Women's Health Connecticut
CCOG Women's Health Group
Member of Women's Health Connecticut

Devoted to women, committed to excellence

Obstetrics & Gynecology
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Nurse Midwifery
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WELCOME AND CONGRATULATIONS!

Your initial prenatal visit is _____(Date) at _____(Time) with _____(Practitioner)
at _____(Location).

PLEASE BRING THIS FORM WITH YOU TO YOUR FIRST PRENATAL VISIT COMPLETED, THIS WILL HELP TO SHORTEN YOUR VISIT.

Please be prepared for your first prenatal visit to last up to two hours. This will include a complete physical exam, review of your medical history, pelvic exam, pap smear, blood work and cultures. You will have a transvaginal pelvic ultrasound prior to your exam which you will need to undress for. For this ultrasound, you are able to bring with you only one adult beside yourself. Children cannot be present for this visit. In addition to the medical conditions in the attached questionnaire, we also need to know if you have ever had or been vaccinated for Chicken Pox. Please research this with your parents or pediatrician if you are unsure.

We typically schedule prenatal visits every 4 weeks until your 28th week, then every 2 – 3 weeks until your 36th week, and every week during the last month. Most visits will be brief. There will only be one more pelvic exam at 36 weeks in all uncomplicated pregnancies.

The doctor on call will be the one to attend your baby's birth. The doctor who attends the birth will see you 2 – 6 weeks after the delivery for your postpartum checkup. After that, you may choose which doctor or midwife you see for further care. For any scheduled procedures such as amniocentesis, you may also choose the physician of your preference.

If you are smoking, stop as soon as you can and call if you need help. Alcohol and drugs should be avoided because of severe risk to your pregnancy.

Tylenol, Tylenol Cold, and Robitussin are safe, over the counter medications that you can take if medically necessary. Please speak to us regarding safety of other medications in pregnancy.

Please treat your early pregnancy gently.

We are looking forward to seeing you soon. Please call if you have any problems or questions.

1131 West Street
Building 2
Southington, CT 06489
860-276-6800
860-276-6801 fax

25 Newell Road
Suite E-35
Bristol, CT 060 0
860-276-6800
860-276-6801 f x

www.womenshealthct.com/ccog

CCOG Women's Health Group

PLEASE COMPLETE AND RETURN TO OUR OFFICE.

Full Name:_____ Maiden Name:_____

Address:_____

Home Phone#:_____ Last 4 of Social Security #:_____

Work Phone#:_____ Marital Status:_____

Name of emergency contact:_____ Relationship:_____

Emergency contact phone #:_____

Your date of birth:_____ Place of Birth:_____

Your age when baby will be born:_____ Race (optional):_____

Marital Status:_____ Education: (# of years) _____

Employer: _____ Occupation:_____

What type of insurance do you have? _____

Subscriber: _____ Relationship: _____

Policy #: _____ Your Religion:_____

Name of father of child:_____

Age:_____ Height:_____ Weight:_____ Race (optional)_____

Employer:_____ Employer's Phone #:_____

Employer's Address:_____Education (# of years):_____

Any significant diseases between either one of you? _____

If yes please explain:_____

_____

_____

(continues on back)

Your Height: _____ Pre pregnancy weight: _____

Age at first menstrual period:_____

How long are your menstrual cycles? (Number of days from one period to the next)____

How many days does your period last?_____ Are they regular?_____

Are they heavy, moderate, light?_____

Was this pregnancy planned?_____ If so, months attempted: _____

Are you happy about this pregnancy?_____

When did your last period begin? _____ Was it normal? _____

If not normal, how was it unusual?_____

List all previous pregnancies, including abortions and miscarriages:

Month/Yr	How far along were you?	Length of Labor	Vaginal or Cesarean	Place of Delivery	Boy or Girl	Wt of baby
1.						
2.						
3.						
4.						
5.						

Any complications of delivery or problems in previous pregnancies?_____

_____

Check if you have had any of the following. List dates and treatments:
Please check this box if you have had none: ☐

Diabetes_____
Hypertension_____
Heart Disease_____
Autoimmune disorder _____
Kidney/UTI _____
Neurologic/Epilepsy _____
Psychiatric _____
Hepatitis/Liver Disease _____
Varicosities/Phlebitis: _____
Thyroid Dysfunction: _____
Trauma/Violence: _____
History of Blood Transfusion: _____

Rh Sensitized_____
Asthma/TB_____
Allergies(drug/latex)_____
Breast _____
GYN Surgery _____
Operations/Hospitalizations:_____
Anesthetic Complications:_____
History of Abnormal Pap:_____
Infertility:_____
Uterine Anomaly/DES:_____
Infertility: _____
Relevant Family History: _____

Other: _____ ART Treatment: _____

Please check if you have the following:
Please check this box if you have none: ☐

Patient's age- over 35 _____
Thalassemia (Italian, Greek, Mediterranean Or Asian background)_____
Neural Tube Defect_____
Congenital Heart Defect _____
Down Syndrome _____
Tay Sachs (EG, Jewish, Cajun, French or Canadian) _____
Canavan Disease _____
Familial dysautonomia_____
Cystic Fibrosis _____
Sickle Cell Disease or Trait _____
Hemophilia or other blood disorder _____
Muscular Dystrophy _____

Huntington Chorea _____
Mental Retardation _____
If yes was person tested for fragile X? ____
Other inherited genetic or chromosomal disorder _____
Maternal Metabolic Disorder (Eg, Maternal Type 1 Diabetes, PKU) _____
Patient or baby's father had a child with a defect not listed above _____
Recurrent pregnancy loss/stillbirth _____
Medication/Alcohol/Street drugs since last menstrual period _____
Other _____

