BAYSTATE OB / GYN GROUP, INC. PATIENT OBSTETRICAL HISTORY FORM

Patient name_____ Spouse or partner's name_____
Date of birth_____ Father of baby (FOB)_____
Occupation_____ FOB. Date of birth_____
FOB. Medical history_____

FAMILY MEDICAL HISTORY: Please list A=Alive, W=Well, A/W=Alive & Well, D=Deceased- include cause of death.
YOUR mother_____
YOUR father:_____
SIBLINGS: #B____#S____ _____
ANY known hereditary problems or birth defects in either of your families? YES_____ NO_____
If yes, please explain:_____

MENSTRUAL HISTORY:
Your age at your first period: _____
1st day of your last period: _____
Are your periods regular or irregular? _____ periods every _____ days
How many days do you have a flow? _____
Did you conceive on birth control pills? _____
Date of your positive pregnancy test: _____

SUMMARY OF PREVIOUS PREGNANCIES:

List in order	Year of delivery	FT = Full term PT = premature	Vaginal or C-section	Length of labor	Baby's birth weight	Male or female	Place of delivery
Pregnancy #1							
Pregnancy #2							
Pregnancy #3							
Pregnancy #4							
Pregnancy #5							
Pregnancy #6							

OTHER PREGNANCIES: _____
LIST year of Miscarriage, termination (abortion), Molar, Ectopic

***YOUR* MEDICAL HISTORY**:	check if yes/explain		check if yes/explain	
Diabetes			Pulmonary (TB, Asthma)	
Hypertension			Seasonal allergies	
Heart Disease			Drug / LATEX Allergies	
Kidney Disease / UTI (s)			Surgery	
Neurologic / Epilepsy			Breast issues	
Psychiatric			GYN Surgery	
Depression / Postpartum Depression			Hospitalization (s)	
Hepatitis / Liver Disease			History of abnormal Pap(s)	
Varicosities / Phlebitis			Uterine anomaly / DES	
Thyroid Dysfunction			Infertility	
Trauma / Violence			Relevant Family History	
History of Blood transfusion (s)			OTHER	
CAT(S) in home				
Current smoker (indicate PPD)				
Former smoker (indicate quit date)				

PLEASE COMPLETE ENTIRE FORM AND RETURN TO US. THIS INFORMATION IS NEEDED AT LEAST 3 DAYS PRIOR TO YOUR FIRST APPOINTMENT. THANK YOU.

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Baystate Ob/Gyn Group, Inc.
382 North Main Street
Suite 205
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Baystate Ob/Gyn Group, Inc.
470 Granby Road
South Hadley, MA 01075

Baystate Ob/Gyn Group, Inc.
50 Union Street
West Springfield, MA 01089

Name _____ Date of Birth _____ Date _____

1. Will you be 35 years of age or older when the baby is due? (circle one) Yes No

2. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders?
   - Down's syndrome Yes No
   - Other chromosomal abnormality Yes No
   - Neural tube defect, i.e. spina bifida, anencephaly Yes No
   - Hemophilia Yes No
   - Muscular Dystrophy Yes No
   - Cystic Fibrosis Yes No

   If yes, indicate the relationship of the affected person to you or to the baby's father:
   _____

3. Do you or the baby's father have a birth defect?
   If yes, who has the defect and what is it? _____
4. In any previous marriage, have you or the baby's father had a child born dead or alive with a birth defect not listed in question 2 above? Yes No
   If yes, what was the defect and who had it? _____
5. Do you or the baby's father have any close relatives with mental retardation? + Yes No
   If yes, indicate the relationship of the affected person to you or to the baby's father _____
   _____

6. Do you, the baby's father, or a close relative in either of your families have a birth defect (such as a heart defect), any familial disorder, any familial defect, or a chromosomal abnormality not listed above? Yes No
   If yes, indicate the condition and the relationship of the affected person to you or to the baby's father:
   _____
7. In any previous marriages, have you or the baby's father had a stillborn child or three or more first trimester spontaneous pregnancy losses? Yes No
   Have either of you had a chromosomal study? Yes No
   If yes, indicate who and the results: _____
   _____

8. If you or the baby's father are of Jewish or French Canadian ancestry, have either of you been screened for Tay Sachs disease? Yes No

9. If you or the baby's father are Black or Puerto Rican, have either of you been screened for sickle cell trait? Yes No

10. If you or the baby's father are of Italian, Greek, or Mediterranean background, have either of you been tested for B-Thalassemia? Yes No
    If yes, indicate who and the results: _____

11. If you or the baby's fathers are of Phillipine or Southeast Asian ancestry, have either of you been tested for A-Thalassemia? Yes No
    If yes, indicate who and the results: _____

12. Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period? (Including non-prescription drugs)? Yes No
    If yes, give the name of the medication and time taken during pregnancy: _____

Patient's signature _____ Date _____

OFFICE USE ONLY

Genetic Counseling Offered Yes ___ No ___ Accepted / Declined Initials _____

Baystate Ob/Gyn Group Inc

For Office Use Only

Staff initials_____
☐ Copy given to patient

Financial Understanding For Pregnancy

Congratulations on your pregnancy! Baystate Ob/Gyn Group believes in caring for your physical and emotional needs throughout your pregnancy as well as preparing you for the financial aspect of your pregnancy. This letter is to help you understand how we will bill your insurance company for your pregnancy (and if applicable your baby's circumcision) and to make you aware of things you should know from your insurance company before any unexpected financial surprises should arise.

We will bill for the majority of your pregnancy visits at the end of your pregnancy with a "global" fee. This fee will include our charges for the delivery as well as most of your prenatal visits; any hospital charged related to your pregnancy will be billed for by the hospital. Any labs, ultrasound-related charges, and (if applicable) your baby's circumcision are billed separate from the global fee. In addition, "problem visits" that are unrelated to your pregnancy or above and beyond normal pregnancy care will be treated as a regular office visit, with applicable co-payments.

HIGH DEDUCTBLE INSURANCE PLAN PAYMENT POLICY

Many of our patients are insured through high deductible plans which often assess a substantial deductible or co payment at the time of service. The insurance carrier deducts this amount from the payment creating a patient balance. Baystate Ob/Gyn Group Inc. requires that this balance be paid via a credit/debit card payment. Our OB financial coordinators will review your insurance plan and contact our patients who are insured through a deductible plan prior to the OB history appointment. Any patient whose insurance carries an OB deductible/co-payment will be required to complete a credit/debit card information form and sign our Patient Waiver Collection of Deductible and Coinsurance form prior to her OB history appointment. The following information will be required: A personal credit/debit card number, expiration date and name that appears on the card. (If applicable, you may also provide information from your HRA or HSA account; however, in those cases we will also require information from a personal credit/debit card to be used as a backup). This information will be held securely until your insurance carrier (s) have paid their portion and notified us of your financial responsibility. Your credit/debit card(s) will be charged for any balance owed by you. This will be of great advantage to you since you will no longer have to write out and mail us a check. It will be an advantage to us as well, since it will greatly decrease the number of statements that we generate and send out. This combination will benefit everybody in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Our office makes every effort to pre-certify your pregnancy; this does not mean that your insurance company will cover 100% of the charges related to your pregnancy. While we make every attempt to work with your insurance company to insure payment, it remains your responsibility to fully understand your health insurance policy and guidelines regarding coverage. We suggest that you refer to an up-to-date insurance policy handbook or contact your insurance company to review pregnancy related coverage (including newborn circumcision if applicable). You are responsible for notifying us of any change in insurance coverage and or insurance eligibility. Please note that non-compliance with this policy may result in cancellation or postponement of your obstetrical history appointment.

If you have any questions regarding our billing procedures, please do not hesitate to contact our business office.

_____
Patient Name

_____ _____
Patient Signature Date