



SAN GABRIEL VALLEY PERINATAL MEDICAL GROUP, INC

Maternal-Fetal Medicine
1135 S. Sunset Ave., Ste. 402
West Covina, CA 91790
Telephone: (626) 337-4425
Fax: (626) 337-4305

REGISTRATION
(PLEASE PRINT)

Date Home Phone () Cell Phone ()

PATIENT INFORMATION

Name Soc. Sec. #
Address E-Mail
City State Zip
Sex M F Age Birthdate Married Widowed Single Minor
Seperated Divorced Partnered for years
Patient Employer/School Occupation
Employer/School Address Employer/School Phone ()
Whom may we thank for referring you?
In case of emergency who should be notified? Phone ()

PRIMARY INSURANCE

Person Responsible for Account Last Name First Name Middle Initial
Relation to Patient Birthdate Soc. Sec. #
Address (If different from patient's) Phone ()
City State Zip
Person Responsible Employed by Occupation
Business Address Business Phone ()
Insurance Company
Contact # Group # Subscriber #

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No
Subscriber Name Birthdate Relation to Patient
Address (If different from patient's) Phone ()
City State Zip
Subscriber Employed by Business Phone ()
Insurance Company Soc. Sec. #
Contact # Group # Subscriber #

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with Name of Insurance Company(ies) and assign directly to
SAN GABRIEL VALLEY PERINATAL MED. GRP. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.
Signature of Patient, Parent, Guardian or Personal Representative Date
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

SAN GABRIEL VALLEY PERINATAL MEDICAL GROUP, INC.
PATIENT FINANCIAL POLICY
TAX ID: 95-4282339

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care. The following is a statement of our Financial Policy in order to reduce confusion and misunderstanding between our patients and practice, which we require you read and sign prior to any treatment. If you have any questions regarding these policies, please discuss them with our front office staff or supervisor.

- ❖ We have made prior arrangements with many health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment, deductibles and/or coinsurance at the time of service. It is our policy to collect the co-payment at the time of service.
- ❖ If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.
- ❖ In the event that your health plan determines a service to be "not covered", "not medically necessary" or "not authorized", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. If you disagree with your insurance company's determination, you must contact your insurance company.
- ❖ Your insurance policy is a contract between you and your insurance company, our group is not involved.
- ❖ HMO's and some other insurance require an official referral/authorization form. If we have not received it in our office at the time of service, you will be required to sign a Waiver of Responsibility Form and deposit of payment may be expected.
- ❖ If you have pending Medi-Cal coverage, we require a \$50.00 deposit at the time of service. If you provide a retroactive Medi-Cal card that covers your service date, we will refund your deposit.
- ❖ In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know you need to reschedule your appointment. There is a cancellation fee if you do not cancel or reschedule your appointment without prior 48 hour advance notice.

Additional services such as laboratory and genetic counseling are an additional charge and you will be billed separately.

THE UNDERSIGNED HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS

Signature of Person Financially Responsible

Date

Please Print Name of Patient

Exhibit 4

San Gabriel Valley Perinatal Medical Group, Inc.

**RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN
ACKNOWLEDGEMENT FORM**

I, _____, have been offered to review a copy of San Gabriel Valley Perinatal Medical Group, Inc's Notice of Privacy Practices.

I, _____, give permission to collect information from my medical chart for review for the purpose of quality control. I understand the information will not identify me in any way and could result in publishable material.

Signature of Patient

Date



SAN GABRIEL VALLEY PERINATAL MEDICAL GROUP, INC

You have been evaluated in our Perinatal Center. The risk of certain complications (as listed below) may be higher in your pregnancy.

I. Preterm labor (i.e. when labor begins before 37 weeks)

Signs and symptoms of preterm labor may include some or all of the following symptoms:

- ❖ Regular or frequent contractions (tightening of the uterus), equal to or greater than 6 times in an hour.
- ❖ Menstrual - like cramps or abdominal cramps
- ❖ Low backache
- ❖ Pelvic pressure
- ❖ Increase or change in vaginal discharge (watery, mucus, or bloody)
- ❖ Leakage of clear water or bleeding from the vagina.

