Atlantic
Health System
Atlantic Medical Group

435 South Street
Suite 380
Morristown, NJ 07960
973.971.7080 Phone
973.290.7316 Fax

11 Overlook Road
Suite LL102
Summit, NJ 07901
908.522.5510 Phone
908.522.5557 Fax

792 Chimney Rock Road
Suite A
Martinsville, NJ 08836
973.971.7082 Phone
732.469.0278 Fax

97 West Parkway
Pompton Plains, NJ 07444
973.831.5335 Phone
973.831.5366 Fax

333 Mount Hope Avenue
Suite 110
Rockaway, NJ 07866
973.895.6602 Phone
973.895.5335 Fax

175 High Street
First Floor
Newton, NJ 07860
973.569.8450 Phone
973.383.7320 Fax

Welcome to Atlantic Maternal-Fetal Medicine (AMFM)

Dear _____

Your appointment is scheduled for: _____ at _____. For your **first** visit, please arrive **twenty minutes** before your appointment. Even though you filled out your paperwork, we still have to register you in the hospital and ultrasound systems.

Directions to Atlantic Maternal-Fetal Medicine are enclosed.

Please fill out the enclosed Registration Form and Questionnaire, and ***bring the completed forms with you***, along with your insurance card, referral or request for services from your referring doctor, and a photo ID (such as a driver's license, passport or county ID).

Special Instructions: (all that apply are checked):

_____ If you are between 19-20 weeks and this is your first visit to our facility, please have your doctor fax your AFP results.

_____ Have a full bladder - for CVS only. If you take Heparin or Lovenox, notify our office. Your blood type and screen are required. Please have your doctor's office fax these results to us. You will also need to be seen by our Genetic Counselor prior to or immediately following the CVS.

_____ For amniocentesis, we require a laboratory copy of your blood type and screen. Please have your doctor fax copies of these results to us. ***The procedure cannot be performed unless we have these results.*** If you are on Heparin or Lovenox, please notify our office.

_____ Have your doctor's office fax the proper insurance referral or precertification if required by your insurance policy. ***If your insurance company does require this and you do not obtain it, you will be responsible for all charges.***

_____ Please arrange to have your records here prior to consults or genetic counseling, or we may need to reschedule your appointment.

We look forward to serving you. If you have any questions, please do not hesitate to call us.

Please note that patients are responsible for checking with their insurance carrier regarding eligibility and benefits.

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Atlantic Maternal-Fetal Medicine (AMFM)
QUESTIONNAIRE

Name: _____ Date of Birth: _____ Age at Delivery: _____

Height: _____ Weight: _____ Name of your Doctor/Group: _____

CURRENT PREGNANCY:

First day of your **last menstrual period:** _____ **Due Date:** _____

Is your **Due Date** based on your period? ☐ **YES** ☐ **NO** Is your **Due Date** based on an ultrasound? ☐ **YES** ☐ **NO**

Did you have any **infertility treatment** with this pregnancy? ☐ **YES** ☐ **NO**

If yes, check all that apply: ☐ **IVF** ☐ **PGD** ☐ **ICSI** ☐ **IUI** ☐ **Clomid** ☐ **Donor Egg** Age of donor: _____

Did you mail in a **1st trimester** blood specimen? ☐ **YES** ☐ **NO** If so, what date? _____

Do you know the sex of the baby/babies? ☐ **YES** ☐ **NO** _____

Did you have **NIPT/Cell Free Fetal DNA** genetic testing? ☐ **YES** ☐ **NO** If yes, was it normal? ☐ **YES** ☐ **NO**

Did you have an **AFP/SEQUENTIAL/QUAD** blood test? ☐ **YES** ☐ **NO** If yes, was it normal? ☐ **YES** ☐ **NO**

OBSTETRICAL HISTORY:

G Total number of times you have been pregnant, including this pregnancy: _____

T Total number of **full term deliveries** (37 weeks or more): _____

P Total number of **premature deliveries:** _____ How pregnant were you? _____

A Total number of abortions: _____ Miscarriages: _____ Ectopic Pregnancies: _____

L Total number of living children: _____

Do you have a history of a pregnancy with a birth defect or chromosomal abnormalities? ☐ **YES** ☐ **NO**

If yes, explain: _____

MEDICAL HISTORY: ☐ NONE *(including hypertension, diabetes, thyroid disorders, blood disorders, etc.)*

_____

SURGICAL HISTORY: ☐ NONE *(including c/section, D&E, D&C, GYN, etc.)*

_____

Have you ever had any surgery on your **CERVIX**? ☐ None ☐ Cone Biopsy ☐ LEEP ☐ Other: _____

ALLERGIES: ☐ NONE *(including latex)*

_____

MEDICATIONS: ☐ NONE *(including over the counter and prenatal vitamins)*

_____

Have you ever been hit, slapped or physically hurt by someone? ☐ **YES** ☐ **NO**

Have you had any falls within the past 3 months? ☐ **YES** ☐ **NO**

Do you have any communication barriers? (hearing loss, vision problems, language, etc.) ☐ **YES** ☐ **NO**

Do you have an Advance Directive? ☐ **YES** ☐ **NO** Would you like more information? ☐ **YES** ☐ **NO**

Signature: _____ Date: _____

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REGISTRATION

PATIENT INFORMATION:	Preferred Language:		
Patient's Name:		Social Security #:	
Birth Date:	Marital Status: S M D W	Race:	Nationality:
Mailing Address:			Apt #:
City:	State:		Zip:
Preferred Phone:	Secondary Phone:		
Email:	Maiden Name:		
Employment Status: ☐ **Full-Time** ☐ **Part-time** ☐ **Self Employed** ☐ **Not Employed** ☐ **Retired**			
Employer:	Address:		
City:	State:		Zip:
Work Phone:	Occupation:		

