



PATIENT INFORMATION SHEET

New Patient Update

Today's Date _____ Please fill out ALL sections completely and legibly.

Your Name _____ Your Age _____ Your Birth Date Month | Day | Year

Patient's Social Security Number _____ Referring Physician _____
Mailing Address _____ City _____ State ____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
How long have you lived in the area? Years | Months Single Married Divorced Widowed Separated
Employer _____ Occupation OR STUDENT How Long Employed Years | Months
Employer's Address _____ City _____ State ____ Zip _____

Spouse/Parent's Name _____ Spouse/Parent's Birth Date Month | Day | Year
Spouse/Parent's Social Security Number _____
Mailing Address _____ City _____ State ____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Employer _____ Occupation OR STUDENT How Long Employed Years | Months
Employer's Address _____ City _____ State ____ Zip _____

ALL CHARGES ARE DUE AT THE TIME OF SERVICES. IF HOSPITALIZATION IS INDICATED, THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE CLAIM FORMS TO THE OFFICE PRIOR TO HOSPITALIZATION.

THIS SECTION MUST BE FILLED OUT COMPLETELY OR INSURANCE CANNOT BE BILLED.

Primary Policy Holder's Name _____ Policy Holder's Birth Date Month | Day | Year
Policy Holder's Social Security Number _____ Self Spouse Parent Other
Mailing Address _____ City _____ State ____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Primary Insurance Company _____ ID No. _____
Policy Holder's Employer _____ Group No. _____
Claim's Address _____ City _____ State ____ Zip _____

Secondary Policy Holder's Name _____ Policy Holder's Birth Date Month | Day | Year
Policy Holder's Social Security Number _____ Self Spouse Parent Other
Mailing Address _____ City _____ State ____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Secondary Insurance Company _____ ID No. _____
Policy Holder's Employer _____ Group No. _____
Claim's Address _____ City _____ State ____ Zip _____

Name of Emergency Contact _____ Spouse Parent Other
Address _____ City _____ State ____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____

INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize OB-GYN Associates to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature _____ Date _____ Email: _____



CONSENT TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

(In compliance with the federal HIPAA Guidelines)

Today's Date _____

Your Name _____ Your Age _____ Your Birth Date Month | Day | Year

How we may use and disclose your health information.

Your protected health information will be used by OB/GYN Associates or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

The notice of privacy practices.

OB/GYN Associates is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" brochure provided to you. Please review it carefully.

You may place restrictions on the use or disclosure of your health information.

You may request a restriction on the use or disclosure of our protected information. However, OB/GYN Associates may or may not agree to your request to restrict the use or to activate this request. Please consult with a practice representative or the Privacy Official if you would like additional information or clarification.

It is a violation of the federal privacy standards if OB/GYN Associates agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information prior to the date of your request. If you still have questions after reviewing the Notice of Privacy Brochure, please consult with a practice representative or the Privacy Official at the location and contact information listed on the back of the brochure.

You may revoke this consent at anytime.

You may revoke this consent at anytime; however, OB/GYN Associates requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect the use and disclosure prior to the date of your request.

Changes to privacy practices.

OB/GYN Associates reserves the right to change or modify the privacy practices outlined in the *Notice of Privacy* brochure. OB/GYN Associates will notify you of any changes of privacy practices either my mail, at your next appointment, or an other pre-approved method that you request.

Signature.

I have reviewed this consent form, received the brochure entitled "Notice of Privacy Policies and Practices" and give my permission to OB/GYN Associates to use and disclose my health information in accordance with this consent and the notice provided.

Patient's Name _____ Please Print

Signature _____ Date _____

Patient's Representative _____ Please Print

Relationship to Patient _____

Signature _____ Date _____

Blood transfusions and our acceptance of patients

Policy acknowledgement

Please read this policy statement from OB/Gyn Associates and sign your name at the bottom of the form to show that you have read and understood the policy.

OB/Gyn Associates respects each person's right to make choices in directing his or her healthcare. This includes the right to refuse medical treatment.

Just as we respect your right to make choices in your healthcare, we trust that you will respect our commitment to providing care that meets the highest standards of the medical profession. For example, the medical profession considers blood transfusions a vital treatment for saving lives.

We understand that some patients view blood transfusions as a violation of their deeply held beliefs. Although the possibility of needing a blood transfusion during your care is small, our commitment to high-quality medical care requires that we have the option of giving you a transfusion. If you are certain that you would not accept a blood transfusion while in the care of an OB/Gyn Associates physician, we recommend that you seek care from another medical practice.

We value you and your beliefs and want you to continue as a patient of OB/Gyn Associates. We also want you to be fully informed about our policies and standards of care. We are not asking you to make a commitment today either to have or to refuse a blood transfusion in the future. If you choose not to have a procedure and later change your mind, please contact OB/Gyn Associates to make an appointment with your physician.

If you have any questions or concerns about signing this policy acknowledgement, please discuss this matter with you physician. Thank you for allowing OB/Gyn Associates to provide your care.

By signing my name below, I confirm that I have read the OB/Gyn Associates policy on blood transfusions and that I understand that OB/Gyn Associates accepts patients based on that policy. By acknowledging this policy I am not making a commitment to accept or to refuse a blood transfusion in the future. I also acknowledge that OB/Gyn Associates will not refuse me any healthcare services that they are required to provide.

Patient name (Please print.) _____

Patient signature _____ Date _____

Legal guardian name (If applicable, please print.) _____

Legal guardian signature _____ Date _____

Please complete the following information as accurately as possible. Your answers on this form will help your provider understand your medical concerns and conditions better. If you cannot remember specific details, please give best estimates.

Name:	Age:	Date:	
1. What is the reason for your visit? (Chief Complaint)			
2. Additional Problems/Concerns:			
3. Past Medical History (Check all boxes that apply):			
General Health	How would you rate your general health? <input type="radio"/> Poor <input type="radio"/> Fair <input type="radio"/> Good <input type="radio"/> Excellent		
GYN	Do you have concerns about your period? <input type="radio"/> No <input type="radio"/> Yes		
	Are you currently using Estrogen Replacement Therapy? <input type="radio"/> No <input type="radio"/> Yes		
	Do you have a history of Breast disease? <input type="radio"/> No <input type="radio"/> Yes, describe:		
	Have you had a hysterectomy? <input type="radio"/> No <input type="radio"/> Yes		
	Are you experiencing menopausal symptoms? <input type="radio"/> No <input type="radio"/> Yes		
	Other Gynecological Surgeries? <input type="radio"/> No <input type="radio"/> Yes, describe:		
	Do you experience pelvic pain? <input type="radio"/> No <input type="radio"/> Yes		
OB/GYN Associates	Please indicate whether you have had any of the following medical problems and when (dates):		
<input type="radio"/> No Medical Problems	<input type="radio"/> Alcoholism _____	<input type="radio"/> Cancer (Malignancy) _____	<input type="radio"/> Heart disease _____
	<input type="radio"/> Bleeding/Clotting Problems	<input type="radio"/> _____ specific type _____	<input type="radio"/> High blood pressure _____
	<input type="radio"/> _____	<input type="radio"/> Depression/suicide attempt _____	<input type="radio"/> High Cholesterol _____
	<input type="radio"/> Blood Transfusion _____	<input type="radio"/> Diabetes _____	<input type="radio"/> Thyroid Problems _____
	<input type="radio"/> Heart attack _____	<input type="radio"/> _____ specific type _____	
	List others:		
Health Maintenance Screening Tests	Lipid (Cholesterol Screening) Date: Results:		
	Mammogram Date:		
	Ever abnormal? <input type="radio"/> No <input type="radio"/> Yes Details:		
	Papsmear Date: Results:		
	Ever abnormal? <input type="radio"/> No <input type="radio"/> Yes Details:		
	Stool test for blood Date: Results:		
	Sigmoidoscopy/Colonoscopy Date: Results:		
Bone Density Date: Results:			
Diet	How do you rate your current diet? <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor		
	Do you take supplements? <input type="radio"/> No <input type="radio"/> Yes What kind?		
	Do you drink 4 large glasses of milk daily or take Calcium supplements? <input type="radio"/> No <input type="radio"/> Yes		
Weight	Are you satisfied with your weight? <input type="radio"/> No <input type="radio"/> Yes		
	Has your weight changed recently? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Gained <input type="radio"/> Lost # of pounds		
Exercise	Do you exercise regularly? <input type="radio"/> No <input type="radio"/> Yes		

