COASTAL PERINATAL CENTER

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name (First, M.I., Last): _____DOB:_____

Mailing Address: _____Apt #: _____ Cell #: ( ) _____

City, State, Zip Code: _____Phone #: ( ) _____

Social Security #: _____/____/_____ Marital Status (Please circle): Single Married Divorced Widowed

Patient's Employer: _____Work #: ( ) _____

Email Address: _____

SPOUSE/GUARDIAN INFORMATION

Name (First, M.I., Last): _____DOB:_____

Mailing Address: _____Apt #: _____

City, State, Zip Code: _____Phone #: ( ) _____

Relationship to Patient: _____

REFERRING PHYSICIAN INFORMATION

Dr.'s Name (First): _____ (Last): _____ Specialty (i.e. Ob/Gyn/PCP): _____

Street Address: _____

City, State, Zip Code: _____

Phone #: ( ) _____ Fax #: ( ) _____

PATIENT RESPONSIBILITY:

I authorize the release of any medical records or other information necessary to process my insurance claims on my behalf. I authorize V SACHAR MD/COASTAL PERINATAL CENTER to appeal all insurance claims as appropriate on my behalf. I agree to be fully responsible for all lawful debts incurred by me or my minor child for services whether or not covered by insurance.

SIGNATURE:_____ _____ DATE: _____

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OBSTETRIC HISTORY QUESTIONNAIRE

Patient Name: _____ DOB: _____

Social Security #: _____/_____/_____ Today's Date: _____

Are you currently pregnant? ☐ Yes ☐ No

If yes, what is your due date?: _____

What was the first day of you last menstrual period?: _____

Have you had any problems in the current pregnancy? ☐ Yes ☐ No

If yes, please specify:

_____

Is This Pregnancy From IVF/ICSI/Infertility or Clomid? _____

History of LEEP/Cold Knife Cone/Abnormal Pap Smear?_____

History of Fibroid Uterus/Myoma? _____ History of Myomectomy?_____

Prior pregnancies

_____ Number of pregnancies _____ Number of full term deliveries _____ Number of preterm deliveries

_____ Number of miscarriages [spontaneous] _____ Number of voluntary abortions

Please fill in the table below for all pregnancies, starting with the first, and include all pregnancies, living or deceased.

Year	**Weeks** term= 40wks	**Length of Labor**	**Weight lbs oz**	**Sex** (circle)	**Type of delivery (vag or C/S)**	**Anes-thesia**	**Hospital**	**Complications**
		hrs	lbs oz	M F				
		hrs	lbs oz	M F				
		hrs	lbs oz	M F				
		hrs	lbs oz	M F				
		hrs	lbs oz	M F				

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Did you have Carrier Screening or NIPT Screening this Pregnancy? _____

If Yes, what were results? _____

What medications/drugs do you take currently?			
Name	**Strength**	**How many times a day?**	**For how long?**

Were you ever on Metformin or Clomid? _____

Were you taking any other medications/drugs when you became pregnant? ☐ Yes ☐ No

If yes, please list:

Name	**Strength**	**Dose**

Do you drink alcohol? ☐ Yes ☐ No

If yes, how often during the pregnancy _____

How often before pregnancy _____

Do you smoke? ☐ Yes ☐ No

If yes, how many packs per day _____ For how many years?: _____

If you smoked in the past, when did you quit?: _____

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MEDICAL HISTORY

Do YOU have, or have you had, any of the following conditions:			
☐ Yes	☐ No	☐ Unsure	Unexplained Fever
☐ Yes	☐ No	☐ Unsure	History of Incompetent/Insufficient Cervix
☐ Yes	☐ No	☐ Unsure	History of Pelvic Inflammatory Disease, Gonorrhea, Chlamydia, or Herpes (Cold Sores), or your partner
☐ Yes	☐ No	☐ Unsure	History of Recurrent Urinary Tract Infections or Kidney Infection
☐ Yes	☐ No	☐ Unsure	History of Heartburn, GERD
☐ Yes	☐ No	☐ Unsure	Repeated Nosebleeds, or bleeding disorder
☐ Yes	☐ No	☐ Unsure	History of Hepatitis (A, B, C etc), or Liver Disease
☐ Yes	☐ No	☐ Unsure	History of Thyroid Disease; Hyperthyroid, or Hypothyroid
☐ Yes	☐ No	☐ Unsure	Asthma or Unexplained Cough, or Pneumonia
☐ Yes	☐ No	☐ Unsure	Close Contact With Persons(s) With Tuberculosis/or Tuberculosis Vaccine (BCG)/or Positive Tuberculosis Skin Test
☐ Yes	☐ No	☐ Unsure	History of Migraine Headaches or Epilepsy, or Seizure Disorder
☐ Yes	☐ No	☐ Unsure	High Blood Pressure, or history of High Blood Pressure in Prior Pregnancy
☐ Yes	☐ No	☐ Unsure	Heart Murmur or Mitral Valve Prolapse or Irregular Heart Beat
☐ Yes	☐ No	☐ Unsure	Unexplained Shortness Of Breath, or Unexplained Fainting

