



Hackensack Meridian Health Pediatric Associates, P.C. Specialty Care Center
Patient Registration

PERSONAL INFORMATION

Patient Name: (Last) _____ (First) _____ (Middle) _____

Birth date: _____ Sex: M or F Marital Status: S M D W

Language: _____

Race: American Indian/Alaska Native Native Asian Black/African American
 Hawaiian /Other Pacific Islander White Choose not to answer

Ethnicity: Hispanic/Latino Not Hispanic/Latino Choose not to answer

Address: (Street) _____ (City/State) _____ (Zip) _____

Preferred Phone: _____ Type: Cell or Home or Business Preferred Method of Contact: Phone or US Mail

E-mail: _____ Employment Status: _____

Guarantor Name: _____ Relationship to Guarantor: _____

Guarantor Address: (Street) _____ (City/State) _____ (Zip) _____

Emergency Contact: _____ Phone: _____ Relationship: _____

AKA/Nickname: _____ Patient Needs: _____

Referring Physician: _____ Address: _____

INSURANCE INFORMATION

Primary Insurance Co. Information: (name, address and phone # of person responsible for payment)

Insurance Company Name: _____ Phone: _____

Policy/ID Number: _____ Group #: _____ Effective Date: _____

Subscriber's Name: _____ Relationship to Patient _____

Subscriber's DOB: _____ Subscriber's Sex: _____

Address: _____ Phone: _____

Subscriber's Employer: _____

Secondary Insurance Co. Information: (name, address and phone # of person responsible for payment)

Insurance Company Name: _____ Phone: _____

Policy/ID Number: _____ Group #: _____ Effective Date: _____

Subscriber's Name: _____ Relationship to Patient _____

Subscriber's DOB: _____ Subscriber's Sex: _____

Address: _____ Phone: _____

Subscriber's Employer: _____

Signature: _____ Date: _____



Hackensack
Meridian *Health*
K. Hovnanian
Children's Hospital

Hackensack Meridian *Health* Pediatric Associates, P.C. Specialty Care Center

CONSENT FOR TREATMENT:

I acknowledge that I have elected on my own behalf or on behalf of my dependent to receive medical services that may or may not be covered by my health plan for any number of reasons.

I understand and acknowledge that I am financially responsible for, and therefore shall pay for, all services rendered to me or my dependent that are not paid or contractually adjusted by my insurance, in whole or in part, by my health plan for any reason whatsoever.

RELEASE OF INFORMATION:

I authorize the release of all information necessary to process my insurance claims and pertinent to my medical care. This release will remain in effect until revoked by me in writing. A photocopy of this release is to be considered as valid as the original.

ASSIGNMENT OF BENEFITS:

I assign all medical and/or surgical benefits including major medical benefits to which I am entitled, including Medicare, BCBS, HMO plans, and commercial insurance to Meridian Pediatric Associates, P.C. This assignment will remain in effect until revoked by me in writing. I hereby authorize the above to release information to secure payment on my behalf.

I understand that I am financially responsible for all charges. I have read this information and understand it.

Patient Name:

DOB:

Signature:

Signature of Parent or Guardian (if patient is a minor):

Date:



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Acknowledgment of Receipt of Notice and Approval of Privacy Practices

I, _____, hereby acknowledge that I have received the corresponding HIPAA Notice of Privacy Practices. I also further approve the uses and disclosures of my PHI as described in the HIPAA Notice of Privacy Practices.

Date: _____

Signature of Patient or Representative:

Patient Contact Authorization

I, _____, authorize and give permission to Meridian Pediatric Associates, P.C., or any practice staff members, to leave messages regarding my medical information on the following telephone(s):

Home: (_____) _____

Cell: (_____) _____

I authorize and give permission to Meridian Pediatric Associates, P.C., or any practice staff member, to speak with the following people regarding my medical status and/or treatment:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____

Date: _____



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Permission to Receive Pre-Recorded Messages and/or Text Messages

As a service to our patients, we provide courtesy appointment reminder calls and, when we can, text messages. We also may place other important calls and send text messages using a pre-recorded or automated message. In order to authorize receiving the calls and messages, please fill out the information below and provide the phone number where you wish to receive these messages.

Important note: By providing your cell phone number below, you consent to receiving appointment reminder calls, important calls and/or text messages on your cell phone. If you would like us to utilize a different number, please provide that number below *instead of* your cell phone number.

