

PATIENT REGISTRATION FORM OB GYN CENTER

(Please print)

PATIENT INFORMATION

Patient's Legal Name: (Last) (First) (MI)

Preferred Full Name (if different from above):

Address:

City, State, Zip:

Home Phone Number (landline): Cell: Work:

E-Mail Address: Date of Birth:

Gender Identity: Female Male Transgender Female to Male Transgender Male to Female Genderqueer Choose not to disclose Additional Gender category not listed

Race: American Indian/Alaska Native Asian Native Hawaiian/Pacific Islander Black/African American White Hispanic Chose not to disclose Other not listed

Ethnicity: Hispanic or Latino Not Hispanic or Latino Choose not to disclose

Preferred Language: English Spanish ASL Japanese Mandarin Korean French Indian: Hindi, Tamil, Gujarati etc Swahili Russian Arabic Vietnamese Haitian Creole Bosnian/Croatian/Serbian/Serbo-Croatian Albanian Burmese Tagalog Farsi-Iranian/Persian Portuguese Cambodian Other not listed

Patient Social Security Number: - -

RESPONSIBLE PARTY INFORMATION (If not self)

(Information used for patient balance statements)

Responsible party: Another patient Guarantor Self Check here if address and telephone information is same as patient

Responsible party name: (Last) (First) (MI)

Date of birth: MM/DD/YYYY Sex: Female Male

Responsible Party Social Security Number: - - Phone number:

Address:

City, State: ZIP:

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) (First)

Phone number: Do you have a living will? Yes No

Emergency contact relationship to patient: Guardian

Address:

City, State: ZIP:

Home phone: Work hone: Ext.

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: Date:

Printed name of patient or personal representative: Relationship to patient:

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: _____