

PLEASE COMPLETE THIS FORM AND RETURN IT TO THE RECEPTIONIST PROMPTLY.

Do you have Medicare? (Circle one) **YES** **NO**

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

GOES BY: _____ DATE OF BIRTH ___/___/___ SSN: ___-___-___ Marital Status _____

HOME ADDRESS: _____

BILLING ADDRESS: (if different) _____

CITY: _____ STATE: _____ ZIP: _____ GENDER: **M** **F** Spouse's Name: _____

Home Phone#: () _____-_____ Cell Phone#: () _____-_____ email: _____

Employer Name: _____ Phone#: () _____-_____

Address: _____ City _____ State: _____ Zip: _____

INSURANCE INFORMATION

PRIMARY Insurance: _____ PPO HMO POS

SUBSCRIBER (if different than patient): _____ Relationship to Patient: _____

Subscriber's DOB: ___/___/___ Policy/Membership# _____ Group #: _____

SECONDARY Insurance: _____

SUBSCRIBER (if different than patient): _____ Relationship to Patient: _____

Subscriber's DOB: ___/___/___ Policy/Membership# _____ Group #: _____

PERSON FINANCIALLY RESPONSIBLE FOR PAYMENT (if other than patient)

LAST NAME: _____ FIRST NAME: _____ MI: _____ DOB: ___/___/___

Address: _____ City: _____ State: _____ ZIP: _____

SS# ___/___/___ Relationship to Patient: _____ Phone #: () _____-_____

EMERGENCY CONTACT

LAST NAME: _____ FIRST NAME: _____ Relationship to Patient: _____

Home Phone#: () _____-_____ Cell Phone: () _____-_____ Other: () _____-_____

REFERRING PHYSICIAN:
Who may we thank for referring you to our office? _____

PLEASE COMPLETE FRONT & BACK OF THIS FORM.

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Heritage OB/GYN is authorized to release any medical records pertinent to the healthcare of the above named patient to, but not inclusive of, any insurance carrier, adjustor, attorney, health care provider, or immediate family member, upon receipt of the signature of the above named patient or the signature of the patient's legal guardian. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage (in the event that claims are submitted to an insurance company on your behalf) for services rendered by any physician of Heritage OB/GYN

LIST NAME OF PERSON (S) WHOM WE MAY DISCUSS ACCOUNT INFORMATION OTHER THAN THE PATIENT: _____

FINANCIAL POLICY

***We participate in most insurance plans.**

1. It is your responsibility to check with your plan prior to your visit to make sure we are participating physicians. Failure to do this could result in reduced payments by your insurance company.
2. We do not file automobile, general liability, or homeowner's insurance.
3. If you have HMO/POS insurance, it is your responsibility to obtain a referral number from your PCP prior to being seen. If you fail to obtain this, the bill is your responsibility.

***You and your insurance company are responsible for your bill.**

1. We realize that insurance requirements are confusing, but knowing your insurance benefits is your responsibility.
2. Any questions concerning your coverage should be directed to your insurance company.
3. We will file secondary insurance, but if the secondary insurance denies payment, you are responsible for the balance.

***If your primary insurance company requires a co-payment, you must make the co-payment at the time of service.**

1. Failure to pay your co-pay at the time of service will result in a billing fee of **\$25.00**. Please remember that we are contractually obligated by your insurance company to collect your co-pays at time of service.
2. The balance of your charges will be billed to your insurance company. After payment of insurance company, any remaining balance will become patient responsibility, which is due upon receipt of statement.
3. If payment of any service results in a credit balance on either entity, the credit balance will first be applied to any outstanding balance you have before being refunded to you.

***Proof of current, valid insurance must be provided at time of service.**

1. If you do not provide this information, you will be considered a self-pay patient.
2. Self-pay patients are required to pay their office visit charges in full. Please ask about your advance payment responsibility when making your appointment.
3. Failure to pay your office visit charges at the time of service will result in a billing fee of \$25.00.
4. You will be billed for the balance of your charges. Payment in full will be expected with receipt of your statement.

***Failure to receive your statement does not relieve you of your financial obligation. It is your responsibility to notify us of any changes in your billing information.**

***We accept cash, checks, money orders and major credit cards.**

1. Returned checks are subject to a \$35.00 return check fee, which **MUST** be paid before return appointments can be scheduled.

***Past due accounts are subject to our collections process. Any fees assessed by a collection agency will be added to the balance.**

PRESCRIPTION POLICY

Prescriptions and refills for medications are issued during office hours only. 8:30 am to 5:00 pm, Monday thru Friday. No medications will be refilled over the phone after hours or on weekends. If you have an emergency situation, you will be directed to the emergency department of the local hospital. During the course of treatment with our office, do not obtain pain medications from any other source.

PATIENT (PRINT & SIGN)

DATE

PERSON RESPONSIBLE FOR PAYMENT

DATE

RELATIONSHIP TO PATIENT:

Patient Questionnaire

Date: _____

Name: _____ SSN#: _____
Home Phone: _____ Work Phone # _____ Cell #: _____
Reason for Visit: _____
Date of Birth: _____ Age: _____ Employer: _____
Spouse: _____ DOB: _____ Employer _____
Primary Care Physician & Phone #: _____
Were you referred here today? _____ If so, by Who? _____

****DRUG ALLERGIES: _____
**** ALLERGIES: _____

Single _____ Married _____ Divorced _____ Separated _____ Widowed _____
Menstrual History _____ Last Menstrual Period: _____

Have you ever been pregnant? _____ No _____ Yes, how many times: _____
Full Term: _____ #Pre Term _____ #Miscarriage/Abortion _____ #Living _____
Children _____ Any pregnancy complications: _____
#Days of flow: _____ Amount (heavy, normal, Light) _____
Length Between Periods: _____

Method of Birth Control
Pills _____ Diaphragm _____ Depo Provera _____ Norplant _____ Abstinence _____ Patch _____
None _____ IUD _____ Vasectomy _____ Tubal Ligation _____ Condoms _____ Rhythm Method _____
Other Injectable _____

Medical History Check if you have had any of the following
Cancer _____ High Blood Pressure _____ Anemia _____ Depression _____ Abnormal Pap Smear _____
Heart Disease/Heart Attack _____ Thyroid Problems _____ Alcoholism/Drug Addiction _____
Pelvic Infection _____ Mitral Valve Prolapse _____ Diabetes _____ Digestive Problems _____
Sexually Transmitted Disease _____ High Cholesterol _____ Tuberculosis _____ Anxiety Disorder _____
Phlebitis _____ Migraine Headaches _____ Hepatitis _____ Other Psychiatric Disorders _____
Blood Clots in Legs _____ Asthma _____ Other Medical Diagnosis not listed _____

Do you take any medications? (Please give dose and schedule if known) _____ No _____ Yes
Please List: _____

Surgical History
Have you had any female surgery? _____ No _____ Yes If so, check below:
Breast _____ Simple Hysterectomy(Ovaries left in) _____ Ectopic Pregnancy _____ Laser/Leep _____
Cryo of Cervix _____ Ovary _____ Complete Hysterectomy(Ovaries taken out) _____ Cesarean _____
Section _____ D&C _____ Other _____

Reason for Surgery/ Findings: _____
Please list any other surgeries (appendectomy, heart surgery.) _____

Medical History/ Habits/Health Maintenance

Do you perform breasts exams on yourself: _____ Yes _____ No How often: _____
Have you had a mammogram on your Breasts? _____ Yes _____ No If so when: _____
Have ever had an abnormal mammogram? _____ Yes _____ No If so when: _____
Do you have Pap Smear Yearly? _____ Yes _____ No
Date of last Pap: _____ Where: _____
Over the age of 50, have you had a Flexible Sigmoidoscopy or Colonoscopy? _____ Yes _____ NO If so
When: _____ Reviewed by: _____

Social History/ Habits/ Health Maintenance (continued)

If postmenopausal, have you had a DEXA (Bone) Screening? _____ Yes _____ No If so, when _____
Have you had a cholesterol level check? _____ Yes _____ No If so when _____

Please complete **Front & Back** of this Form

Have you ever smoked? Yes No How much? _____ Quit Years? _____
 Do you drink alcohol? Yes No How much? _____ How often _____
 Do you use street drugs? Yes No What Kind? _____ How often _____
 Do you exercise? Yes No How often? _____
 Are you at risk for HIV infection? Yes No
 Are you or have you ever been threatened or physically, sexually or mentally abused? Yes No

Immunization

Year of last tetanus shot if known? _____
 Have you been vaccinated for Hepatitis B? Yes No If yes, when? _____
 Have you had or been vaccinated for Chicken Pox? Yes No If yes, when _____
 Have you received a Flu shot this year? Yes No
 If over age 65 or with chronic cardiac/pulmonary disease, or immunocompromised, have you received the pneumococcal vaccine? Yes No
 If over age 18, have you had a Rubella booster? Yes No
 If you have had a splenectomy or have an immunodeficiency have you had the pneumococcal vaccine?
 Yes No

Sexual History

Do you experience any significant discomfort with intercourse? Yes No

Family History (siblings, Parents, Grandparents)

Family Member	Family Member
<input type="checkbox"/> Breast Cancer _____	<input type="checkbox"/> Tuberculosis _____
<input type="checkbox"/> Ovarian Cancer _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Other Cancer _____	<input type="checkbox"/> Bleeding Disorder _____
<input type="checkbox"/> Birth Defects _____	<input type="checkbox"/> Alcoholism _____
<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> Mental Retardation _____
<input type="checkbox"/> Heart Attack _____	<input type="checkbox"/> Cystic Fibrosis _____
<input type="checkbox"/> High Cholesterol _____	<input type="checkbox"/> Other _____

Review of Systems Please check if you are having problems with any of the following:

Genital/ Urinary Vaginal Warts Heavy Vaginal Bleeding Painful Intercourse
 Urination at Night Vaginal Dryness Irregular Vaginal Bleeding Urinary Urgency
 Bladder Control/Leakage Painful Menstrual Periods Pain/Burning with Urination
 Urinary Tract Infections

Endocrine

Fatigue Hair Loss Absence of Menstrual Periods Hot Flashes

Skin/Breasts

Nipple Discharge Sore that Does not Heal Changes in Mole Rashes/Persistent Itching
 Breast Lumps/ Tenderness.

Neurological

Frequent Headaches Poor Coordination Muscle Weakness Trouble Sleeping

Psychiatric

Depression Anxiety Memory Changes Counseling or Treatment
 Mood Swings Eating Disorder

Ear/Nose & Throat

Visual Problems Allergies/Hayfever Frequent Sore Throat Mouth Ulcers
 Hearing Loss Hoarseness Sinus Problems

Digestive

Heart Burn Rectal Bleeding Diarrhea Yellow Jaundice Vomiting
 Black Stools Significant Weight Change (< or > 10-15 lbs/yr)

Cardiac

Chest Pain Irregular Heart Beat Fainting/Dizziness

Respiratory

Shortness of Breath Coughed Blood Wheezing

ENGLISH

Acknowledgement of Receipt of Notice of Privacy Practices (to be filed in patient's medical record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed: _____ Date: _____

Relationship (if not signed by patient): _____

Internal Use Only

If patient/patient's representative refused to sign acknowledgement, please document date and time notice as presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____

ESPAÑOL

RECONOCIMIENTO DEL RECIBO DE LA DECLARACION DE PRIVACIDAD (debera ser archivado en el expediente del registro medico del paciente)

Me han presentado una copia de la Declaracion de Privacidad, detallando como mi informacion medica puede ser usada y divulgada como sea permitido bajo las federales y estatales, y un resumen de mis derechos con respecto a mi informacion medica.

Firma: _____ Fecha: _____

Relacion (si no esta firmando el paciente): _____

Usa Interno Solamente

Se el paciente/el representante del paciente se niega a firmar este reconocimiento, favor de documentar la fecha y la hora que el aviso fue presentado al paciente y firme abajo.

Presentado el (fecha y hora): _____

Por (nombre y titulo): _____

DEAR PATIENTS:

DUE TO PATIENT CONFIDENTIALITY, THIS FORM MUST BE COMPLETED IF YOU WISH TO ALLOW US TO SPEAK TO ANYONE BESIDES YOURSELF, REGARDING ANY OF YOUR MEDICAL CARE. THIS PERTAINS TO ANY FAMILY MEMBERS, INCLUDING YOUR SPOUSE, OR ANY CLOSE FRIENDS. IF THERE NAME IS NOT LISTED BELOW, PLEASE BE AWARE THAT WE CAN NOT AND WILL NOT RELEASE ANY INFORMATION TO THEM WITHOUT YOUR WRITTEN CONSENT.

PATIENT NAME _____ DOB _____

I HEREBY GIVE HERITAGE OB/GYN AUTHORIZATION TO RELEASE INFORMATION REGARDING APPOINTMENTS, TEST RESULTS, AND MEDICAL INFORMATION ON MYSELF TO THE FOLLOWING PEOPLE.

NAME _____ RELATIONSHIP _____

I UNDERSTAND THAT THIS WILL REMAIN IN EFFECT UNTIL I GIVE WRITTEN NOTICE TO HERITAGE OB/GYN TO REMOVE ANY OF THE PERSONS LISTED ABOVE.

PATIENT SIGNATURE _____

DATE SIGNED _____