This authorization permits us to leave messages, call or text you on the phone number that you provide below. If you provide your cell phone number, you will receive automated or pre-recorded messages on your cell phone. We are required by law to advise you of this.

You do not need to sign this authorization; however, if you do not sign this authorization, we will not be able to provide you with courtesy reminder calls, text messages or other important calls.

Patient name:

Signature:

Signature of Parent or Guardian (if patient is a minor):

Phone number authorized by Patient or Patient Guardian to receive calls and message as set forth above:

Cell Phone Number:

Telephone Number:

Date:



Hackensack
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Hackensack Meridian *Health* Pediatric Associates, P.7. Specialty Care Center

Center for Breastfeeding

61 Davis Avenue, Neptune, New Jersey 07753

732-776-3329

27 South Cooks Bridge Road, Suite 2-20, Jackson, NJ 08527

732-987-5705

We thank you for choosing our office to help serve you and your child's needs. While our office participates with many insurance companies, there are some insurance plans that will not cover lactation services. As a service to you, we will bill all insurances. However, you are financially responsible for the services rendered if your insurance company declines payment. We suggest you confirm with your insurance company if this is a covered service.

By signing below you agree to accept full financial responsibility as a parent/guardian of a patient who is receiving services. Your signature verifies that you are the responsible party for the patient and that you have read the above disclosure statement, understand your responsibilities and agree to these terms.

Child Name (Print):

Parent Name (Print):

Parent Signature:

Date:

Edinburgh Postnatal Depression Scale¹ (EPDS)

Name: _____ Address: _____
Town/Zip _____ Phone: _____
Your Date of Birth: _____ Baby's Date of Birth: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- Yes, all the time
- Yes, most of the time This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.
- No, not very often
- No, not at all

In the past 7 days:

- | | |
|---|--|
| <p>1. I have been able to laugh and see the funny side of things</p> <ul style="list-style-type: none"><input type="checkbox"/> As much as I always could<input type="checkbox"/> Not quite so much now<input type="checkbox"/> Definitely not so much now<input type="checkbox"/> Not at all <p>2. I have looked forward with enjoyment to things</p> <ul style="list-style-type: none"><input type="checkbox"/> As much as I ever did<input type="checkbox"/> Rather less than I used to<input type="checkbox"/> Definitely less than I used to<input type="checkbox"/> Hardly at all <p>*3. I have blamed myself unnecessarily when things went wrong</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, some of the time<input type="checkbox"/> Not very often<input type="checkbox"/> No, never <p>4. I have been anxious or worried for no good reason</p> <ul style="list-style-type: none"><input type="checkbox"/> No, not at all<input type="checkbox"/> Hardly ever<input type="checkbox"/> Yes, sometimes<input type="checkbox"/> Yes, very often <p>*5 I have felt scared or panicky for no very good reason</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, quite a lot<input type="checkbox"/> Yes, sometimes<input type="checkbox"/> No, not much<input type="checkbox"/> No, not at all | <p>*6. Things have been getting on top of me</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time I haven't been able to cope at all<input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual<input type="checkbox"/> No, most of the time I have coped quite well<input type="checkbox"/> No, I have been coping as well as ever <p>*7 I have been so unhappy that I have had difficulty sleeping</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, sometimes<input type="checkbox"/> Not very often<input type="checkbox"/> No, not at all <p>*8 I have felt sad or miserable</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, quite often<input type="checkbox"/> Not very often<input type="checkbox"/> No, not at all <p>*9 I have been so unhappy that I have been crying</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, quite often<input type="checkbox"/> Only occasionally<input type="checkbox"/> No, never <p>*10 The thought of harming myself has occurred to me</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, quite often<input type="checkbox"/> Sometimes<input type="checkbox"/> Hardly ever<input type="checkbox"/> Never |
|---|--|

Administered/Reviewed by _____ Date _____

1

Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

2

Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Users may reproduce the scale without further permission providing they respect copyright by quoting the names of the authors, the title and the source of the paper in all reproduced copies.

**Hackensack Meridian *Health* Pediatric Associates
P.C. Specialty Care Center**

Center for Breastfeeding

732-776-3329

61 Davis Avenue, Neptune, New Jersey 07753

732-776-4860

27 South Cooks Bridge Road, Suite 2-20, Jackson, NJ 08527

732-987-5705



Hackensack
Meridian *Health*
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Children's Hospital

Name: _____

Phone: _____

Email: _____

Thank you for coming to the Center for Breastfeeding. We are asking our clients to complete the following questions to help us identify and manage your breastfeeding difficulties in the most efficient way possible.

