

**BAY POINT MATERNITY & WOMEN'S HEALTH**  
**1029 Nichols Rd Ste E, Osage Beach, Mo 65065**  
**573-302-4884**  
**PATIENT REGISTRATION FORM**

Date \_\_\_\_\_

First Name \_\_\_\_\_ Mi \_\_\_\_\_ Last Name \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Date Of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Race \_\_\_\_\_

Marital Status (**Please Circle One**) – Married \* Single \* Divorced \* Widowed \* Engaged

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Referring Physician \_\_\_\_\_ Primary Physician \_\_\_\_\_

How Did You Hear About Us? \_\_\_\_\_



**EMERGENCY CONTACT: Must List Parent or Legal Guardian if under the age of 18. Otherwise, Please List Anyone Not Living With You.**

First Name \_\_\_\_\_ Mi \_\_\_\_\_ Last Name \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Relationship \_\_\_\_\_



**SPOUSE/ Significant other INFORMATION:**

First Name \_\_\_\_\_ Last Name: \_\_\_\_\_

Date Of Birth \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_



Primary Insurance \_\_\_\_\_ Cardholders name: \_\_\_\_\_

Secondary Insurance Company Name \_\_\_\_\_

## OBSTETRICAL MEDICAL HISTORY FORM

Patient Name: \_\_\_\_\_

History	Pos/Neg	Date	Comments
Allergic Rhinitis			
Anemia/Hematologic			
Asthma/Pulmonary			
Autoimmune Disorder			
Abnormal Pap Smears			
Blood Transfusion			
Breast Disorder			
Depression			
Psychiatric Disorder			
Diabetes			
Heart Disease			
Hypertension			
Infertility			
Liver Disease			
Neurological Disorder			
Renal Disease			
(Rh) Sensitized			
Thyroid Disorder			
Trauma History			
Uterine Abnormalities			
Varicosities/DVT			
Anesthetic Complications			
Other Family History			
Other			
Other			
Other			

Substance	Yes/No	Amt/Day Prepreg	Amt/Day Preg	#Years Used	Comments
Tobacco					
Alcohol					
Illicit Drugs					

Surgery/Hospitalizations	Year	Comments

Last Menstrual Cycle: \_\_\_\_\_ Last Mammogram: \_\_\_\_\_

Last Pap Smear: \_\_\_\_\_ (normal? Y / N )

Have you had any recent tests pertaining to this visit? (if so, what tests and when were they taken)?

# of Pregnancy's \_\_\_\_\_ # of Births \_\_\_\_\_ # of Living Children \_\_\_\_\_  
 # of Miscarriages \_\_\_\_\_ # of Abortions \_\_\_\_\_

Patient Name: \_\_\_\_\_

Genetic Screening	Yes/No	Comments
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Patient Age >=35 as of Est Date of Delivery		
Neutral Tube Defect (Spina Bifida, Anencephaly)		
Trisomy 21 (Down Syndrome)		
Congenital Heart Defect		
Cystic Fibrosis		
Tay Sachs (Jewish, Cajun, French Canadian)		
Thalassemia (Italian, Greek, Mediterranean, Asian)		
Canavan Syndrome		
Hemophilia or Hematologic Disease		
Huntington's Chorea		
Autism		
If Yes, Was Person Tested For Fragile X?		
Mental Retardation		
If Yes, Was Person Tested For Fragile X?		
Muscular Dystrophy		
Sickle Cell Disease or Trait (African)		
Other Inherited Genetic or Chromosomal Disorder		
Maternal Metabolic Disorder (Type 1Diabetes,PKU)		
Recurrent Pregnancy Loss or a Stillbirth		
Other Birth Defects		
Other Genetic Screening		

<b>Exposure/Infection History</b>	<b>Yes/No</b>	<b>Comments</b>
Partner Has History of HIV		
Patient or Partner Has History of Genital Herpes		
Exposure To TB		
Rash or Viral Illness Since Last Menstrual Cycle		
History of Sexually Transmitted Disease		
Other Exposure or History of Infection		

**MEDICATIONS:** Please list all medications with dosage. Include over the counter drugs.

<b>Drug</b>	<b>mg</b>	<b>dosage</b>	<b>Drug</b>	<b>mg</b>	<b>dosage</b>

**ALLERGIES:** List drug and your reaction to it.

<b>Drug</b>	<b>Reaction</b>

# Family History Form

Patient Name: \_\_\_\_\_

This is part of your medical record and is kept confidential. It will not be released to any other person without your written consent.

