OBSTETRICS & GYNECOLOGY ASSOCIATES

1101 East Jefferson Street
Charlottesville, VA 22902
Tel: 434-979-2121 Fax: 434-979-2365
Website: obgynassociatescville.com

REGISTRATION FORM *(PLEASE PRINT)* **Chart #** **TODAY'S DATE:**

Last Name:	First Name:		MI:
DOB: / /	Age:	Martial Status (circle one) Single / Married / Divorced / Separated / Widowed	
Street Address:	Email	Smoking Status Current ☐ Former ☐ Never ☐	Ethnicity Hispanic/Latino ☐ Not Hispanic/Latino ☐ Prefer Not To Answer ☐
City:	State: Zip Code:		
Cell Phone:	Home Phone:	Work Phone:	
Occupation:	Employer:	SS#:	
How were you referred to us?			
Spouse/Partner Name:	DOB: / /	SS#:	Phone Number:

INSURANCE INFORMATION ***(Please give your Insurance card and photo ID to the receptionist)***

Primary Insurance:	Subscriber's Name:	Subscriber's DOB / /
Secondary Insurance:	Subscriber's Name:	Subscriber's DOB / /

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

PHARMACY INFO ***PLEASE ALLOW 24 - 48 HOURS FOR PRESCRIPTIONS REFILLS TO BE CALLED INTO YOUR PHARMACY***

Preferred Pharmacy: Location:

CASE OF EMERGENCY

Name of local friend or relative (not living at same address):

Home Phone #:	Work Phone #:	Relationship to Patient:

AUTHORIZATION FOR USE AND DISCLOSURE OR PROTECTED HEALTH INFORMATION

It is the policy of OB/GYN ASSOCIATES to make confirmation phone calls for certain appointments, because of HIPAA, it is necessary for us to get your authorization on certain items. I authorize your staff to call of text (preferred number) _____ and leave a message on my answering machine regarding appointments.
I authorize the staff to speak with and release ALL medical information to the following individual (s):

Name:	Relationship to patient:

I AUTHORIZE THE STAFF TO LEAVE A MESSAGE ON MY VOICEMAIL AT MY WORK NUMBER. YES NO

I acknowledge that I have reviewed and/or been offered a copy of Notice of Privacy Practices. I understand that I may request and review a copy of these Practices at any time from the office staff. I certify that I have insurance with the above company and assign benefits to OB/GYN ASSOCIATES. I authorize this practice to release information necessary to secure benefits and payment. I authorize use of the signature on all claims.

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

FINANCIAL POLICY **Chart #** **Date:**

As a courtesy to our patients, we file claims to most insurance companies. Please be aware that some or perhaps all of the services rendered may or may not be covered. Benefits are determined by you and your insurance company. Please be aware of your benefits. If you insurance company denies payment, you will be billed and payment is due upon receipt of statement.

We cannot file your insurance unless an active card is presented or on file. Your insurance must be current and verifiable at the time of service. Payment assignment must be made to this office. Co pays, deductibles and non-covered services fees are due at the time of service.

Full payment is due at time of service if insurance payments are sent to the patient.

If referral or preauthorization for services is required, you are responsible for confirming this prior to receiving services. If referral/preauthorization is not obtained, services may be rescheduled or you may be responsible for payment in full.

Please be aware that attending scheduled appointments is important. A fee will be assessed after the 3rd (third) "No Show" or cancellation within less than 24 hour notice.

Should it be necessary to utilize an outside collection means for a past due account, you are responsible for all costs including attorney, court and collection fees (25%). A $35 fee will be assessed on all returned checks. Financial non-compliance is grounds for discharge from the practice.

I have read the above and understand the Financial Policies of OB/GYN ASSOCIATES. I have completed this form to the best of my ability and will not hold the practice responsible for my errors or omissions.

Signature: _____ **Date:**_____

DEEMED CONSENT

I voluntarily consent to medical care in this practice. No promises have been made as to the results of the examinations or treatments. I authorize the release of pertinent medical information to other providers involved in my care.

Virginia law requires health care providers to notify you that Hepatitis B and C and HIV testing be done if a healthcare worker is exposed to your blood or body fluids. This notice is to advise you that this is in effect at this facility. As a health care provider under Virginia Acts Assembly, Section 32.1.45.1, whenever a health care worker associated with OB/GYN ASSOCIATES is directly exposed to body fluids of a patient in a manner which, according to the CDC guidelines, may transmit HIV, Hepatitis B or C, this practice will proceed to test both the patient and health care worker who was exposed.

Signature: _____ **Date:** _____

MEDICARE AUTHORIZATION (if applicable)

I request payment of authorized Medicare benefits to me made to OB/GYN ASSOCIATES for services rendered by this practice. I authorize release of my information to HCFA and its agents, information required to determine benefits. If I have other insurance, my signature authorizes release of information to that insurance company. In Medicare assigned cases, the practice agrees to accept Medicare's determination as payment in full, noting the patients' responsibilities for deductibles, co insurance and non covered services.

Signature: _____ **Date:** _____

Thank you for your time completing this form!!

