



Precious Life Medical Services, LLC
Precious Perinatology, LLC

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New Patient Packet

One form, one signature (Section 5). Your name, date of birth and contact details are only needed in Section 1.

Section 1 | Patient Information

Patient Name: Last _____ First _____
Date of Birth: _____ SSN: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ Email: _____
Emergency Contact Name: _____ Emergency Contact Phone: _____
Primary Care Provider: _____ OB Provider: _____
Insurance Information: _____ Member ID: _____

Section 2 | OB Intake

Current Pregnancy Information

First day of last menstrual period (LMP): _____ Estimated due date (EDD): _____
Cycle regular? ☐ Yes ☐ No Height: _____ Weight: _____
How was pregnancy confirmed? ☐ Home test ☐ Office test ☐ Ultrasound
Are you currently experiencing: ☐ Bleeding ☐ Cramping ☐ Other: _____

Obstetric History (Previous Pregnancies)

Total number of pregnancies including current pregnancy: _____
Total number of: _____
Full term deliveries: _____ Preterm deliveries: _____ Miscarriages: _____ Abortions: _____
Ectopic: _____ Cesarean sections: _____ Stillbirths: _____ Multiple births (twins): _____
☐ Preeclampsia _____ ☐ Gestational diabetes _____ ☐ Postpartum depression _____

Medical History

Hypertension	☐ Yes ☐ No	Heart disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Autoimmune disorder	☐ Yes ☐ No
Thyroid disorder	☐ Yes ☐ No	Seizure disorder	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Other: _____	☐ Yes ☐ No

Current medications: _____

Allergies (medications/food/latex): _____

Surgical History – Prior surgeries (type & year): _____

Family / Personal History

Diabetes	☐ Yes ☐ No ☐ Self ☐ Family	Birth defects	☐ Yes ☐ No ☐ Self ☐ Family
Hypertension	☐ Yes ☐ No ☐ Self ☐ Family	Blood clotting disorders	☐ Yes ☐ No ☐ Self ☐ Family
Genetic disorders	☐ Yes ☐ No ☐ Self ☐ Family	Mental health disorders	☐ Yes ☐ No ☐ Self ☐ Family

Social History

Marital/Partner status: _____ Occupation: _____
Tobacco use? ☐ Current ☐ Former ☐ Never Alcohol use? ☐ Yes ☐ No Recreational drug use? ☐ Yes ☐ No

Genetic & Screening History

Cystic fibrosis ☐ Yes ☐ No Sickle cell disease ☐ Yes ☐ No Tay-Sachs ☐ Yes ☐ No
Other inherited conditions: _____

Patient Name: _____

Date of Birth: _____

Section 3 | Financial Responsibility Form**1. Individual's Financial Responsibility**

- a. I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service
- b. Co-payments are due at time of service
- c. If my plan requires a referral, I must obtain it prior to my visit.
- d. In the event that my health plan determines a service to be "not payable". I will be responsible for the complete charge and agree to pay the costs of all services provided.
- e. If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.
- f. If Precious Life Medical Services is out of network, I am responsible for the payment of uncovered procedures.

2. Insurance Authorization For Assignment of Benefits

I hereby authorize and direct payment of my medical benefits to Precious life Medical Services on my behalf for any services furnished to me by the providers.

3. Authorization To Release Records

I hereby authorize Precious Life Medical Services to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical providers.

4. Medicare Request for Payment

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished by me or in Precious Life Medical Services. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Section 4 | HIPAA Authorization to Release Protected Health Information

I HEREBY REQUEST A COPY OF THE FOLLOWING PATIENT'S MEDICAL RECORD. (Patient: the person named in Section 1.)

INFORMATION TO BE RELEASED: This authorization includes release of information concerning treatment of psychiatric/psychological conditions, drug and/or alcohol related conditions, and HIV or AIDS related conditions.

Date of service or date ranges requested: _____

☐ Discharge Summary	☐ Pathology Reports	☐ Medical Imaging
☐ History & Physical	☐ Laboratory Reports	☐ Other
☐ Face Sheet	☐ Immunization Records	☐ Entire Medical Record
☐ Emergency Department Record	☐ Outpatient Records	☐ Personal Interest
☐ Operative Reports	☐ Itemized Bill	☐ Insurance Claim Processing
☐ Continue Medical Care	☐ Legal Claim Processing	☐ External Quality/Utilization Review

Other (Specify): _____

Section 5 | Acknowledgment, Agreement and Signature

By signing below, I confirm that the information I have given in this packet is accurate and complete, and that I have read, understand and agree to the **Financial Responsibility Form (Section 3)** and the **HIPAA Authorization to Release Protected Health Information (Section 4)**.

Signature of Patient or Authorized Representative

Date

Print Name of Patient or Authorized Representative

Relationship to Patient