**Diseases in Blood Relatives:** Do not include yourself, family only

[ ] **ADOPTED**-STATUS UNKNOWN

Health Status Number System:

1. Alive and well
2. Alive and disabled
3. Alive and chronically ill
4. Deceased

	AGE	HEALTH STATUS: <small>Please use the numbering system to describe health status of family</small>	IF DECEASED, CAUSE AND AGE OF DEATH <small>If disabled, cause or reason of disability</small>
Father			
Mother			
Brother 1			
2			
3			
4			
5			
Sister 1			
2			
3			
4			
5			
Husband			
Children 1			
2			
3			
4			
5			

- Who?
- [ ] Heart Disease \_\_\_\_\_
  - [ ] Stroke \_\_\_\_\_
  - [ ] Diabetes \_\_\_\_\_
  - [ ] Tuberculosis \_\_\_\_\_
  - [ ] Anxiety \_\_\_\_\_
  - [ ] Breast Lumps \_\_\_\_\_
  - [ ] Kidney Stones \_\_\_\_\_
  - [ ] Ulcers \_\_\_\_\_
  - [ ] Anemia \_\_\_\_\_
  - [ ] Thyroid Disease \_\_\_\_\_
  - [ ] Cancer: Breast \_\_\_\_\_
  - Uterine \_\_\_\_\_
  - Ovarian \_\_\_\_\_
  - [ ] Other Type Cancer \_\_\_\_\_
  - please specify type: \_\_\_\_\_

- Who?
- [ ] High Blood Pressure \_\_\_\_\_
  - [ ] Genetic Disorders \_\_\_\_\_
  - [ ] Asthma \_\_\_\_\_
  - [ ] Lung Disease \_\_\_\_\_
  - [ ] Depression \_\_\_\_\_
  - [ ] Seizures \_\_\_\_\_
  - [ ] Epilepsy \_\_\_\_\_
  - [ ] Hepatitis \_\_\_\_\_
  - [ ] Headaches \_\_\_\_\_
  - [ ] Migraines \_\_\_\_\_
  - [ ] Cervical Dysplasia \_\_\_\_\_
  - [ ] Other Known diseases \_\_\_\_\_

Bay Point Maternity & Women's Health  
*Martin Schwartz, MD*  
1029 Nichols Rd, Ste E Osage Beach, MO 65065

**Financial And Insurance Agreement**

Assignment of Benefits: Authorization to Release Medical Information

- 1) I request that payment of authorized benefits be made on my behalf to the provider listed on this form, for any services furnished to me by that physician and/or supplier. I authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment to my insurance company, the Family Services Department or Centers for Medicare and Medicaid Services and its agents any information needed in order to determine these benefits or the benefits for other related services.
- 2) As Bay Point Maternity & Women's Health, LLC is not a lending institution I understand that full payment is due at the time of service. This company accepts Master Card, Visa, American Express, personal checks (with proper ID) and cash. I agree to pay any remaining balance after insurance response/payment has been made to the provider upon receipt of my first statement.
- 3) I accept financial responsibility for non-payment of claims if for any reason I fail to notify Bay Point Maternity of any **changes in insurance status**. **If you apply for Missouri Medicaid assistance we must be informed IMMEDIATELY!**
- 4) We bill insurance that is current at the time services are provided. **We NO NOT back bill for "back-dated" insurance policies including Missouri Medicaid.**

\_\_\_\_\_  
**Cardholder/Guardian Signature Required for Insurance Billing**

\_\_\_\_\_  
Date

**COLLECTION FEES NOTICE:**

Signature Required

A \$30 fee will be charged on all **returned checks**. A 2% surcharge will be added on all **unpaid guarantor balances** per month. I understand that if my account goes unpaid, Bay Point Maternity & Women's Health may be forced to turn the account over to an outside collection agency. Responsible party shall be liable for any and all costs incurred (including late fees) in connection with any legal or collection action brought by Bay Point Maternity & Women's Health to enforce the terms of this agreement including but not limited to reasonable fees or charges by attorney, investigators, collection agency, and court costs. The corporation and the patient and co-signers hereby waive notice of non-payment protests, presents and/or demand.

\_\_\_\_\_  
**Patient Signature /Legal Guardian**

\_\_\_\_\_  
Date

The policy of Bay Point Maternity & Women's Health is to provide an environment that provides equal opportunity to all patients of this facility. In accordance with federal and state law, Bay Point Maternity prohibits unlawful discrimination on the basis of race, color, religion, sex, national origin, age, disability, citizenship, and veteran status. Discrimination on the basis of sexual orientation is also prohibited pursuant to Bay Point Maternity policy.

Bay Point Maternity & Women's Health L.L.C.

ACKNOWLEDGEMENT OF RECEIPT OF BAY POINT MATERNITY  
NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with Bay Point Maternity & Women's Health Notice of Privacy Practices.

Patient Signature: \_\_\_\_\_

Legal Representative Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

I hereby authorize the below listed individuals access to my health information including future appointment date and time:

Individual

Relationship

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient or legal representative was unwilling/unable to sign acknowledgement.

Reason: \_\_\_\_\_

Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**BAY POINT MATERNITY  
OB PATIENT  
FINANCIAL POLICY**

Dear OB Patient:

We would like to take this opportunity to advise you of our policies and offer you some helpful suggestions. At the time of your first initial OB visit we request a copy of your insurance card at which time we will verify your coverage and benefits. Based on your coverage we will prepare an estimated statement showing you what your portion of your bill will be. If you have a deductible or co-insurance we ask that you pay toward this amount each visit. A plan will be set up and we request that you have your portion paid in full by the 24<sup>th</sup> week of your pregnancy.

In February 1999 the State Medicaid program set up a new Health Insurance Program for people who do not have access to health insurance. We ask that you apply to the Division of Family Services office **immediately**. Within the MC+ program are three “lock-in” plans that you will be expected to choose from. At this time our office is **only accepting** the “HEALTHCARE USA” or “MOLINA HEALTH PLAN” program for your complete pregnancy care. Temporary Medicaid and Straight Medicaid are accepted for your first initial visit only. We require that you present a “Healthcare USA” or “Mercy Care Plus” card with eligible benefits or have a note from your caseworker stating your Medicaid ID# and your “lock-in” plan, by your next visit. **Please Note: If you move or your insurance status changes please inform us as soon as possible. You may become financially responsible for failure to provide up-to-date insurance information.**

Part of the State Medicaid program was to establish new Medicaid Eligibility Codes (ME Codes) to designate which coverage you have. We verify which ME Code you currently have. If you have ME Code 80, ME Code 58 or 59 **your pregnancy is not covered or is limited**. Contact your caseworker immediately and have them change your status to “Medicaid for Pregnant Women” and sign up for a “lock-in” plan. Again we do not accept these codes for pregnancy care other than your first visit and we need you to be “locked-in” to a plan by your next visit.

If you do not present this information at your next visit you will be financially responsible for any previous charges and payment will be expected at this time or your appointment will need to be rescheduled. These charges may include an office visit, ultrasound, and any lab tests performed in this office. You will be considered a “self-pay” patient and a payment plan will need to be set for future charges. **WE DO NOT BACKDATE ANY SERVICES TO OBTAIN MEDICAID PAYMENT IF MEDICAID IS APPROVED AFTER SERVICES ARE RENDERED (even if Medicaid backdates your application).**

If you are a “self-pay patient” or an “advanced pregnancy patient without a lock-in plan”, our policy was explained at the time your appointment was scheduled and a down payment is expected on your first visit. You will also receive a written policy on your first visit.

**IMPORTANT NOTES TO REMEMBER:**

- “Temporary Medicaid” will NOT cover “problems” or anything unrelated to your pregnancy. You will become financially responsible for all problem charges at the time of service.
- Temporary Medicaid and Straight Medicaid are accepted for your first initial visit only.
- **Medicaid will not pay for a circumcision**

If at any time during your pregnancy you decide you want to have a Tubal Ligation to prevent further pregnancies, you must sign a consent form. Please talk to one of the nurse’s, as these forms must be signed 31 days prior to your delivery. This consent does not obligate you in any way. Once the form is signed it is good for up to 180 days from the date it was signed. You must be at least 21 years of age on the date you sign the consent form.

Congratulations on your pregnancy and if you have any questions, please do not hesitate to ask any of our staff.