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GENETIC/FAMILY HISTORY

How would you describe your ancestry (check all that apply):

☐ Caucasian (white)	☐ French Canadian	☐ Samoan	☐ Vietnamese
☐ African (black)	☐ Native American	☐ Chinese	☐ Laos
☐ Hispanic	☐ Greek	☐ Cambodian	☐ Taiwanese
☐ Ashkenazi Jewish	☐ Italian	☐ Filipino	☐ Korean
☐ Cajun	☐ Middle Eastern	☐ Japanese	☐ Other Southeast Asian
☐ Guamanian	☐ Hawaiian	☐ Asian – East Indian	☐ Unknown Race
☐ Other	☐ Other 2		

Are you and the father of this baby blood relative (example: cousins)? ☐ Yes ☐ No

What is your occupation? _____

What is the name of the father of this baby? _____

What is the occupation of the father of this baby? _____

What is the age of the father of this baby? _____

How would you describe the ancestry of the father of this baby (check all that apply):

☐ Caucasian (white)	☐ French Canadian	☐ Samoan	☐ Vietnamese
☐ African (black)	☐ Native American	☐ Chinese	☐ Laos
☐ Hispanic	☐ Greek	☐ Cambodian	☐ Taiwanese
☐ Ashkenazi Jewish	☐ Italian	☐ Filipino	☐ Korean
☐ Cajun	☐ Middle Eastern	☐ Japanese	☐ Other Southeast Asian
☐ Guamanian	☐ Hawaiian	☐ Asian – East Indian	☐ Unknown Race
☐ Other	☐ Other 2		

Is the father of this baby your partner? ☐ Yes ☐ No

Comments: _____

_____

_____

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Does the father of the baby, or any close relative of yours or the father, have any of the following (if yes, please note who):

Disease/Condition	Yes	No	Relation
1. Thalassemia MCV<80			
2. Neural Tube Defect (Spina Bifida, or Anencephaly)			
3. Congenital Heart Defect			
4. Down Syndrome			
5. Tay-Sachs			
6. Sickle Cell Disease or Trait			
7. Hemophilia or bleeding Problems (Type:)			
8. Muscular Dystrophy			
9. Cystic Fibrosis			
10. Mental Retardation/Autism/Learning disorder			
11. Other inherited genetic or chromosomal disorder			
12. Patient or baby's father had a child with birth defects not listed above			
13. Blindness or deafness			
14. Bone or skeletal disorder			
15. Kidney disorder			
16. Blood clots/stroke			

Reviewed by_____ _____

Provider signature Patient signature

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Authorization for Verbal Release of Protected Health Information

STANDARD DISCLOSURE

I authorize V SACHAR MD dba Coastal Perinatal Center to discuss my medical history, diagnosis, treatment and prognosis with those listed below. I understand this may include information regarding testing, examination and treatment for HIV, AIDS related illness, mental health and drug, alcohol or chemical abuse, as well as confirmation of any appointments for me to be seen in the office, hospital, or at another physician's office.

SPOUSE: _____

CHILDREN: _____

PARENT(S): _____

OTHER: _____

NO INFORMATION

I do not authorize release of any information concerning my treatment. I understand that this includes confirmation of appointment dates, times and locations.

This authorization will expire at the end of my treatment with V SACHAR MD dba Coastal Perinatal Center unless I revoke the consent prior to that time.

_____ _____

Signature of Patient Date

_____ _____

Witness Date

COASTAL PERINATAL CENTER

V SACHAR MD/COASTAL PERINATAL CENTER
PATIENT ACKNOWLEDGEMENT FORM

Our notice of Privacy Practices ("Notice") provides information about: 1.) the privacy rights of our patients; and 2.) how we may use and disclose protected health information ("PHI") about our patients.

Federal regulation requires that we give our patients or their authorized representatives ("You") the opportunity to review our Notice before signing this acknowledgement. A on-page summary of our Notice is displayed in our offices and in the hospitals we serve. A copy of our Notice will be made available to you and you may also view our Notice by visiting our internet web site, http://www.coastalperinatalcenter.com

By signing this form, you acknowledge only that we have provided you with immediate access to our Notice of Privacy Practices.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Print Name of Patient Print Name of Authorized Representative

COASTAL PERINATAL CENTER

FINANCIAL POLICY

OUR FINANCIAL POLICY: Our physicians and staff are very concerned about the cost of your health care and want to address some issues related to the cost of medical services in our office. Considerable care has been taken in setting our fees. We want to assure you that the charges accurately reflect the complexity of care rendered and the skill and expertise required for your care.

HMO and PPO MEMBERS: If you are a member of an HMO or PPO in which we participate, your deductible or co-payment is required at the time of service. Sonograms may have a different co-payment that routine visits. You are responsible to see that we have a current referral on file if your insurance carrier requires one. If we do not have this referral at the time of your visit, your insurance company may hold you responsible for all charges. You may also be sent back to see your Primary Care Physician prior to being treated to obtain a current referral.

If you are not sure that our physicians are providers for your PPO, call your insurance carrier for clarification.

NEW INSURANCE/CHANGE OF INSURANCE: Should your insurance change at anytime during your pregnancy it is your responsibility to notify us in writing within 10 working days of this change. We have to have this information in order to file your claim with the correct carrier before the insurance company's filing deadline.

FEE FOR SERVICE: Our policy requires payment of your deductible and/or coinsurance at the time of service.

Our agreement is with you, not your insurance company. Although we will assist you in submitting your claim to your insurance carrier, you are ultimately responsible for the service you receive. Payment to our office is neither contingent nor dependent upon your insurance carrier.

We are pleased to accept MasterCard, Visa, Discover, American Express, checks, cash, money orders, or traveler's checks.

MEDICARE: We are participating providers for Medicare. Please present your Medicare card at your visit. Patients are responsible for 20% of the amount that Medicare allows. If you have a supplemental insurance, we will submit a claim for you.

MEDICAID: We are Medicaid providers. Please present your Medicaid letter of eligibility at each of your visits.

AMNIOCENTESIS, OTHER SPECIALIZED TESTING: Our office will charge you for the services we provide. You will receive a separate bill from the laboratory that processes the test. Our office will be happy to provide you with an approximation of the laboratory charges.

If you have any questions regarding our financial policy or your insurance reimbursement, please feel free to discuss them with our billing office or the practice manager.

I have read and understand my financial responsibilities under this policy of V SACHAR MD/COASTAL PERINATAL CENTER.

_____ _____

Signature of Patient Date

COASTAL PERINATAL CENTER, INC.

V. Sachar, MD, FACOG, CHCQM

Maternal Fetal Medicine

FINANCIAL RESPONSIBILITY FORM

Positive verification of your medical coverage cannot be made at this time. You will receive services today under the understanding that in the event your coverage is NOT in effect, you will be held financially responsible for all services rendered.

If you are uncertain of your insurance coverage, please contact your insurance company prior to your appointment to make sure we are in network providers and that the reason for your visit is a covered benefit.

You will be held responsible for all services not covered by your insurance such as copays, deductibles, coinsurances, laboratory test, ultrasounds, hospital visits..etc.

_____ **DOB:** _____

Patient Name

_____ _____

Insurance Company **Insurance ID Number**

I have read the above information and i am aware that i will be responsible for the payments of all bills in the event that my coverage is not active or not in-network.

_____ _____

Patient Signature **Date**

COASTAL PERINATAL CENTER

V. Sachar, MD, FACOG, CHCQM

Maternal Fetal Medicine, Perinatal Diagnostic Center

I, _____hereby consent to have my physician/physician office Coastal Perinatal Center/Dr. V Sachar, communicate with me or members of his staff, where appropriate or other physicians, nurse practitioners and pharmacists via e-mailing regarding the following aspects of my medical care and treatment: [test results, prescriptions, appointments, billing, etc.]. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my physician and me or members of my physician's office staff, or between my physician and other physicians, nurse practitioners and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between my physician and me or members of his office staff, or between my physician and other physicians, nurse practitioners or pharmacists regarding my medical care and treatment will be printed out and made a part of my medical record. I understand that in an urgent or emergent situation I should call my primary provider or go to the Emergency Room/Labor & Delivery and not rely on e- mail.

Signature: _____Date:_____

3440 Lomita Blvd, Suite 440, Torrance CA P: 424-250-9186 F:323-345-6468
2785 Suite B, Pacific Ave, Long Beach, CA P: 562-317-5531 F: 844-825-0061