



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 \_\_\_\_\_



## **GENERAL INFORMATION**

### **OFFICE VISITS:**

**First Visit:** Your first visit is designed to let us get acquainted with you and your pregnancy. We will screen for risk factors pertinent to your health care. We will also perform a complete physical examination. With the information obtained from this interview and examination, we will be able to design an individual plan for your prenatal care.

**Subsequent Visits:** The frequency of your visits is quite individual. Usually, we like to see you about once every four weeks during the first thirty weeks. Then every two weeks until thirty-six weeks, and weekly thereafter until delivery. This, of course, is a general schedule and may vary according to the patient's specific needs.

### **CHILDBIRTH CLASSES:**

We recommend that you consider taking a childbirth preparation class. Tari Justice R.N. APN offers an excellent class in our office. We have flyers available concerning this class. The receptionist can answer any questions that you may have. Tari's phone number is 972-3107.

### **HOSPITALS**

We are on staff at both Renown Medical Center and Saint Mary's Regional Medical Center.

### **FEES AND INSURANCE**

The business office is located in the lobby. They are available to answer all your questions regarding insurance, billing charges, and payment policies.

On your second visit we ask that you visit our Business Office to discuss your charges and insurance coverage with our OB Financial Coordinator.

Our office is more than happy to work with you and your insurance company to ensure that insurance billing is done in a timely and appropriate manner. It is the philosophy of OB/GYN Associates that the patient is ultimately responsible for all fees related the services received.

## GENERAL INFORMATION (Page 2)

### MEDICATIONS AND DRUGS

Everyone experiences at least a few of the classic discomforts of pregnancy during her nine months of pregnancy (I.E. morning sickness, back pain, constipation, and heartburn). For everyday ailments, some medications are considered safer than others. Whenever possible, it is best to try appropriate, non-medical remedies first, and avoid any medications during the first trimester. The following is a list of medications that are considered reasonably safe to take during pregnancy:

#### ANTACIDS

*Maalox*  
*Roloids*  
*Tums*  
*Riopan*  
*Mylanta*  
*Gelusil*

#### COLDS

*Actifed*  
*Tylenol*  
*Robitussin*  
*Sudafed*  
*Chlor-Trimeton*  
*Sucrets Lozenges*  
*Cepacil Lozenges*

#### LAXATIVES

*Doxidan*  
*Metamucil*  
*Milk of Magnesia*  
*Senokot*  
*Colace*  
*Peri-Colace*  
*Citucel*

#### DIARRHEA

*Immodium AD*  
*Kaopectate*

#### HEMORRHOIDS

*Preparation H*  
*Anusol*

#### NAUSEA

*Vitamin B-6 50mg twice daily*



## **OB/GYN ASSOCIATES**

**INTRODUCES:**

### ***PREPARED CHILDBIRTH CLASSES***

**INSTRUCTOR: TARI JUSTIS, R.N., APN  
775-972-3107**

*THIS CLASS COVERS: NUTRITION, EXERCISE, WARNING SIGNS, PREGNANCY DISCOMFORTS AND COMFORT MEASURES, WHAT TO EXPECT DURING LABOR, DELIVERY AND POSTPARTUM, BREATHING, RELAXATION AND PAIN RELIEF TECHNIQUES, AND MORE!!!*

SIX WEEK PRENATAL SERIES - MORE THAN 20 WEEKS PREGNANT

EVERY WEDNESDAY NIGHT FOR SIX WEEKS

7:00 P.M. TO 9:00 P.M.

FEE: \$75.00 PER COUPLE - INCLUDES 6 WEEK SERIES

LOCATION: OB/GYN ASSOCIATES LOBBY



## PATIENT HISTORY QUESTIONNAIRE

PATIENT'S NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

### ***The PROGRAM Genetic History Questionnaire for Prenatal Patients***

- The answers to these questions will help in the care of your pregnancy
- Please answer these questions to the best of your knowledge. All answers are confidential.
- If you need help answering the questions, please ask.

1. When your baby is born, will you be 35 years of age or older?     No     Yes     Not sure

### ***Where your ancestors came from may sometimes give us important information about the health of your baby.***

2. Is your family or your baby's father's family from:
- Southeast Asia, Taiwan, China, or the Philippines?     No     Yes     Not sure
- Italy, Greece, or the Middle East?     No     Yes     Not sure
- African American/Black?     No     Yes     Not sure
3. Is your family or your baby's father's family:
- Eastern European (Ashkenazi) Jewish?     No     Yes     Not sure

The next ten questions will be about you, your baby's father, or both of your families. When we say "blood relative", we mean your child, (or unborn baby), mother, father, siblings, grandparents, aunts, uncles, niece, nephew, or cousin.

4. Were you or any of the baby's blood relatives born with an opening in the back or spine (also called Spina Bifida)?     No     Yes     Not sure
5. Was there ever a baby (or unborn baby) in your family or the baby's father's family who had an opening in the head, (also called anencephaly)?     No     Yes     Not sure
6. Is any blood relative in your family or baby's father's family mentally retarded?     No     Yes     Not sure

## PATIENT HISTORY QUESTIONNAIRE (page 2)

7. Have you or your baby's father, or any blood relative had an unborn baby or child who had Down Syndrome?  No  Yes  Not sure
8. Do you or your baby's father, or any blood relative have any other chromosome problems?  No  Yes  Not sure
9. Do you or your baby's father, or any blood relative have:
- a. Cystic Fibrosis (CF)  No  Yes  Not sure
  - b. Fragile X Syndrome  No  Yes  Not sure
  - c. Muscular Dystrophy  No  Yes  Not sure
  - d. Hemophilia, Von Willebrand, or any other bleeding disorders  No  Yes  Not sure
  - e. Huntington Disease  No  Yes  Not sure
  - f. Neurofibromatosis  No  Yes  Not sure
10. Were you or your baby's father or any blood relative born with:
- a. Heart Defects  No  Yes  Not sure
  - b. Cleft Lip or Palate  No  Yes  Not sure
  - c. Any other birth defects  No  Yes  Not sure
11. Have you ever had:
- a. A miscarriage  No  Yes  Not sure
  - b. Two or more miscarriages  No  Yes  Not sure
  - c. Stillborn baby  No  Yes  Not sure
12. Are you and the baby's father related by blood?  No  Yes  Not sure
13. Do you have Diabetes?  No  Yes  Not sure
14. Do you have, or have you ever had treatment for PKU (phenylketonuria) or Hyperphenylalaninemia (hyperphe)?  No  Yes  Not sure
15. During this pregnancy, have you used or taken:
- a. Medication for seizures?  No  Yes  
(EX. Dilantin, Valproic Acid, Depakene, Tegretol, Mysoline, Tridione)
  - b. Acne Medication?  No  Yes  
(EX. Accutane, Isotretinoin)
  - c. Medication for depression?  No  Yes  
(EX. Lithium, Eskalith, Lithobid, Lithonate)
  - d. Alcohol  No  Yes

Completed by \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature \_\_\_\_\_



## **INFORMED CONSENT FOR ULTRASONOGRAPHY**

**Your physician has requested that you have an ultrasound examination of your pregnancy. This information sheet will answer several important questions about this diagnostic procedure.**

### **WHAT IS ULTRASOUND AND WHAT CAN IT SHOW ABOUT MY PREGNANCY?**

Ultrasound uses the same principle as sonar. Sound waves (far beyond the range of hearing) from the ultrasound probe, bounce off your uterus and your developing baby producing echoes which a computer converts into detailed images.

### **IS ULTRASOUND SAFE?**

There has been extensive evaluation of the safety of ultrasound over the course of 15 years. There is no evidence that diagnostic ultrasound causes harm to either the mother or the fetus.

### **TYPES OF EXAMS**

A **basic or standard sonogram** provides information concerning placental location, fetal position, twin pregnancies, gestational age, and the possible presence of fetal malformation.

A **complete or extensive sonogram** is a more detailed exam providing not only the information of a basic scan, but in addition, a more specific evaluation for fetal growth and/or fetal abnormalities.

A **vaginal sonogram** is when a special ultrasound instrument, about the thickness of a tampon, is inserted into the vagina. It is occasionally used to provide extremely detailed views of the uterus, ovaries, or portions of the fetus that are low in the pelvis. This may also be used to see the heartbeat or the location of a very early pregnancy, or to evaluate the placenta or birth canal. As with other ultrasound exams, the procedure is safe. It is generally less uncomfortable than a Pap smear.

### **DOES A NORMAL ULTRASOUND PROVE THAT MY BABY WILL HAVE NO ABNORMALITIES?**

While a basic sonogram will detect many abnormalities, it is not definitive for fetal malformations. Despite a normal interpretation of the test, some babies may be born with anomalies not identified by the examiner during the study. You should realize that even with a complete sonogram, the examiner may still be unable to find fetal abnormalities which are later discovered after birth. Thus, although ultrasonography is a very helpful diagnostic tool, it should not be considered an absolute proof of the absence of fetal defects.