PERSON HOLDING INSURANCE (if other than above):			
Relation to Patient: ☐ Spouse ☐ Parent		Other (list relation):	
Name:			Date of Birth:
Mailing Address: ☐ Same as above		Other:	
Social Security #:			Phone:
Employment Status: ☐ **Full-Time** ☐ **Part-time** ☐ **Self Employed** ☐ **Not Employed** ☐ **Retired**			
Employer:	Address:		
City:	State:		Zip:
Work Phone:	Occupation:		

EMERGENCY CONTACT:		
Relation to Patient: ☐ Spouse ☐ Parent		Other (list relation):
Name:		
Preferred Phone:	Secondary Phone:	

May we leave a detailed voice message on your preferred phone number? YES NO

May we give detailed medical information to the emergency contact? YES NO

RESPONSIBILITY OF PAYMENT:
Signing below indicates that if my insurance does not cover or approve the services rendered by Atlantic Maternal-Fetal Medicine and Atlantic Health or because I do not have insurance, I will be billed and will be responsible for any balances that may accrue.

Signature: _____ Date: _____

PLEASE NOTE:

Per hospital policy, you must present:

- **Photo ID**
- **Proof of Insurance**
- **Request for Services/Prescription**

Without these items, we will be unable to see you.

These items may be faxed ahead of time:

Atlantic Maternal-Fetal Medicine

- Bridgewater
  P: 973-971-7082 F: 732-469-0278

- Chilton
  P: 973-831-5335 F: 973-831-5366

- Morristown
  P: 973-971-7080 F: 973-290-7316

- Overlook
  P: 908-522-5510 F: 908-522-5557

- Rockaway
  P: 973-895-6602 F: 973-895-5335

- Newton
  P: 973-579-8450 F: 973-383-7320

Atlantic Maternal-Fetal Medicine (AMFM)

To Our Patients:

Atlantic Maternal-Fetal Medicine is an outpatient hospital-based facility of Atlantic Health System.

You must present a photo ID, proof of insurance and a prescription or request for services to be seen at our facility.

Hospital policy does not allow cameras or recording devices in the room. You will be provided with ultrasound pictures to take home with you.

It is the patient's responsibility to check for their individual insurance plans requirements regarding coverage, copayments and authorization.

Please arrange to have your records here prior to consult and genetic appointments, or we may have to reschedule your appointment.

Visitor Policy:
Atlantic Maternal-Fetal Medicine supports family centered care, however our space only allows up to 3 visitors in the room. A young child has to be accompanied by another adult who is able to take the child outside if they have difficulty sitting still during the exam.

Billing Policies:

1. Hospital Technical Charge - Atlantic Health System:
This fee covers equipment, supplies and technical services. This bill comes directly from the hospital - Morristown Medical Center (435 South Street, Rockaway, and Bridgewater/Martinsville office), Chilton Medical Center or Overlook Medical Center. If you have questions about this bill, please call 800-619-4024.

2. Professional Fee - Maternal-Fetal Medicine of Practice Associates:
This fee is for the Maternal-Fetal Medicine specialist's interpretation and report. You will be billed separately for this bill under Maternal-Fetal Medicine Practice Associates. If you have questions about this bill, please call 800-845-2785.

3. Referrals/Precertification:
It is important for you, the patient, to know the requirements for your particular insurance policy regarding referrals and precertification. If you have any further questions about tis, please call 973-971-7085.

Tax ID #030376421

NPI #1487610952

Website: atlantichealth.org/maternal-fetal

Email: amfm@atlantichealth.org

Atlantic Maternal-Fetal Medicine (AMFM)
LOCATIONS and INFORMATION

Chilton Medical Center: 97 West Parkway, Pompton Plains, NJ 07744
phone: 973-831-5335 fax: 973-831-5366
- Please arrive 20-30 minutes before your scheduled appointment to register.
- Our office is located on the third floor.

792 Chimney Rock Road, Suite A, Martinsville, NJ 08836
phone: 973-971-7082 fax: 732-469-0278
- For your first visit only, please arrive 20 minutes early with completed paperwork as we have to register you into the hospital and ultrasound systems.
- The office complex is a low brick building, next to "The Loft" development.
- Please park in the back of the complex, Suite A is in the rear, near the trees.
- If you are using GPS, please be sure to enter Martinsville, not Bridgewater.
- Chimney Rock Road runs north and south of Route 22, we are on the North side.

11 Overlook Road, MAC 2, Suite LL 102, Summit, NJ 07901
phone: 908-522-5510 fax: 908-522-5557
- For your first visit only, please arrive 20 minutes early with completed paperwork as we have to register you into the hospital and ultrasound systems.
- Please park in the **East Garage on Overlook Road** and bring your ticket in to be validated.
- We are located on the left side of the lobby and behind the Breast Center.

435 South Street, Suite 380, Morristown, NJ 07960
phone: 973-971-7080 fax: 973-290-7316
- For your first visit only, please arrive 20 minutes early with completed paperwork as we have to register you into the hospital and ultrasound systems.
- The office building is across the street from Seaton Hackney Stables.
- Please park in the parking lots in front or either side of the building.
- We are located on the third floor and down the hall to the left.

333 Mount Hope Avenue, Suite 110, Rockaway, NJ 07866
phone: 973-895-6602 fax: 973-895-5335
- The office is located on the outside of the Rockaway Mall, next to the hotel.
- Our office is on the left hand side of the main lobby.

Newton Medical Center: 175 High Street, First Floor, Newton, NJ 07860
phone: 973-579-8450 fax: 973-383-7320
- Parking is located by the front entrance of the hospital.
- When you come in the front doors, take the hall to the right and follow the signs to Maternal Fetal Medicine.