4. Past Surgical History		
Year	Illness or Operation	Complications?
	<input type="radio"/> No past surgeries	

5. Allergies (Drugs, food, environmental)	Reactions
<input type="radio"/> No Allergies	

6. Family History										
Please indicate below significant medical problems of family members. Indicate which family members by checking the appropriate columns.										
	Mother	Father	Brother	Sister	Grandmother (maternal)	Grandmother (paternal)	Grandfather (maternal)	Grandfather (paternal)	Aunt	Uncle
Arthritis										
Blood Clots										
Breast Cancer										
Cervical Cancer										
Colon Cancer										
Diabetes										
Elevated Cholesterol										
Heart Disease										
High Blood Pressure										
Ovarian Cancer										
Stroke										
Other Cancer not mentioned:										
Other disease not mentioned:										

7. Reproductive History	Menstrual	Pregnancy
	Age at first period:	Number of pregnancies:
	Frequency of periods:	Number of Full Term:
	Length of each period:	Number of Pre-mature:
	(LMP) 1 st day (date) of most recent period:	Number of abortions (Induced):
	Method of Birth Control:	Number of miscarriages (Spontaneous):
	Number of deliveries:	

8. Social History	
Occupation	What is your current occupation?
Marital Status	<input type="radio"/> Divorced <input type="radio"/> Domestic Partner <input type="radio"/> Married <input type="radio"/> Married again <input type="radio"/> Single <input type="radio"/> Widowed

Sexual Activity	Are you sexually active: <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Not currently
	Have you had a new sexual partner in the past year? <input type="radio"/> No <input type="radio"/> Yes
	Current sex partner(s) is/are: <input type="radio"/> Male <input type="radio"/> Female
	Have you ever had any sexually transmitted diseases (STDs)? <input type="radio"/> No <input type="radio"/> Yes
	Interested in being screened for sexually transmitted diseases? <input type="radio"/> No <input type="radio"/> Yes

Alcohol Use	<input type="radio"/> No <input type="radio"/> Yes	Is alcohol use a concern for you or others? <input type="radio"/> No <input type="radio"/> Yes
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Drug Use	Do you use recreational drugs? <input type="radio"/> No <input type="radio"/> Yes	Have you ever used needles? <input type="radio"/> No <input type="radio"/> Yes
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Tobacco Use	Do you smoke, packs per day _____ Number of years: _____
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Safety	Is violence at home a concern for you? <input type="radio"/> No <input type="radio"/> Yes
	Have you ever been abused? <input type="radio"/> No <input type="radio"/> Yes

9. Current Medications Prescription and non-prescription medicine, vitamins, home remedies, birth control pills, herbs:

<input type="radio"/> Not taking any medications	Dosage (mg)	Frequency	Date started	Prescribing Physician

10. Review of Body Systems (Check all that are applicable and explain if needed)

Constitutional	<input type="radio"/> Chills <input type="radio"/> Excessive urination <input type="radio"/> Fever <input type="radio"/> Weight gain <input type="radio"/> Excessive thirst <input type="radio"/> Fatigue <input type="radio"/> Night sweats <input type="radio"/> Weight loss
Eyes	<input type="radio"/> Recent changes in vision
HENT	<input type="radio"/> Hay fever or allergies <input type="radio"/> Problems with teeth or gums <input type="radio"/> Sinus pain/congestion
Breasts	<input type="radio"/> Changes in skin <input type="radio"/> Discharge <input type="radio"/> Lumps <input type="radio"/> Pain
Cardiovascular	<input type="radio"/> Chest pain <input type="radio"/> Palpitations
Respiratory	<input type="radio"/> Cough <input type="radio"/> Shortness of breath <input type="radio"/> Wheezing
Gastrointestinal	<input type="radio"/> Abdominal pain <input type="radio"/> Blood in stools <input type="radio"/> Diarrhea <input type="radio"/> Vomiting <input type="radio"/> Bloating <input type="radio"/> Constipation <input type="radio"/> Nausea
Genitourinary/ Gynecological	<input type="radio"/> Frequency <input type="radio"/> Incontinence <input type="radio"/> Sexual dysfunction <input type="radio"/> urinary retention <input type="radio"/> Dyspareunia <input type="radio"/> Pain with urination <input type="radio"/> Urgency <input type="radio"/> vaginal discharge <input type="radio"/> Hematuria (Blood in urine)
Integument	<input type="radio"/> Changes to existing skin lesions or moles <input type="radio"/> Rash
Neurological	<input type="radio"/> Dizzy/lightheaded <input type="radio"/> Headaches
Psychiatric	<input type="radio"/> Anxiety <input type="radio"/> Depression <input type="radio"/> Difficulty sleeping
Heme-Lymphatics	<input type="radio"/> Bleeding disorder <input type="radio"/> Unexplained lumps
Others not mentioned above	