	AMT/DAY	AMT/DAY	#YEARS
Tobacco	PRE/PREG_____	PREG_____	USED _____
	AMT/DAY	AMT/DAY	#YEARS
Alcohol	PRE/PREG_____	PREG_____	USED _____
	AMT/DAY	AMT/DAY	#YEARS
Drugs	PRE/PREG_____	PREG_____	USED _____

INFECTION HISTORY

Please check if you have any of the following:
Please check this box if you have none: ☐

High Risk for HIV ☐
High Risk for Hepatitis B ☐
Have you been immunized for Hepatitis B ☐
Live with someone with or exposed to TB ☐
Patient or partner has history of genital herpes ☐
Rash or viral illness since last menstrual period ☐
History of STD, GC, Chlamydia, HPV or Syphilis ☐
Other _____

Women's Health Connecticut

www.womenshealthct.com

For Internal Use Only
PT ID Number
Last Verified _____

Patient Information

Last Name_____ First Name_____ M.I._____ Maiden or Nickname_____

Street Address_____ Apt._____ PO Box_____ City_____

State_____ Zip_____ DOB_____ Last Four Digits of SS#_____ Preferred Language_____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐ Other **Ethnicity** ☐ Hispanic ☐ Non-Hispanic

Race ☐ Asian ☐ Black ☐ Caucasian ☐ Multi-Racial ☐ Native American ☐ Pacific Islands ☐ Other

Home phone:_____ Work phone:_____ Ext_____ Cell Phone:_____
Primary # to call me: ☐ H ☐ W ☐ C

Email address_____ May we email you for other than medical reasons? ☐ Yes ☐ No

Employer Name_____ Employer Address_____

Occupation_____ If Student ☐ Full time ☐ Part time School Name_____

Insurance Information — Do you have health insurance? ☐ Yes ☐ No

Primary Insurance_____ Insurance Address_____

Policy #_____ Group #_____ Copay_____

Policy Holder_____ DOB_____ Relationship_____

Secondary Insurance_____ Insurance Address_____

Policy #_____ Group #_____ Copay_____

Policy Holder_____ DOB_____ Relationship_____

Complete for Policy Holder if other than self: Last Four Digits of SS#_____

Employer_____ Employer's Phone #_(_____)_____

Employer Address_____

Other Information

Primary Care Physician_____ Referring Physician_____

Primary Physician in This Office_____ Pharmacy Name & Phone_____

In case of Emergency/Urgent matter, we may contact: MUST BE COMPLETED (e.g. nearest relative preferably not living with you)

Name_____ Relationship_____ Phone #_(_____)_____

Clinical Research: We do clinical research to advance women's health. May we notify you of upcoming studies? ☐ Yes ☐ No

May we examine your medical record, and/or billing information to determine your eligibility for a Clinical Study? ☐ Yes ☐ No

Authorization for Treatment, Payment & Healthcare Operations

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. Additionally, I authorize and assign any payment of medical benefits to the Physicians for Women's Health LLC, its successors and assigns, or any individual it may designate for services provided.

As part of this authorization, Physicians for Women's Health LLC will release HIV, Drug and Alcohol, and Mental Health/Psychiatric information as required by law unless otherwise indicated. I understand that I have the right to request that services for which I have paid out-of-pocket, not be disclosed to my health plan.

I agree to pay interest at the prevailing rate for amounts 30 days past due, as well as costs including attorney's fees, associated with the collection of any amounts due for services rendered. I understand that I am financially responsible to Physicians for Women's Health LLC, its successors and assigns, or any individual it may designate, for amounts owed by me in accordance with my health benefit coverage. I understand an acknowledge that I will be responsible for all unpaid claims if I fail to provide insurance information within my health plan's filing limit for services rendered.

_____
Signature of Patient or Parent of Minor — Date

Medicare Authorization for Treatment, Payment & Healthcare Operations, Medicare Recipients Sign both Authorizations.

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. I request that payment of Authorized medicare benefits be made either to me or on my behalf to Physicians for Women's Health LLC for services furnished to me by the providers. I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits for related services rendered.

_____
Patient's Signature — Date

CT0990115 Rev. 0212

Notice of Privacy: ☐ Received ☐ Refused _____
Signature of Patient or Parent of Minor — Date

May release protected health information to: _____
Name — Relationship

Confidential Communication Request

CCOG Women's Health Group

1131 West Street , Southington, CT 06489

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have a right to request communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided. This medical practice will respond to your written request within 14 days after receiving this request. Please complete entire form and forward to Privacy Officer at address listed above.

I, _____ hereby request use of confidential channels for communication of
(print name)

information related to personal health, treatment or payment for treatment of _____.
(print patient name)

Patient: Date of Birth: _____ Social Security # (last 4 digits): _____

How may we contact you?

Home Phone: ☐ Do NOT leave message ☐ May leave return number only ☐ May leave message

Work Phone: ☐ Do NOT leave message ☐ May leave return number only ☐ May leave message

Cell Phone: ☐ Do NOT leave message ☐ May leave return number only ☐ May leave message
Text Messages: ☐ Yes ☐ No

Email: (when available): ☐ Do NOT send message ☐ May leave return number only
☐ May relay message

☐ Authorized persons with whom we may share patient's personal health information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Describe below other means you may request for confidential communication:

_____

I understand that it is my responsibility to notify the office of any changes to my calling information.

Patient Signature: _____ **Date:** _____

If this form were not completed by the patient, please sign below and state relationship to patient:

Signature: _____ **Date:** _____

Relationship to Patient: ☐ Parent ☐ Legal guardian ☐ Conservator ☐ Personal representative