Call your doctor if you notice any of the above symptoms

II. Preeclampsia (high blood pressure during the second half of pregnancy and can affect all organs)

Symptoms of preeclampsia which require attention:

- ❖ Headache not relieved by Tylenol
- ❖ New onset of major visual disturbance
- ❖ Pain in right upper abdomen
- ❖ Decreased fetal movement

Call your doctor if you notice any of the above symptoms

III. Placenta Previa

If you are diagnosed of having placenta previa, call your doctor if you experience any of the following symptoms:

- ❖ Bright red vaginal bleeding
- ❖ Leakage of clear water from vagina
- ❖ Regular or frequent contractions, equal to or greater than 6 times in an hour

Avoid douching, strenuous activity, heavy lifting, sexual activity or sexual stimulation until advised.

Call your obstetrician if you have any questions or problems

*** Please go to L&D if you are concerned with baby's well being or your baby's movements are less than normal.**

*** Please bring your glucometer to all appointments at the Perinatal Center if you have diabetes mellitus.**

*** Take all prescribed medications as instructed. Do not skip doses.**

*** It is important to keep all of your scheduled appointments as instructed. Failing an appointment may delay the appropriate diagnosis and management.**

I have received, read, and understood the above instructions.

Patient signature: _____ **Date:** _____

Witness signature: _____ **Date:** _____

PATIENT MEDICAL INFORMATION SHEET

Name _____

Date of Birth _____

Please answer these questions honestly so we can help you receive the best possible care for you and your baby. Ask the nurse for help if you have any difficulty with these questions. Your answers will be a confidential part of your medical record. Thank you for completing this assessment. It will help us provide better prenatal care.

ALLERGIES

Are you allergic to any Medicines?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, what medicines?
Are you allergic to Latex?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Are you allergic to Iodine?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

MEDICATIONS

Are you taking any medications?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, what medicines?
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OBSTETRICAL HISTORY

Have you ever been told that you had one of the following while pregnant?

Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
High blood pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Preeclampsia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Incompetent cervix	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

DELIVERIES

Please include miscarriages and abortions.

Year	Vaginal	Cesarean	D&C	Birth weight	Weeks at delivery	Complications
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

Have you had any ultrasounds during this pregnancy? If yes, when and where was the Ultrasound(s) done?

<input type="checkbox"/> No	<input type="checkbox"/> Yes	
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PATIENT MEDICAL INFORMATION SHEET

Name _____

MEDICAL HISTORY

Have you ever been told that you have one of the following conditions?

High blood pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please specify.
Heart Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please specify.
Kidney problem (such as infection, stones, or cysts)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please specify.
Lung problems (other than asthma)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please specify.
Liver problems (such as hepatitis or gallstones)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please specify.
Intestinal problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please specify.
Thyroid problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, have you ever taken medications for thyroid disease?
Seizures (epilepsy)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, have you ever taken medications for seizures? And when was your last seizure?
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, have you ever taken medications for Diabetes?
Lupus	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please specify.
Tuberculosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please specify.
Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please specify.
Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, do you take any medications for asthma?
Blood disorder (such as Sickle cell, thalassemia, or Von Willebrands disease)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please specify.
Blood clots	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please specify.
Low platelets	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please specify.
Genital Herpes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, when was your last outbreak?
HIV	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Psychiatric disorder (Depression, anxiety, bipolar disorder, etc.)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please specify.

PATIENT MEDICAL INFORMATION SHEET

Name _____

SURGICAL HISTORY

Have you had any operations? (Including LEEP, cone biopsy, or cerclage)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, what type and when?
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Transfusion History

Have you ever received a blood transfusion?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, when and why?
Have any of your children ever received a blood transfusion?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, when and why?

EXPOSURES

X-rays	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, when and why?
Chemicals	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, what was the chemical, and date of exposure?
High fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, when and why?

FAMILY HISTORY

Is there any history of birth defects such as heart defects, extra fingers or toes, etc.

In your family?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please describe the defect.
In the baby's father's family?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please describe the defect.
Has any one in your family had a problem with blood clots or stroke?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how old was the family member when they had the clot or stroke?

HABITS

Have you ever smoked?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how many cigarettes per day?
Do you drink alcohol?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how many drinks per day and when was your last drink?
Have you ever used drugs that were not prescribed? (PCP, marijuana, cocaine, heroin, amphetamine)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, what drugs have you used and when did you last use them?
Has anyone hit you or physically abused you in the last year?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, when?

Patient Signature

Date

SAN GABRIEL VALLEY PERINATAL MEDICAL GROUP, INC.

1135 S. Sunset Ave. #402

West Covina, Ca. 91790

Phone 625-337-4425 Fax 626-337-4305

Please provide us with the name and phone number of your current pharmacy.

PHARMACY NAME:

PHONE NUMBER:

PLEASE PRINT PATIENT NAME

PATIENT SIGNATURE

DATE

San Gabriel Valley Perinatal Medical Group
Your Pregnancy Ultrasound Scan
 Please read this carefully

As part of your antenatal care you are having an ultrasound examination (also known as a level II ultrasound scan or sonogram) of your pregnancy. Ultrasound examination of the fetus during pregnancy is generally considered safe when limited to that required to produce the needed information [1]. The examination does not involve x-rays.

Usually the examination will be through your abdomen and you should have a full bladder. For the examination you will be asked to lie down on an examination table and a clear gel will be applied to your skin over your abdomen. The gel will help to transmit the sound waves generated by the ultrasound probe. The sound waves that bounce back to the ultrasound probe are used to create pictures on the ultrasound monitor similar to a television screen.

Sometimes the examination will be done through the vagina (transvaginal) to provide a more detailed image, but the doctor will talk to you about this if it proves necessary.

The examination will look for abnormalities in your baby or babies and will attempt to determine the age and size of your baby or babies. The examination will also look for abnormalities in the placenta. If you do decide to have an ultrasound examination we will assume that you wish to know about anything that we find.

About 60% of major abnormalities will be seen on ultrasound examinations performed between 16 to 20 weeks. Findings suggestive of Down syndrome may be detected about 50% of the time [3,4]. Conditions such as cerebral palsy and autism are not detectable by sonogram before birth. Some malformations of the heart, digestive tract, and face as well as hydrocephalus are most likely to be detected after 26 weeks [2]. In addition to the age of the baby other factors such as maternal obesity, previous abdominal surgery, and the baby's position may prevent detection of abnormalities.

The table below lists the chances of detecting an abnormality by organ system during a 16 to 20 week sonogram [3].

Organ system	Chance of an abnormality being seen
Central nervous system (brain and spine)	92%
Lungs	78%
Genitourinary (kidneys and bladder)	69 %
Gastrointestinal (diaphragm, stomach, esophagus, intestines)	69 %
Skeletal (long bones, feet, and hands)	35 %
Heart	30 to 50 %
Craniofacial (jaw, lip, palate, eye sockets, and skull)	35 %

If a problem is found you will be told at the time of the examination that there is a problem. A full discussion of the problem may require you to come back to the office for further evaluation. Some problems that need repeat examination are not serious or are "false alarms".

The examination can sometimes tell what sex the baby appears to be, but not always. If you do not want to know the sex of your baby, please inform the examiner before you begin the examination.

REFERENCES

1. US Department of Health and Human Services, Public Health Service, Food and Drug Administration: An Overview of Ultrasound: Theory,

- Measurement, Medical Applications, and Biological Effects. Publication # FDA 82-8190
2. Grandjean H, Larroque D, Levi S. The performance of routine ultrasonographic screening of pregnancies in the Eurofetus Study. *Am J Obstet Gynecol.* 1999;181(2):446-54. [PMID 10454699](#)
 3. Anderson N, et al.. Prenatal sonography for the detection of fetal anomalies: results of a prospective study and comparison with prior series. *AJR Am J Roentgenol.* 1995;165(4):943-50. [PMID 7676997](#)
 4. Ultrasound Screening July 2000 Supplement to Ultrasound Screening for Fetal Abnormalities 2006 Royal College of Obstetricians and Gynaecologists <http://www.rcog.org.uk/index.asp?PageID=1185#app2> Accessed 10/6/06

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