FINANCIAL POLICIES

- ✓ OB/GYN Associates strives to provide the very best level of care and service to our patients. This includes working with many insurance companies and plans. In order to facilitate insurance billing, we require the most up-to-date insurance information so that we may bill all services in a correct and efficient manner. We do bill the insurance for services; however the patient is responsible for knowing her coverage and benefits. OB-Gyn Associates has a foremost relationship with our patients, and the patient is ultimately responsible for payment of services. We will honor accurate contractual adjustments (discounts) from your health plan; however the patient may be billed up to the correct contractual allowance. The patient responsibility for payment supersedes any agreement OB-Gyn Associates may have with any insurance network, plan or carrier. Additionally, each plan has varying requirements for prior authorization for services that are subject to change. OB-Gyn Associates will help with medical information to obtain prior authorization, but it is the patient that is ultimately responsible for understanding the authorization requirements for her plan and obtaining the same. All copays/deductibles/co-insurance or other patient financial responsibilities are due at the time of the appointment.
- ✓ A current copy of the insurance card is required at every service, and is vital in ensuring that services are billed correctly. If a patient does not have a current copy of her insurance card, she has the option of paying in full for that day, and we will promptly refund the patient once the service has been paid by the insurance company.
- ✓ In order to ensure that all of our patients are seen in a timely manner, we ask that you please cancel or reschedule your appointments at least 24 hours prior to your appointment time. If an appointment is missed or cancelled without prior notification, the patient may incur a fee for the missed appointment.
- ✓ Part of our service to you is to complete FMLA/disability paperwork and we will have it returned to you within 3 business days. In order to maintain this level of service, we charge a fee of \$20, which is due upon our receipt of the paperwork.
- ✓ We accept personal checks; however should any checks come back to us as non-sufficient funds, we will charge a \$20 fee to cover the bank charges, and we will ask for all subsequent payments to be made by cash or credit card. We can not hold checks for a later deposit date, so please make sure there are sufficient funds in your account prior to writing us a check.

Authorization for Treatment & Financial Agreement

I authorize treatment of the patient named below and agree to pay all fees and charges for such treatment. Charges shown on statements are considered to be correct, unless notification is received in writing within 30 days of statement issue date. I agree to pay all charges within 15 days of statement issue date. I agree to assign my insurance benefits to OB/GYN Associates, if applicable, for today's service, and any subsequent services with OB/GYN Associates. I am aware that if I fail to pay any overdue balances and/or fail to commit to a pre-arranged payment plan, my account may be forwarded for further collection action, which may include, but is not limited to, late fees, attorney fees, and possibly third party collection agencies. In the event amounts become overdue, I agree and understand that credit reports and/or credit history may be obtained from credit reporting agencies. All costs associated to this action will be the responsibility of the patient or financially responsible guardian.

Authorization for Release of Medical Information

I authorize any holder of medical information about me to release said information requested by insurance companies with whom I have coverage or any public agents for the purpose of payment, treatment, or operations for services provided. Release of information for any other purposes will require written consent from the patient/guardian/parent.

I have read and understand these policies and hereby acknowledge receipt of a copy of this form, and agree to it's terms

Please Print Name

Signature

Date

Patient Name (if different)

NGYN-008 (12/08)