PATIENT REGISTRATION FORM

PERSONAL INFORMATION				
FIRST NAME	**MIDDLE NAME**	**LAST NAME**		
ADDRESS				
CITY	**STATE**	**ZIP**	**HOME PHONE**	**CELL PHONE**
DATE OF BIRTH	**AGE**	**GENDER** ❑ Male ❑ Female Other_____	**MARITAL STATUS** ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Domestic Partner ❑ Other_____	
RACE ❑ Caucasian ❑ Black ❑ Hispanic ❑ Asian ❑ Other_____	**PREFERRED LANGUAGE** ❑ English ❑ Spanish ❑ Other_____	**ETHNICITY** ❑ Hispanic/Latino ❑ Not reported/refused ❑ Other_____		
HOME PHONE	**WORK PHONE**	**CELL PHONE**		
EMAIL	**CONTACT PREFERENCE** ❑ Work ❑ Cell ❑ Email			
SSN#	**DRIVERS LICENSE**			
PRIMARY PHYSICIAN	**PREFERRED PHARMACY**	**LOCATION**		
EMERGENCY CONTACT	**RELATIONSHIP**	**PHONE**		
EMPLOYMENT STATUS ❑ Employed ❑ Unemployed ❑ Retired ❑ Student ❑ Other _____				
EMPLOYER NAME				

INSURANCE INFORMATION		
PRIMARY INSURANCE NAME	**PHONE**	
POLICY ID NUMBER	**GROUP NUMBER**	
NAME OF INSURED PERSON / GUARANTOR	**DATE OF BIRTH**	**ADDRESS**
RELATIONSHIP TO GUARANTOR	**SSN#**	**EMPLOYER**
SECONDARY INSURANCE NAME	**PHONE**	
POLICY ID NUMBER	**GROUP NUMBER**	
NAME OF INSURED PERSON / GUARANTOR	**DATE OF BIRTH**	**ADDRESS**
RELATIONSHIP TO GUARANTOR	**SSN#**	**EMPLOYER**

How did you hear about us? _____

SIGNATURE _____ **DATE** _____

MEDICAL HISTORY

NAME	DATE OF BIRTH

REASON FOR VISIT	PRIMARY PHYSICIAN

PLEASE LIST ANY MEDICAL/HEALTH PROBLEMS

ALLERGIES TO ANY MEDICATIONS OR FOODS ❑ Yes ❑ No

ALLERGEY TO LATEX ❑ Yes ❑ No

PREVIOUS SURGERIES (INCLUDE DATE)

FAMILY HISTORY

NUMBER OF SISTERS	NUMBER OF BROTHERS

PLEASE INDICATE IF ANY OF YOUR RELATIVES HAD ANY OF THE FOLLOWING IN THE BLANK SPACES

HEART DISEASE ❑ Yes ❑ No **Whom:**_____

DIABETES ❑ Yes ❑ No **Whom:**_____

HYPERTENSION ❑ Yes ❑ No **Whom:**_____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

ANXIETY ❑ Yes ❑ No **DEPRESSION** ❑ Yes ❑ No

BIPOLAR DISORDER ❑ Yes ❑ No **SUICIDAL IDEATION** ❑ Yes ❑ No

FAMILY CANCER

BREAST ❑ Yes ❑ No

OVARIAN ❑ Yes ❑ No

COLON ❑ Yes ❑ No

OTHER ❑ Yes ❑ No

RELATIONSHIP AND AGE

_____

SOCIAL HISTORY

PROFESSION: _____ ❑ Retired ❑ Student

❑ Yes ❑ No - Do you drink alcohol? ❑ Frequently ❑ Sometimes ❑ Social

❑ Yes ❑ No - Do you exercise? ❑ Frequently ❑ Sometimes

❑ Yes ❑ No - Do you smoke? (___ packs per day)

How many years have you been smoking? _____

When did you stop smoking? _____

❑ Yes ❑ No - Do you have a spiritual practice?

Religion: _____

❑ Yes ❑ No - Do you feel safe at home?

❑ Yes ❑ No – Have you ever been a victim of Domestic Violence from Spouse or Partner?

SIGNATURE _____ **DATE** _____

OB/GYN HISTORY

NAME(s)	DATE OF BIRTH	DATE

AGE AT FIRST PERIOD: _____ years

LAST MENSTRUAL PERIOD: _____

POST-MENOPAUSAL: _____

MENSTRUAL FLOW ❑ Moderate ❑ Light **Duration:** _____

Are you sexually active? ❑ Yes ❑ No

Partners: ❑ Men ❑ Women ❑ Both

NUMBER OF PREGNANCY _____ **FULL TERM** _____ **ELECTIVE ABORTION** _____

PRETERM DELIVERIES _____ **C-SECTIONS** _____ **ECTOPIC** _____

FETAL DEMISE _____

Have you had any difficulty becoming or keeping any pregnancy? ❑ Yes ❑ No

Please list any complications you've had in your past pregnancies:

Are you currently or have you used any form of contraceptive? ❑ Yes ❑ No

Pills ❑ **IUD** ❑ **Implants** ❑

Condoms ❑ **Other** _____

When was your last pap and how long ago? _____

❑ Normal ❑ Abnormal

Are you currently or have you experienced the following?