Today's Date: _____ Your Obstetrician/Midwife: _____

Your Child's Pediatrician: _____ Office Location: _____

Why are you being seen today: Painful nursing Baby not gaining weight well Low milk production Latch issues Other (please explain) _____

General Medical History

In the list below, place a check in the "YES" column and fill out further details as appropriate.

	YES	If yes, please explain
I have had breast surgery:		If yes, was it to: Reduce the size of your breasts? Increase the size of your breasts? Another type of breast surgery? (specify)
I have breast pain when I am not pregnant or breastfeeding.		
My breasts are painful in the cold.		
My fingers turn white or pale in damp or cold weather.		
I have irregular periods (less than 25 days/more than 35 days).		
I have Polycystic Ovarian Syndrome (PCOS.)		
I have been treated for a vaginal yeast infection (ever).		If yes, how many times? Fewer than 5 times More than 5 times
I have had another surgery, other than a C/Section.		(Specify)

I have thyroid problems.	YES	If yes: (low) hypothyroid (high) hyperthyroid Other (specify):
I am allergic to some medications.		If yes, please list:
I have environmental allergies.		If yes, what are you allergic to? Please list:
I have allergies or sensitivities to foods.		If yes, what are you allergic or sensitive to? Please list:
I have been diagnosed with depression, anxiety, or a panic disorder.		If yes, please describe:
I often have pain.		If yes: ___migraines ___pain with sex ___bowel pain ___low back pain ___ pain with periods ___ other (specify):
I have other chronic medical conditions:		If yes, please list:
I am currently taking prescription medications.		If yes, please list:

About You

How old are you? _____years

What is your race/ethnicity? _____

About your birth and your baby

Where did you receive prenatal care? Private Physician/Midwife Hospital Clinic No prenatal care

Where did you give birth?

Jersey Shore University Medical Center Other: _____

How many pregnancies have you had? _____ How many children have you had? _____

How old is your baby today (use days only if under 28 days)? _____ days weeks (circle one)

How many weeks pregnant were you when your baby was born? _____ weeks

What is the sex of your baby? Boy Girl

How did your labor start? I went into labor on my own I was induced I had a scheduled C/S

How was your baby born? Spontaneous vaginal birth Vacuum Forceps C/Section

How long did your labor last? _____ (Hours)

Did your breasts change/get bigger during your pregnancy? Yes No

What was your weight before pregnancy? _____ (pounds)

How tall are you? _____ ft _____ in.

About how much weight did you gain during your pregnancy? _____ (pounds)

How much did your baby weigh at birth? _____ lbs. _____ oz.

How many days after birth did your milk come in? _____ days

What was your baby's lowest weight after birth? _____ lbs. _____ oz.

What was your baby's age with this weight? _____ days

What was your baby's most recent weight? _____ lbs. _____ oz. Date: _____

During an average 24 hour period, how many times did your baby stool? _____ times Wet? _____ times

What color is your baby's stool? black/brown green yellow other _____

Is your baby on medication? Yes No

If yes, please specify: Zantac Prilosec Mylicon Other (please specify):

In the list below, please check everything that applies to your pregnancy and birth.

	YES	
I had complications during my pregnancy.		<input type="checkbox"/> Pre-eclampsia <input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Preterm Labor <input type="checkbox"/> Other: (specify)
I used medications during my pregnancy.		If yes, please list medications:
I used fertility treatment for this pregnancy.		If yes, what treatment?
It took me more than 1 year to get pregnant.		
I received medication during my labor.		If yes, which medications? <input type="checkbox"/> Epidural <input type="checkbox"/> Magnesium <input type="checkbox"/> Narcotics <input type="checkbox"/> Antibiotics <input type="checkbox"/> Other (specify):
I bled a lot after my baby was born.		If yes, how was it treated? <input type="checkbox"/> Blood transfusion <input type="checkbox"/> Iron
My baby was in an unusual position or injured during pregnancy or birth.		If yes, please select: <input type="checkbox"/> Breech <input type="checkbox"/> Posterior <input type="checkbox"/> Asynclitic(head turned) <input type="checkbox"/> Shoulder dystocia <input type="checkbox"/> Bruising <input type="checkbox"/> Don't Know <input type="checkbox"/> Other:
I have taken antibiotics since leaving the hospital or birth center.		If yes, which ones? Why?
My baby has been treated with antibiotics since leaving the hospital or birth center.		If yes, which ones? Why?
My baby has taken medicine for a yeast infection since leaving the hospital or birth center.		If yes, where was it?
I am currently taking herbal supplements, vitamins or non-prescription medications specifically for nursing.		If yes: Which ones? <input type="checkbox"/> Fenugreek <input type="checkbox"/> Blessed Thistle <input type="checkbox"/> Alfalfa <input type="checkbox"/> Malunggay <input type="checkbox"/> Mother's Milk Tea <input type="checkbox"/> Fennel <input type="checkbox"/> More Milk Plus <input type="checkbox"/> Goat's Rue <input type="checkbox"/> Other: (specify)

About your Breastfeeding History

Is this your first baby? ___YES ___NO (If yes, go to next section)

Did you breastfeed your other children? ___YES ___NO

Age of other children:

How old was your youngest baby when you stopped breastfeeding? _____

With one or more of my previous children, I had difficulty with:

___ Low milk supply ___ Mastitis ___ Nipple Pain ___ Yeast Infection ___ Recurrent plugged duct
___ Baby with tongue-tie ___ Other: _____

ABOUT NURSING

If everything was going well, before introducing solids, what was your goal for breastfeeding?

___ Exclusive breast milk only at breast ___ Exclusive breast milk at the breast & pumped milk
___ Breast milk and formula

Comments: _____

Have you seen anyone else for the breastfeeding problems you are currently experiencing?
(specify): _____

Did this person refer you to our care? ___YES ___NO

What has your baby eaten?		Number of feedings in last 24 hours	Comments
Has your baby ever had milk at the breast	YES NO		
Has your baby ever had pumped breast milk	YES NO		
Has your baby ever had infant formula	YES NO		
Has your baby ever had solid foods	YES NO		

Do you pump your breasts? YES NO If so, how often? _____ Number of times in last 24 hours
Usually pump _____oz. from left breast and _____oz. from right breast

If you are not pumping → skip to next section “About your Breastfeeding”

What type of breast pump do you use? _____

How old was your baby when you first began pumping milk? _____ days or _____ weeks

About your Breastfeeding

	All of the time	Some of the time	Rarely	Never
How often does your baby have difficulty latching?				
How often does your baby seem satisfied after breastfeeding?				
How often does the baby soften at least one breast during a feeding?				
How often can you hear the baby swallow during a feed?				
How often do your nipples turn white during/after feeding or pumping?				
How often does your baby have stools that are not yellow?				
How often does your baby have explosive stools?				
How often does your baby spit up?				
How often does your baby have quiet/alert times between feedings?				

How long does your baby typically nurse? _____ minutes

How many times a day does your baby nurse? (circle) 5 6 7 8 9 10 11 12 Other _____

How long is the range between the beginning of one feed and the beginning of the next? _ hrs to _ hrs

Does your baby ever cough or choke at the breast? YES NO

Is your baby distressed at the breast while nursing? YES NO Briefly describe _____

Are you currently waking your baby for feedings? YES NO

Are you currently using a nipple shield? YES NO If yes, size _____ Why? _____

Is your baby currently using a pacifier? YES NO

Is your baby currently being supplemented? YES NO → **If no, skip to About Pain section**

What type of supplementer are you using? ___ syringe feeding ___ cup ___ spoon ___ finger feeding
 ___ supplemental nursing system(SNS) ___ bottle

How much is your baby taking each time he/she is supplemented _____ ml oz. (circle measurement)

About Pain with Breastfeeding

Are you experiencing pain? YES NO → If no, you are done! Thank you!

Currently, is your pain worse on one side than the other?

___worse on left ___worse on rt. ___same on both

When is the pain most intense?

___beginning of feed ___during feed ___after feed ___with pumping ___all the time

Mark the column that represents the degree of pain you are feeling at the following times during the **past 48 hours.**

	None	Mild	Moderate	Severe
Nipple pain while breastfeeding				
Nipple pain while expressing milk				
Nipple pain even while not feeding or expressing milk				
Breast pain while breastfeeding				
Breast pain while expressing milk				
Breast pain even while not feeding or expressing milk				

How would you describe your pain?