**Should you have any questions concerning ultrasonography, do not hesitate to discuss them with your doctor or ultrasound technologist before undergoing the procedure.**

### **CONSENT**

You are requested to sign this document prior to the performance of your ultrasound examination, and thereby acknowledge that you have read and understood the information contained herein and have given an informed consent to this procedure.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS SIGNATURE



**TO OUR NEW OB PATIENTS**

Once it has been determined you are pregnant, it is the policy of this office that you remain under the care of the physician that you are currently seeing to continue continuity of care. Depending who is on call, there is a chance that a different physician may deliver your child; However, we strongly discourage patients from switching physicians within this office.

If you have any questions regarding this policy, please discuss them with your physician.

I have read and understand this policy

\_\_\_\_\_  
Initials

\*\*\*\*\*

At some point prior to the delivery of your child, the physician's nurse may give you copies of your own medical records to take to the hospital when you go into labor. This saves time and ensures that the records are available to the physician when you are ready to deliver. Your signature is required to provide you with a copy of these records.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Name

# **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.

<b>Name:</b>		<b>Age:</b>		<b>Date:</b>		
<b>1.</b>	<b>What is the reason for your visit? (Chief Complaint)</b>					
<b>2.</b>	<b>Additional Problems/Concerns:</b>					
<b>3. Past Medical History (Check all boxes that apply):</b>						
<b>General Health</b>	How would you rate your general health? <input type="radio"/> Poor <input type="radio"/> Fair <input type="radio"/> Good <input type="radio"/> Excellent					
<b>GYN</b>	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					
<b>OB/GYN Associates</b>	<b>Please indicate whether you have had any of the following medical problems and when (dates):</b>					
<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:					
<b>Health Maintenance Screening Tests</b>	<b>Lipid (Cholesterol Screening)</b>		Date:	Results:		
	<b>Mammogram</b>		Date:			
	Ever abnormal? <input type="radio"/> No <input type="radio"/> Yes		Details:			
	<b>Papsmear</b>		Date:	Results:		
	Ever abnormal? <input type="radio"/> No <input type="radio"/> Yes		Details:			
	<b>Stool test for blood</b>		Date:	Results:		
	<b>Sigmoidoscopy/Colonoscopy</b>		Date:	Results:		
<b>Bone Density</b>		Date:	Results:			
<b>Diet</b>	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					
<b>Weight</b>	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					
<b>Exercise</b>	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 <sup>st</sup> 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

<b>Sexual Activity</b>	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	
<b>Alcohol Use</b>	<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
<b>Drug Use</b>	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
<b>Tobacco Use</b>	Do you smoke, packs per day _____ Number of years: _____	
<b>Safety</b>	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)**

<b>Constitutional</b>	<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
<b>Eyes</b>	<input type="radio"/> Recent changes in vision			
<b>HENT</b>	<input type="radio"/> Hay fever or allergies <input type="radio"/> Problems with teeth or gums <input type="radio"/> Sinus pain/congestion			
<b>Breasts</b>	<input type="radio"/> Changes in skin	<input type="radio"/> Discharge	<input type="radio"/> Lumps	<input type="radio"/> Pain
<b>Cardiovascular</b>	<input type="radio"/> Chest pain <input type="radio"/> Palpitations			
<b>Respiratory</b>	<input type="radio"/> Cough	<input type="radio"/> Shortness of breath	<input type="radio"/> Wheezing	
<b>Gastrointestinal</b>	<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	
<b>Genitourinary/ Gynecological</b>	<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)			
<b>Integument</b>	<input type="radio"/> Changes to existing skin lesions or moles		<input type="radio"/> Rash	
<b>Neurological</b>	<input type="radio"/> Dizzy/lightheaded <input type="radio"/> Headaches			
<b>Psychiatric</b>	<input type="radio"/> Anxiety	<input type="radio"/> Depression	<input type="radio"/> Difficulty sleeping	
<b>Heme-Lymphatics</b>	<input type="radio"/> Bleeding disorder <input type="radio"/> Unexplained lumps			
<b>Others not mentioned above</b>				

PAST PREGNANCIES									
Date	GA Weeks	Length of Labor	Birth Weight	Sex M/F	Type of Delivery	Anesthesia	Place of Delivery	Pre-term Labor	Comments/Complications

INFECTION HISTORY	
1. Live with someone with TB or exposed to TB?	<input type="radio"/> No <input type="radio"/> Yes
2. Patient or partner has history of genital herpes?	<input type="radio"/> No <input type="radio"/> Yes
3. Rash or viral illness since last menstrual period?	<input type="radio"/> No <input type="radio"/> Yes
4. History of STD, Gonorrhea, Chlamydia, HPV, Syphilis?	<input type="radio"/> No <input type="radio"/> Yes
5. Other:	



## 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)

NOB-015 (12/08)