❑Colpo ❑Cryo ❑Leep ❑Liver Problems ❑Depression ❑Mammo

❑PCOS ❑STD ❑Kidney Problems ❑Frequent Urination ❑Excessive Menstruation Bleeding

❑Pain with Intercourse (Dyspareunia)

Give the date of your last study, if you remember:

Blood Stool Test _____ **Tetanus** _____ **Pneumonia Shot** _____

Flu Shot _____ **Hepatitis B Series** _____ **Hepatitis A Series** _____

SIGNATURE _____ **DATE** _____

Notice of Health Information Practices Summary

Your Medical Record Each time you visit a hospital or physician, a record is made of your visit. This information, commonly known as a medical record, contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care. The confidentiality of your medical record is protected under the State-specific and Federal law.

Your Health Information Rights Your medical record is the physical property of the physician or healthcare facility that compiled it, but the information belongs to you. Therefore, you have rights regarding the use and disclosure of your health information.

Our Responsibilities *Pineridge Obstetrix & Gynecology Inc* is required by the Federal Privacy Rule to maintain the privacy of your medical record and to provide you with a notice of our legal duties and privacy practices.

Uses and Disclosures for Treatment, Payment, and Health Care Operations *Pineridge Obstetrix & Gynecology Inc* will use your health information in order to treat you. We will provide other providers or hospitals with copies of your medical record to assist them in treating you, should that become necessary. We will also use and disclose health information about you to make appointments with you. information that identifies you, as well as your diagnosis, procedures, and supplies used.
Pineridge Obstetrix & Gynecology Inc will use your health information for regular health operations to assess the quality of your care. *Pineridge Obstetrix & Gynecology Inc* will disclose your health information to business associates, such as a medical *Pineridge Obstetrix & Gynecology Inc* will use your health information for payment. The information on a bill may include transcription or billing service; so that they can perform the job we have asked them to do.

Uses and Disclosures that We May Make Unless You Object You have the right to object to certain situations in which *Pineridge Obstetrix & Gynecology Inc* may disclose information from you medical record.

Disclosures Permitted without Consent Pineridge *Obstetrix & Gynecology Inc* is required by state and Federal law to disclose health information from your medical record under specific circumstances.

Uses and Disclosures Specifically Authorized by You *Pineridge Obstetrix & Gynecology Inc* expects to make other uses and disclosures of your protected health information only on the basis of specific written authorization forms signed by you.

To Report a Problem You have the right, under Federal law, to report a problem or file a complaint about how your personal health information is being handled. You can do this directly with *Pineridge Obstetrix & Gynecology Inc* or to the Secretary of Health and Human Services in Washington, D.C.

Pineridge Obstetrix & Gynecology Inc will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care.
We have prepared a detailed *Notice of Privacy Practice* to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our office and have copies available for distribution.

Patient Name_____

Patient Signature_____Date_____

Patient Agreement Form

___ I authorize medical healthcare and treatment by PineRidge Obstretix & Gynecology Inc.

___ I understand that all refills, referrals and letters will be taken care of at the time of an appointment.

___ Co- payment is as authorized by patient's insurance and it is patient's responsibility. Payment is due at the time of service and **there is no refund**. I agree to a $30.00 fee for any returned check.

___ PineRidge Obstetrix & Gynecology Inc. notifies patients about the results of all tests that are ordered, regardless of whether the findings are normal or abnormal. Occasionally, the results do not get sent to the office. If you have undergone routine medical testing and have not received the results within 14 business days, please call the office to ensure that the results of all completed tests are reported back to you.

___ I acknowledge that I have reviewed a copy of the Notice of Health Information Privacy Practice, and have taken a copy if desired.

___ I authorize PineRidge Obstetrix & Gynecology Inc. to release my medical information to any Physician or Healthcare Practitioner to whom I am being referred for care and to any payer of my care including my insurance company or managed care program upon their specific request. This also extends to records regarding my child, if applicable.

___PineRidge Obstetrix & Gynecology Inc. respects your privacy and will only release information required to further your treatment, assist you in obtaining payment, managing her own internal operation, or as specifically authorized by you.

___I understand that I am responsible for all charges incurred for treatments rendered, even if my Insurance company determines that any services are non-covered or excluded.

___I may revoke these authorizations in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

___ I consent to allow the following person(s) to my protected health information. I understand I may revoke this access at any time.

Name(s) _____

Initials_____ Date_____

Patient Signature_____ (or Guardian's Signature, if patient is a minor)

PineRidge
Obstetrix & Gynecology Inc.
Healthy Women. Healthy Community.

APPOINTMENTS

PINERIDGE OBGYN is committed to providing superior care to all patients. Patients are required to call and reschedule appointments in case they cannot honor appointments. Patients who miss two or more appointments should consider themselves discharged from the care of Dr. Israel Brown.

CHILD SUPERVSION

PINERIDGE OBGYN, at its own discretion, will allow children to accompany their parents to their office visits. It is the sole responsibility of parents to ensure their children are properly supervised, well behaved and have respect for other patients present.

Name:

Date:

Signature: