SAN GABRIEL VALLEY PERINATAL MEDICAL GROUP, INC.

Maternal-Fetal Medicine

1798 N. Garey Ave.
Pomona CA 91767

Telephone: (909) 865-9705
Fax: (909) 622-5309

REGISTRATION

(PLEASE PRINT)

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ (Last Name / First Name / Middle Initial) Soc. Sec. # _____

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ 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 _____

Contract # _____ 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. # _____

Contract # _____ 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 we require you read and sign this statement 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 directly.

- 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 and/or 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 a deposit of payment may be expected.

- If you have pending Medi-Cal coverage, we require a $75.00 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

SGV Perinatal
Medical Group, Inc.

1135 S SUNSET AVE STE 402
WEST COVINA, CA 91790
Phone: 626.337.4425
Fax: 626.337.4305
www.peridocs.com

E-PRESCRIBING PBM CONSENT FORM

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions--** Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions--**Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form you are agreeing that San Gabriel Valley Perinatal Medial Group can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Patient Name (printed) _____ Date of Birth ____/____/_____

Signature of patient (or representative)_____

Date ____/____/_____ Relationship if other than patient_____

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Consent to Communicate Medical Information

Voicemail Communication

Welcome to our practice! Many times during the course of your care our providers will want to provide information to you about laboratory results or other medical issues. Sometimes it is difficult to connect with patients by phone which delays our ability to relay information. Some patients prefer that we leave messages on their voicemails as a way to eliminate delays. We are bound to protect patient privacy, we cannot use this method of communication unless we have permission to do so. Please indicate your preference as to how we can communicate information to you during your care as a patient here:

- ☐ Yes, you may leave a message on my:
  - o Home # _____
  - o Cell # _____
- ☐ No, you may not leave a message on my voicemails.

Communicate with Family Members or Significant Others

Some patients would like us to discuss their medical care with a spouse, family member or other trusted associate. To assure privacy, we require patient permission to do so. Please list any other persons with whom we may share your medical information.

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

Request for E-mail Communication

Some patients prefer to communicate with our clinical and administrative support staff by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before giving consent. Communications over the internet and/or using the email system are not encrypted and are inherently insecure. There is no assurance of confidentiality of information when communicated this way. Nevertheless, you may request that we communicate with you via e-mail. To do so, please provide us with your email information below:

- ☐ Yes, I authorize E-mail communication
- ☐ No, I do not authorize E-mail communication

_____
E-Mail Address

_____
Patient Signature

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

SGV Perinatal Medical Group, Inc.

PRENATAL GENETICS HISTORY

I. MOTHER OF PREGNANCY

Name:_____ Maiden Name:_____

Date of Birth:_____ Your age at delivery:_____

Occupation:_____

Ethnic Origin (Africa, Asian, Hispanic, Italian, Etc.)_____

Central Eastern European (Ashkenazi) Jewish ☐ Yes ☐ No

Cajun or French Canadian? ☐ Yes ☐ No

FATHER OF PREGNANCY

Name:_____

Date of Birth:_____ Age_____

Occupation:_____

Ethnic Origin (Africa, Asian, Hispanic, Italian, Etc.)_____

Central Eastern European (Ashkenazi) Jewish ☐ Yes ☐ No

Cajun or French Canadian? ☐ Yes ☐ No

II. PREGNANCY HISTORY: During this pregnancy, have you had any of the following:

Yes	No	Not Sure/ Do not know	
☐	☐	☐	Vaginal bleeding or leakage of fluid
☐	☐	☐	Infections, rashes or other illness
☐	☐	☐	Fever over 101F, used hot tub or sauna
☐	☐	☐	X-rays, hospitalizations or surgery
☐	☐	☐	Cigarettes or alcoholic beverages
☐	☐	☐	Drugs or medications (other than prenatal vitamins or iron)
☐	☐	☐	Ultrasound (sonogram)
☐	☐	☐	Occupational, chemical or other exposures
☐	☐	☐	Alpha-fetoprotein (AFP) or other maternal serum testing (please specify)
☐	☐	☐	Pregnancy reduction (termination of a fetus due to quadruplets, for example), artificial insemination, donor egg or donor sperm.