HEALTH QUESTIONNAIRE

Chart #	TODAY'S DATE:

Patient's Last Name: _____ Patient's First Name: _____

Date of Birth: _____ Primary Physician: _____

Reason For Visit Today: _____

Current Method of Contraception (including Vasectomy or Tubal Ligation):

Current Meds Prescribed by Our Office:	**Other Meds Currently Taking:**
Surgery/Hospitalization History:	**Current Medical Conditions:**
Allergies:	**Adverse Reactions:**
Provider notes:	

OBSTETRICAL HISTORY

How many time have you been pregnant? _____ How many children do you have? _____

Any Miscarriages? YES NO How many? _____ Have you had any abortions? YES NO How many? _____

Have you had any of the following complications during pregnancy, delivery or post delivery care:

High Blood Pressure	YES	NO	Diabetes	YES	NO	Pre-Term Labor	YES	NO
Infection	YES	NO	Bleeding	YES	NO	Post Partum/Depression	YES	NO
Cesarean Section	YES	NO	Anemia	YES	NO	Other:		

Provider Notes:

GYNECOLOGICAL HISTORY

Date of your last normal period?			At what age did you begin your periods?		
How often do your periods occur?			How long do your periods last?		
Are you sexually active?	YES	NO	Date of your last mammogram _____		
Do you perform self breast exams?	YES	NO	Any history of abnormal mammograms?	YES	NO
Do you have any vaginal itching?	YES	NO	Any history of abnormal Pap Smears?	YES	NO
Do you have any abnormal discharge?	YES	NO	Date of your last Pap Smear: _____		

Provider Notes:

REVIEW OF SYSTEMS (Please circle any that apply)

Fatigue	YES	NO	Migraines	YES	NO	Food Intolerance	YES	NO
Dizziness	YES	NO	Intestinal Problems	YES	NO	Eating Disorder (name)	YES	NO
Blurred/Double Vision	YES	NO	Varicose Veins	YES	NO	Urinary Stress Incontinence	YES	NO
Chest Pain	YES	NO	Phlebitis	YES	NO	Burning w/Urination	YES	NO
Chronic Cough	YES	NO	Edema (swelling)	YES	NO	Blood in Urine	YES	NO
Breathing Problems	YES	NO	Blood Transfusion (date)	YES	NO	Anxiety/Nervousness	YES	NO
Indigestion/GERD	YES	NO	Reaction to transfusion	YES	NO	Insomnia	YES	NO
Weight loss/gain (amt?)	YES	NO	Poor Appetite	YES	NO	Breast Lump	YES	NO
Breast Tenderness	YES	NO	Other: List			Unusual Vaginal Discharge	YES	NO
Pelvic Pain or Pressure	YES	NO				Irregular Bleeding	YES	NO

Provider Notes:

You are almost done . . . Please review and complete back page!

Name:	Chart #	TODAY'S DATE:

PAST MEDICAL HISTORY: Please circle any that apply to you now or in the past

Asthma	YES	NO	Kidney Stones	YES	NO	Hepatitis (A/B/C)	YES	NO
Blood Transfusion	YES	NO	Lung Disease/Cancer	YES	NO	Herpes	YES	NO
Bowel Problems	YES	NO	Thyroid Disease	YES	NO	HPV	YES	NO
Gallbladder Disease	YES	NO	Lupus	YES	NO	Syphilis/Gonorrhea	YES	NO
Fibromyalgia	YES	NO	Migraines	YES	NO	Substance Abuse	YES	NO
Depression	YES	NO	Mitral Valve Prolapse	YES	NO	Ulcers	YES	NO
Human Immunodeficiency	YES	NO						
Virus	YES	NO	Chlamydia	YES	NO	Skin Cancer	YES	NO
High Cholesterol	YES	NO						

Provider Notes:

FAMILY HISTORY: Have you or anyone in your family had (Use MGM for maternal grandmother, PGF for Paternal grandfather, etc.)

	Self	*OTHER FAMILY MEMBER*		Self	*OTHER FAMILY MEMBER*
Alzheimer's			Kidney Disease		
Birth Defects			High Blood Pressure		
Blood Clot History			Diabetes		
Breast Cancer			Stroke		
Colon Cancer			Epilepsy		
Ovarian Cancer			Twins		
Heart Disease			Osteoporosis		

Have you ever had a colonoscopy?

YES NO

Normal ☐ Abnormal ☐

Date of your last one? _____

Was told to follow-up in yrs. _____

Provider Notes:

SOCIAL HISTORY

Do you smoke cigarettes?	YES NO	Do you exercise?	YES NO
How many packs per day?	/ How long?	How many times per _____Week?	_____ Month?
Do you drink alcohol?	YES NO How many?	Seat Belt Use	YES NO

Provider Notes:

Please do not fill below out, until you return next year !!!!!

RETURN PATIENT HEALTH UPDATE **UPDATE FOR NEXT YEAR (return visit) Date: _____/_____/_____**

Reason for your visit today?			Date of your last period? _____		
Date of your last Mammogram?		Date of last PAP?	Surgery/Hospitalization since last visit?	YES	NO
Medications **CHANGES** since last visit?	YES NO		Any **CHANGES** to illness History?	YES	NO
List Changes:		List Change:			

To the best of my knowledge, the questions on this form have been answered. **Patient Signature:**

I have read and reviewed the information provided by the Patient/ Guardian above. **Providers Signature:**

Provider Notes:

RETURN PATIENT HEALTH UPDATE **UPDATE FOR NEXT YEAR (return visit) Date: _____/_____/_____**

Reason for your visit today?			Date of your last period? _____		
Date of your last Mammogram?		Date of last PAP?	Surgery/Hospitalization since last visit?	YES	NO
Medications **CHANGES** since last visit?	YES NO		Any **CHANGES** to illness History?	YES	NO
List Changes:		List Change:			

To the best of my knowledge, the questions on this form have been answered. **Patient Signature:**

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Provider Notes: