metro OBGYN

OB INFORMATION FORM

DOWNTOWN_____ WOODBURY_____

MAPLEWOOD_____ APPLE VALLEY_____

PATIENT NAME:_____

DOB:_____

ACCOUNT NUMBER:_____

METRO OB/GYN PHYSICIAN NAME:_____

DATE OF LAST MENSTRUAL PERIOD:_____

DUE DATE:_____

NUMBER OF PREGNANCIES(INCLUDING THIS ONE):_____

PREVIOUS C-SECTION YES_____ NO_____

INSURANCE COMPANY:_____

REFERRING PHYSICIAN:_____

PRIMARY CARE CLINIC:_____

WHAT HOSPITAL WILL YOU DELIVER AT?

UNITED_____ST JOHNS_____WOODWINDS_____RIVER FALLS_____

PLEASE ROUTE TO THE CODING DEPARTMENT.

FOR BILLING USE ONLY

HOSP ADM DATE:_____ DELIVERY DATE:_____ D/C DATE:_____

HOSPITAL: UHI—NE—WW—RF PHYSICIAN: _____ DELIVERING PHYSICIAN:_____

CPT:_____ DIAGNOSIS: _____

_____ _____

_____ _____

_____ BMI @ FIRST OB_____ _____

Updated 6/7/2018

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GLOBAL OB PACKAGE

Metro OB/GYN bills under the Global OB Package. The package includes the following services:

All Uncomplicated office visits
Urinalysis
Delivery of infant
Six week post partum check

Fee for vaginal delivery and OB care: $5698.00
Fee for Caesarean Section and OB care: $6324.00

At the end of your pregnancy we will bill one fee to either you or your insurance company for this package.

There are some services that may be performed during your pregnancy that **are not included** in the global package. They are the following:

The Initial OB visit
Ultrasounds
Non Stress Tests
AFP/Triple screen
Glucose Tolerance Test
Any lab work other than a urinalysis
Pap Smear

If you have any questions regarding this please contact our business office at 651-265-6750.

Signature Date

Prices are subject to change effective the 15th of each new year. This will affect those patients signing in one year and delivering in another.

Updated 5/24/19

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GENETIC AND FAMILY HISTORY

Patient Name _____ DOB _____ Date _____

Attitude towards Pregnancy: ☐ Planned ☐ Unplanned ☐ Plan to parent/keep ☐ Adoption

Drug use: (Past/Current):

Tobacco	☐Y	☐No	Prepregnancy amt. _____	Pregnancy amt. _____	Yrs. total use _____
Alcohol	☐Y	☐No	Prepregnancy amt. _____	Pregnancy amt. _____	Yrs. total use _____
Caffeine	☐Y	☐No	Prepregnancy amt. _____	Pregnancy amt. _____	Yrs. total use _____
Street Drugs	☐Y	☐No	Prepregnancy amt. _____	Pregnancy amt. _____	Yrs. total use _____

Herbal Supplements Current/Past _____

Have you or any members of your family been born with or affected by any known genetic problem, retardation, birth defects, or major medical problems?

	Patient	*Father of Baby*	*Family*
1. Patient's age • 35 yrs or over	☐		
Father of baby • 50 years or over		☐	
2. Italian, Greek Mediterranean or Asian background (thalassemia): …….....	☐	☐	
3. Ashkenazi, Jewish, Cajun, Fr. Canadian background (Tay Sachs)? …….....	☐	☐	
4. African or Latin American background (sickle cell)?	☐	☐	
5. Down syndrome or other chromosomal problem?	☐	☐	☐
6. Hemophilia or other bleeding disorder?	☐	☐	☐
7. Muscular dystrophy or anyone in family in a wheelchair?	☐	☐	☐
8. Cystic fibrosis or any other metabolic disorder?	☐	☐	☐
9. Huntington's Chorea?	☐	☐	☐
10. Mental retardation or autism?	☐	☐	☐
11. Maternal medical problems? (diabetes, lupus, epilepsy, PKU, etc.) …….	☐		
12. Other inherited genetic or chromosomal disorder?	☐	☐	☐
13. Child with birth defects not listed above? ……	☐	☐	☐
14. Patient or Father of Baby with birth defect? …….....	☐	☐	
15. More than 3 first trimester spontaneous abortions or a stillbirth?	☐		☐

Infection History	Yes	No
Do you live with someone that has or ever been exposed to TB?	☐	☐
Have you ever had chicken pox?	☐	☐
Have you received chicken pox (Varicella) Vaccine?	☐	☐
Have you had a rash or any viral illness since LMP?	☐	☐
Have you ever been diagnosed with an STD?	☐	☐
Do you have cats in your home?	☐	☐
Do you have close contact with young children on a regular basis?	☐	☐