_

ALLERGIES (list or indicate none if applicable): \_\_\_\_\_

**BIRTH HISTORY ON PREVIOUS PREGNANCIES: (please list separately)**

Siblings Name: \_\_\_\_\_

Type of delivery: \_\_ Vaginal \_\_ C-Section Baby was: \_\_ Full Term \_\_ Premature Birth weight: \_\_\_\_\_

Other complications: \_\_\_\_\_

Siblings Name: \_\_\_\_\_

Type of delivery: \_\_ Vaginal \_\_ C-Section Baby was: \_\_ Full Term \_\_ Premature Birth weight: \_\_\_\_\_

Other complications: \_\_\_\_\_

Siblings Name: \_\_\_\_\_

Type of delivery: \_\_ Vaginal \_\_ C-Section Baby was: \_\_ Full Term \_\_ Premature Birth weight: \_\_\_\_\_

Other complications: \_\_\_\_\_

**FAMILY HISTORY**

Bleeding

Problems with anesthesia

Cancer or blood disorder

Heart disease or liver disease

Please explain: \_\_\_\_\_

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician (s) is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or Hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand by law that I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS**

I authorize Pediatric Surgical Associates to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Pediatric Surgical Associates for the medical and surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

Parent/Guardian signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_