Inside Passage Midwifery
853 Basin Road Juneau, AK 99801
phone: (907) 463-2600
fax:: (907) 463-2675

Client Registration

Date: _____ Social Security Number: _____
Name: First _____ Middle. _____ Last: _____
Address: _____ City: _____ Zip: _____
Mailing Address: _____
Home Phone: _____ Cell/other phone: _____
Birth date: _____ Marital Status: _____ email: _____
Employer: _____ Occupation _____
Work Status: Full ___ Part time___ Retired___ Student____
Spouse/Partner's Name: _____ Occupation: _____
Emergency Contact: _____ Phone: _____

Responsible Party (Primary Insurance Holder. If same as above leave blank)
First Name: _____ M.I.___ Last Name: _____
Address: _____
Home Phone: _____ Birth date: _____ Marital Status: S M D W
Social Security Number: _____ Employer: _____
Occupation: _____
Work Status: Full___ Part time___ Retired____ Student___

Payment and Insurance Information

Primary Insurance: _____
Address: _____
Phone Number: _____
ID#: _____ Group Name: _____ Group #: _____
Policy Holder: _____ Birth date: _____ Relation: _____

Other Insurance: _____
Address: _____
Phone number: _____
ID#: _____ Group Name: _____ Group #: _____
Policy Holder: _____ Birth date: _____ Relation: _____

Assignment of Benefits, Release of Information & Payment Agreement

I understand that Inside Passage Midwifery and Natural Medicine will be filing my insurance on my behalf. I agree to have the benefits from my insurance assigned to Inside Passage.

I permit Inside Passage to release any information deemed necessary to any insurance or third party, within the guidelines of HIPAA (Health Insurance Portability & Accountability Act)

I agree that I am responsible for full payment on this account. I agree if 60 days pass without payment or discussion of a payment plan, my account will be sent to collections and I will be responsible for the outstanding balance and any fees incurred in the collections process.

Client signature: _____ Date: _____

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How to Reach Your Midwife

Cell Phone: (907) 321-2041
Email: gillespiend@gmail.com

1. If you have concerns about your pregnancy or baby, please feel free to call or text me on my cell phone any time of day or night.

2. If you are in labor or think you may be in labor, please call my cell phone. I don't typically wake up to texts.

3. During regular business hours, 9am-5pm Monday – Friday, please feel free to call or text

4. If you have a non-urgent question or concern outside of regular business hours, please email me or wait until regular business hours. I value my family time and try hard not to interrupt it with texts that can wait.

5. If you do text me and I don't respond, please call me if you need immediate attention. If you have texted me and I don't respond during regular business hours, please call or text to remind me.

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Inside Passage Midwifery

Name: _____ Date: _____

What was the first day of your last menstrual period? _____
Are you sure of the date? _____
Was your period normal in length and flow? _____
Are your cycles regular? _____
How many days in your cycle? _____
How many days do your normally bleed? _____
Date of positive pregnancy test: _____
What day do you think you conceived? _____
Is this a planned pregnancy? _____
Most recent birth control used: _____
Past Contraception: type, when, any problems: _____
_____

Previous Pregnancies:
Total number of past pregnancies _____
Full term deliveries: _____
Premature deliveries: _____
Miscarriages: _____
Therapeutic Abortions: _____
Cesarean section: _____
Twins: _____
Number of living children: _____

	1	2	3	4
Name of child				
Date of birth				
Boy or Girl?				
Weight at birth				
Home/hospital/birth center				
Length of labor				
Anesthesia/medications				
Episiotomy or tears?				
Breastfed? How long?				
Any Complications? High blood pressure, pre-eclampsia, shoulder dystocia, hemorrhage, retained placenta, Problems with baby or breastfeeding, etc.				

Name: _____ Date: _____

Medical History

Please mark if you have any of the following conditions. In the space below record date, treatment and any follow-up care received. Also feel free to list any other conditions or concerns:

____ Endocrine: diabetes, disorders involving thyroid, adrenal, pituitary or parathyroid glands, etc.
____ Cardiovascular: high blood pressure, heart or valve problems, chest pain, etc.
____ Gastrointestinal: abdominal pain, constipation, colitis, GERD/reflux, ulcers, etc
____ Genitourinary: bladder infections, kidney infections, kidney stones, etc,
____ Hematological: anemia, bleeding disorders, blood transfusions, thrombophlebitis, Rh disease. etc.
____ Musculoskeletal: fractures, neck problems, back problems, scoliosis, injuries, arthritis, fibromyalgia
____ Pulmonary: asthma, cough, pneumonia, pulmonary embolism, tuberculosis, etc.
____ Neurological: epilepsy, seizure, strokes, neuropathy, headaches, head injury, etc.
____ Autoimmune: lupus, multiple sclerosis, rheumatoid arthritis, celiac disease, etc
____ Dermatological: eczema, allergy, psoriasis, warts, skin tags, etc.
____ Mental/Emotional: depression, anxiety, eating disorders, addictions, postpartum depression, etc.
____ Other: accidents, surgery, significant illness, domestic violence, etc.