III. MEDICAL HISTORY

Yes	No	Not Sure/ Do not know	
☐	☐	☐	Do you or the father of this pregnancy have any medical problems? (Examples: diabetes, seizures, heart conditions)
☐	☐	☐	Have you or the father of this pregnancy ever been screened for sickle cell trait, cystic fibrosis, thalassemia, Canavan disease or Tay-Sachs disease?
☐	☐	☐	Have you or the father of this pregnancy had *two or more* pregnancies that ended in miscarriage or still birth?
☐	☐	☐	Have you and the father of this pregnancy had any history of infertility?
☐	☐	☐	Have you ever had an amniocentesis or chorionic villus sampling?
☐	☐	☐	Are you and the father of this pregnancy related (for example, as cousins)?

IV. FAMILY HISTORY: Is there a history of any of the following conditions in you family or that of the father of this pregnancy (living or not)? Please include all relatives, including yourself, the father of this pregnancy, your children, patents, brothers, sisters, their children, aunts, uncles and cousins.

Yes	No	Not Sure/ Do not know	
☐	☐	☐	Any birth defects (such as cleft lip, spina bifida, heart defect)
☐	☐	☐	Stillbirth or childhood death
☐	☐	☐	Chromosome disorder (for example, Down syndrome)
☐	☐	☐	Bleeding disorder of Sickle cell, Thalassemia, Anemia, etc
☐	☐	☐	Multiple miscarriages
☐	☐	☐	Cystic fibrosis (a severe childhood lung disease), Tay-Sachs or Canavan disease
☐	☐	☐	Mental retardation, learning problems or autism
☐	☐	☐	Blindness or deafness
☐	☐	☐	Bone or skeletal disorder
☐	☐	☐	Nerve or muscle disorder, including neurofibromatosis or muscular dystrophy
☐	☐	☐	Breast, ovarian or colon cancer
☐	☐	☐	(Poly) cystic kidney disease or other kidney disorders
☐	☐	☐	Anything that seems "to run in the family"

Use this space to explain any **Yes** answers above or list any concerns you have about this pregnancy:

FOR OFFICE USE ONLY

Reviewed with patient by _____ Date _____ Patient alone / accompanied by _____

Translator: _____

Carrier Screening in Pregnancy for Common Genetic Diseases

Although most people have healthy babies, with every pregnancy there is a 3-4% chance to have a baby born with problems. The following are a few common, serious disorders that can occur even without a family history. You can have carrier screening (a simple blood test) before the baby is born to determine if you *carry* the genes that cause the disorders shown below.

What is a carrier?
A carrier is a person who has a gene that increases the risk to have children with a specific genetic disease. People do not know if they are carriers until they have a blood test or an affected child. Some disorders occur only if both parents are carriers and other disorders occur only when the mother is a carrier.

What is carrier screening?
Carrier screening involves a blood test from one or both parents to determine if they carry a specific gene that increases the risk for that disorder. If you turn out to be a carrier, prenatal testing such as amniocentesis or chorionic villus sampling (CVS) is available to determine if your unborn baby is affected. All testing is optional and you can choose which disorder(s) for which you want to be tested.

Disease	Cystic Fibrosis (CF)		Spinal Muscular Atrophy (SMA)
Symptoms of Disease	*Most common inherited disease in North America.* A chronic disorder that primarily involves the respiratory, digestive and reproductive systems. Symptoms include pneumonia, diarrhea, poor growth and infertility. Some people are only mildly affected, but individuals with severe disease may die in childhood. With treatments today, people with CF can live into their 20's and 30's. CF does not affect intelligence.		*Most common inherited cause of infant death.* SMA destroys nerve cells that affect voluntary movement. Infants with SMA have problems breathing, swallowing, controlling their head or neck, and crawling or walking. The most common form of SMA affects infants in the first months of life and can cause death between 2 and 4 years of age. Less commonly the disease starts later and people can survive into adulthood. SMA does not affect intelligence. There is no cure or treatment.
Inheritance	If both parents are carriers, there is a 1 in 4 (25%) chance to have a child with cystic fibrosis.		If both parents are carriers, there is a 1 in 4 (25%) chance to have a child with SMA.
General Population Carrier Frequency	1 in 25 Caucasians 1 in 26 Ashkenazi Jewish 1 in 46 Hispanics 1 in 65 African Americans ~1 in 90 Asian		1 in 54 persons Occurs in all ethnic backgrounds
Have you ever had testing for this condition? (please circle one)	YES NO Not Sure		YES NO Not Sure
Do you want this testing or more information?	YES NO		YES NO

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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:** _____

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POMONA VALLEY PERINATAL CENTER
1798 North Garey Avenue
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Why Tdap During Pregnancy

Currently there is a whooping cough epidemic in California.

Your baby will very likely be exposed to Whooping cough after he/she is born.

Whooping cough is very dangerous for newborn babies often times requiring hospitalizations and sometimes causing death.

It is very important to protect your baby before it is born. You can protect your baby by receiving the Tdap Vaccine between 26-37 weeks of pregnancy.

When you get the vaccine you make antibodies which will be transferred to your baby and protect him /her against the whooping cough when he/she is born.

With the vaccine your baby is less likely to get sick but if he/she does get sick he/she will not be as sick as if you do not take the vaccine.

It is also important to make sure that anyone who will be handing your baby is current on their Tdap Vaccines. Please make sure that they are current prior to you baby being born.

Actualmente hay una epidemia de tos ferina en California.
Es muy probable que su bebé esté expuesto a la tos ferina después de que él / ella nazca.
La tos ferina es muy peligrosa para los bebés recién nacidos a menudo requieren hospitalizaciones y algunas veces causa la muerte.
Es muy importante proteger a su bebé antes de que nazca. Usted puede proteger a su bebé recibiendo la vacuna Tdap entre 26 a 37 semanas de embarazo.
Con la vacuna usted produce anticuerpos que serán transferidos a su bebé y lo protegeran contra la tos ferina cuando nazca /.
Con la vacuna tiene menos probabilidad de que so bebé se enferme y si se enferma no será tan grave como si usted no toma la vacuna.
También es importante asegurarse de que cualquier persona que se encarga de su bebé, este al día en sus vacunas Tdap. Por favor, asegúrese de que están al día antes de haber nacido su bebé.

目前在加州有百日咳疫情。
您的寶寶很可能在出生后感染到百日咳。
百日咳對新生嬰儿很危險，通常需要住院治療，有時甚至造成死亡。
在寶寶出生前做好保護是非常重要的。您可以通過在26～37周的妊娠期间接種Tdap

SGV Perinatal
Medical Group, Inc.

Risks Associated With Maternal Obesity (BMI >30)

In Pounds and Inches			
Height (inches)	Overweight Point (lbs)	Obesity Point (lbs)	Severe Obesity Point (lbs)
4' 9"	115.29	138.35	184.47
4' 10"	119.38	143.25	191
4' 11"	123.53	148.23	197.64
5' 0"	127.75	153.3	204.4
5' 1"	132.04	158.45	211.27
5' 2"	136.41	163.69	218.25
5' 3"	140.84	169.01	225.35
5' 4"	145.35	174.42	232.56
5' 5"	149.93	179.91	239.89
5' 6"	154.58	185.49	247.32
5' 7"	159.3	191.16	254.88
5' 8"	164.09	196.91	262.54
5' 9"	168.95	202.74	270.32
5' 10"	173.88	208.66	278.21
5' 11"	178.89	214.66	286.22
6' 0"	183.96	220.75	294.34
6' 1"	189.11	226.93	302.57
6' 2"	194.32	233.19	310.92

BMI = (weight in pounds/ (height in inches x height in inches))x703

A BMI less than 18.5 is *underweight*

A BMI of 18.5–24.9 is *normal weight*

A BMI of 25.0–29.9 is *overweight*

A BMI of 30.0–39.9 is *obese*

A BMI of 40.0 or higher is *severely (or morbidly) obese*

Weight gain recommendations during pregnancy by weight status

underweight BMI less than 18.5	27-40 lbs
normal weight BMI of 18.5–24.9	25-35 lbs
overweight BMI of 25.0–29.9	15-25 lbs
obese BMI of 30.0–39.9	less than 15 lbs

Increased risks for the Mother:

- Miscarrige
- Diabetes
- Preeclampsia
- Hypertension
- Blood clots: Stroke, pulmonary embolism
- Induction
- Cesarean Delivery
- Complications from anesthesia
- Hemorrhage
- Wound infection
- Death

Increased risks for the Infant:

- Stillbirth
- Neonatal death
- Birth trauma
- Childhood and adolescent obesity
- Childhood and adolescent diabetes
- [redacted]

Why Breast feeding is important:

- Decreased risk of breast cancer
- Decreased risk of ovarian cancer
- Reach pre pregnancy weight faster
- Healthier Baby
- Convenient
- Less expensive

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