Patient Registration Form (The OB/GYN Center)

PATIENT INFORMATION

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms.

Patient's Name (Last) _____ (First) _____ (MI)_____ Previous Name_____

Address: _____ City, State _____ Zip _____

Home Phone: _____ Cell No. _____ Work Phone _____ Ext. _____

Primary Care Provider (PCP) _____ Referring Provider _____

Rendering Provider (this practice): _____ E-Mail: _____

Date of Birth MM_____/DD_____/YYYY_____ Sex: ☐ Female ☐ Male ☐ Transgender

Race: ☐ American Indian or Alaska Native ☐ Asian ☐Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Declined

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language: ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-_____-_____ Employer Name _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Self-Employed ☐ Retired ☐ Active Military

Student Status: ☐ Full-Time Student ☐ Part-Time Student ☐ Not a Student

Emergency Contact: _____ Phone Number _____

Emergency Contact Relationship to Patient: _____ Do you have a Living Will? ☐ Yes ☐ No

Address :_____ City, State _____ Zip _____

Home Phone: _____ Cell No. _____ Work Phone _____ Ext. _____

Pharmacy: _____ Phone: _____Cross Streets_ _____

RESPONSIBLE PARTY INFORMATION

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self Check here if information is same as patient ☐

Responsible Party Name: (Last) _____ (First) _____ (MI) _____

Guarantor Account Number: _____ Date of Birth MM_____/DD_____/YYYY_____ Sex: ☐ Female ☐ Male

Address: _____ City, State _____ Zip _____

Employer Name: _____ Employer Phone Number: _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Phone Number: _____

Name of Insured: _____ Patient Relationship to Insured: _____

Subscriber ID (Policy Number): _____ Group ID: _____ Copay Amount: _____

Effective Date: _____ Termination Date: _____ Date of Birth MM_____/DD_____/YYYY_____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Phone Number: _____

Name of Insured: _____ Patient Relationship to Insured: _____

Subscriber ID (Policy Number): _____ Group ID: _____ Copay Amount: _____

Effective Date: _____ Termination Date: _____ Date of Birth MM_____/DD_____/YYYY_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature: _____ Date _____

GYNECOLOGIC HISTORY QUESTIONNAIRE

Name:_____ DOB: _____ Date: _____

Chief reason for today's visit: _____

First day of last menstrual period: _____

Date of last pap smear: _____Results: _____

Type of birth control currently using: _____
(including vasectomy, tubal ligation, condoms, abstinence, or natural family planning methods)

Are you happy with this method of birth control? _____

Were you referred to our office? If so please tell us by who._____

OBSTETRICAL HISTORY

Are you currently pregnant? **Y N** If so, on what date was first positive pregnancy test? _____

Total number of times pregnant (include miscarriages and abortions): _____

Total number of live births (include dates and type of delivery): _____

_____

Total number miscarriages: _____ Total number abortions: _____

Any complications during your pregnancies? If so, please explain: _____

_____

Did you have a Caesarean Section? If so, when: _____

Any family history of inherited disorders (i.e. Tay Sachs, Spina Bifida, Down Syndrome, other genetic disorder)?

_____

GYNECOLOGICAL HISTORY

Age at first period: _____ How many days do your periods last? _____

How often do your periods come? □ Every 28-30 days □ More frequently □ Less frequently

How heavy is your menstrual flow? □ Light □ Moderate □ Heavy □ Extremely Heavy

Do you have bad cramps? **Y N** Do you have any PMS symptoms? **Y N**

Any bleeding between periods? **Y N** Any bleeding after intercourse? **Y N**

Any problems with urination (loss of urine while coughing, sneezing, etc.)? **Y N**

Check any of the following problems that you have had either in the past or currently:

□ Gonorrhea □ Pelvic Inflammatory Disease (PID) □ Herpes □ Vaginal Infections

□ History of physical or sexual abuse □ IUD Related problems

□ Abnormal pap smears (what abnormality and when)? _____

******MORE QUESTIONS ON THE OTHER SIDE OF THIS SHEET*******

MEDICAL HISTORY

How is your health in general? □ Excellent □ Good □ Fair □ Poor

Do you smoke? **Y N** How much? _____packs per day How many years have you smoked?_____

Are you a past smoker? **Y N** When did you quit? _____ How many years did you smoke? _____

Do you drink alcohol? **Y N** How many alcoholic beverages do you have in a week? _____

Social drug use? **Y N** If so, what type of drugs do you use? _____

Have you ever been diagnosed with a MEDICAL or PSYCHOLOGICAL condition? If so, what was the diagnosis and when? _____

_____

Have you ever been hospitalized for a medical illness? If so, please explain: _____

_____

What surgeries have you had? (please give year of surgery, including cosmetic): _____

_____

_____

Do you have any allergies to medications? **Y N** Do you have any other allergies? **Y N**

Please List: _____ Please list: _____

_____ _____

_____ _____

Do you have any history of a bleeding disorder? **Y N** Had a blood transfusion? **Y N**

Do you use medication on a regular basis? Please list name and dose of medication: _____

_____

Have you had a mammogram? **Y N** Date & result of last mammogram: _____

Do you have any problems with your breasts? (lumps, discharge, or pain)? _____

FAMILY HISTORY (Please check if anyone in your family has any of these conditions and tell us who has it)

□ Breast Cancer □ Uterine Cancer □ Ovarian Cancer □Colon Cancer

□ Diabetes □ Heart disease □ High Blood Pressure □ Stroke

□ Osteoporosis □ Thyroid disease □ Autoimmune □ Other

SOCIAL HISTORY

Marital status: **M S D W P** Sexual Orientation? **Heterosexual** **Homosexual**

Occupation: _____ Religion: _____

OBGYN CENTER PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name**:** _____

Date of Birth: _____

_____(Patient/Representative initials) **Notice of Privacy Practices.**

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient/Representative initials) **Release of Information.**

I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

____ (Patient/Representative Initials) ***I consent*** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

____ (Patient/Representative Initials) ***I do not consent*** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

We want to stay connected with our patients.

Patients in our practice may be contacted via email and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email address or text number below, you understand that you may get these communications from the Practice. You may opt out of these communications at any time. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

OR

_____ (Patient/ Representative Initials) I decline to receive communication via text.

_____ (Patient/ Representative Initials) I decline to receive communication via email.

If you have previously consented to receive communication via text/email and wish to remove the consent

Opt Out/Revocation of communications via email and/or text. In other words, I do not want my email address or cell number to be used any longer for the above mentioned communications.

*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **text**.*

*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **email**.*

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ *Time:* _____

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

____ (Patient/Representative Initials) I ***wish*** to designate the following individual to pick up a prescription order on my behalf:

Name: _____ Date: _____

Name: _____ Date: _____

____ (Patient/ Representative Initials) I ***do not want*** to designate anyone to pick-up my prescription order.

Patient/Parent/Guardian/Patient Representative Signature _____ **Date:** _____

Patient/Parent/Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ **Date of Birth:** _____