_____
_____
_____
_____
_____
_____
_____

Gynecologic History:

How old were you when you had your first menstrual period? _____
When was your last Pap? _____
Have you ever had an abnormal Pap? _____
If yes please explain _____

Please check if you've ever had any of the following conditions or procedures:

	Yeast infection		Pelvic Inflammatory disease		Uterine fibroids
	Bacterial vaginosis		Cervicitis		Uterine surgery
	Chlamydia		Cervical polyps		Breast lumps
	Gonorrhea		Ovarian cysts		Breast surgery
	Syphilis		Polycystic ovarian syndrome, PCOS		Repeated miscarriage
	Trichomonas		Endometriosis		Infertility
	Genital herpes		Abnormal bleeding		Other
	Genital warts		Cervical surgery/LEEP		
	Group B strep		HPV: human papilloma virus		

Name: _____ Date: _____

Allergies

Do you have any allergies to medications or foods?_____

Surgical History: Please list any past surgical procedures and dates: _____

Family History

Father: Alive and well? Y N If no explain: _____
Mother: Alive and well? Y N If no explain: _____
How many pregnancies did your mother have? _____ How many miscarriages? _____
How many times did she give birth? _____ Did she have any C-sections? _____
Siblings: Alive and well? Y N If no explain _____

Please check if you have a family history of the following conditions:

____ Diabetes _____
____ Hypertension _____
____ Cancer _____
____ Blood Disorder _____
____ Congenital Anomalies _____
___ Twins _____
___ Down's syndrome _____
___ Genetic Disorders _____
___ Cystic Fibrosis _____
___ Neural Tube defects _____

Current Pregnancy Problems and Exposures:

Please check if you've had any of these problems in this pregnancy

	Nausea	Constipation	Anemia	Backache	Depression
	Vomiting	Hemorrhoids	Fatigue	Sciatic nerve pain	Anxiety
	Vaginal bleeding	Varicose veins	Weakness	Leg cramps	Relationship issues
	Uterine cramping	Diarrhea	Fainting	Swelling	Family issues
	Bladder infection	Heartburn	Vaginal discharge	Headache	Work issues
	Kidney infection	Poor appetite	Vaginal infection	Dizziness	Difficulty sleeping
	Fever	Indigestion	Pelvic pain	Breast pain	Other

Have you used or been exposed to any of the following during this pregnancy?

	Prenatal vitamins	Nutritional supplements	Marijuana	Ultrasound
	Prescription Medication	Caffeine	Street drugs: cocaine, oxycontin, methamphetamine, etc.	Chemicals, fumes, sprays
	Over the counter medications	Alcohol	Vaccinations	Cat litter
	Herbal Medicines	Tobacco	X-rays	Other

Name: _____ Date: _____

Y N – Have you had a previous baby with birth defect or mental retardation?
Y N – Do you have a history of genetic or inherited conditions or genetic counseling?
Y N – Do you have a history of hepatitis?
Y N – Do you have a history of IV drug use or blood transfusion?
Y N – Do you have a history of a sexual partner who used IV drugs, had bisexual relations or blood transfusions?
Y N – Have you had a history of anorexia, bulimia or other eating disorder?
Y N – Have you ever been in an abusive relationship, including now, or been abused – physically, emotionally, sexually

Do you know where you plan to give birth? Home, hospital, birth center?

_____

_____

If no, what information or support do you need to help you in making this decision?

_____

_____

How do you feel about this pregnancy?

_____

_____

How does your partner feel about this pregnancy?

_____

_____

Are there any particular ethnic, cultural or religious preferences for your care that you'd like to discuss?

_____

_____

Do you feel you have adequate resources for this pregnancy, i.e. food, shelter, money?

_____

_____

Why did you choose to see me?

_____

_____

What expectations do you have of me professionally as your midwife?

_____

_____

_____

Name: _____ Date: _____

What is your present level of commitment to address any lifestyle issues that may relate to your pregnancy? Rate from 0 to 10, 10 being 100% committed

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What behavior or lifestyle habits do you currently engage in regularly that you believe are detrimental to your pregnancy?

_____

_____

_____

Do you feel you have people in your life that will sincerely and consistently support you during this pregnancy?

_____

_____

_____

Many people seek midwifery care because they believe pregnancy and birth to be a normal natural process. As a naturopathic doctor I have knowledge of various nutrients, herbs and homeopathic remedies that may be helpful and supportive of your pregnancy and birth. Would you be interested in suggestions or taking additional supplements during your pregnancy?

_____

_____

_____

Thank you for taking the time to complete these many forms. I look forward to providing you with the best possible care. If there is anything else you would like to add at this time please do so here.

_____

_____

_____

_____

_____

_____

_____