LAUREL WOMEN'S MEDICAL GROUP PATIENT REGISTRATION

PATIENT NAME: _____ DATE OF BIRTH: _____

HOME ADDRESS: _____ APT. #_____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORK:_____ CELL: _____

EMAIL ADDRESS_____

WHICH PHONE NUMBER MAY WE CONTACT YOU AT DURING BUSINESS HOURS: _____

MAY WE LEAVE A CONFIDENTIAL MESSAGE AT THIS NUMBER: YES/NO

PATIENT SOCIAL SECURITY #: _____ MARITAL STATUS: S M D W

SPOUSE/PARTNER NAME_____

GUARDIAN NAME (IF MINOR)_____

EMERGENCY CONTACT_____ PHONE NUMBER_____

MEDICAL INSURANCE COMPANY _____

INSURANCE SUBSCRIBERS NAME: _____

SUBSCRIBERS DATE OF BIRTH: _____ **EMPLOYER**_____

PRIMARY CARE PHYSICIAN_____ PHONE NUMBER_____

I agree to be personally and fully responsible for payment. In case of default I will be responsible for all costs incurred in the collection of this and future outstanding balances.

Signature _____ Date_____

*** OFFICE USE ONLY***

INSURANCE_____ MEMBER ID#_____

INS VERIFIED_____ COPAY_____

GENERAL CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

Patient's Name: _____

Patient's Date of Birth: _____

1.) **Consent:** I, the undersigned patient or authorized representative of the patient, hereby voluntarily request, consent to, and authorize Laurel Women's Medical Group and its staff to provide medical care including treatments, examinations, diagnostic procedures, and the administration of medications as deemed necessary and advisable by the Practice and its healthcare provider to me.

2.) **Release of Information:** I hereby authorize the Practice to release and to disclose to any third-party payer, or its representative, which may be responsible for payment in my case, or as required by law, such information from my patient records as is necessary in order to receive reimbursement for any healthcare services rendered to me by the Practice. I also authorize release and disclosure of my patient records to other healthcare providers who may, in the opinion of the Practice, be of assistance in providing treatment or the most appropriate medical care to me.

3.) **Physician Referral:** I understand that if my health insurance is provided by a managed care plan, I am responsible for contacting my primary care physician and obtaining necessary referrals for any services rendered at this office. Failure to do so will result in my being financially responsible for said services.

4.) **Payment:** I understand that I am responsible for any health insurance deductibles and/or copayments. I understand that I am financially responsible for the cost of services at the time they are rendered unless prior arrangements have been made. I understand that if my medical insurance plan (or third-party benefit plan) denies payment of services or the services are not covered under such plan, I will be responsible for payment of said services and I agree to pay all charges submitted by the Practice for the care given to me. I authorize my medical insurance plan (or third-party benefit plan) to make payments directly to the Practice for any services the Practice furnishes to me.

5.) **Accuracy & Integrity:** I hereby acknowledge the information I provided on the patient registration form and patient history to be true and correct and completed to the best of my ability.

6.) **No Guarantees:** I am aware that the practice of medicine if not an exact science, and I acknowledge that no guarantees are made as to the result of the care and treatment which I have hereby authorized.

7.) **Contact Authorization:** I ___ **do** ___ **do not** (check one) authorize information to be left on my voice mail.

We will ordinarily contact you using your home phone number and home address. If you want us to contact you in another manner, please provide us with specific instructions about how we may contact you.

_____

Is there any person with whom you would like us to share confidential medical information with? Yes / No

Name_____ ***phone number***_____

I have read this form or it has been read to me and I am satisfied that I understand the entire contents and significance of this form, and all my questions (if any) have been answered. Further, I understand that this consent will be deemed continuing and I am free to revoke my consent at any time.

Signature of Patient/Guardian: _____ Date: _____

Relationship to Patient if not signing for self: _____

Health History Questionnaire

Laurel Women's Medical Group

Name: _____ Phone: _____ Date: _____

Age: _____ Birthdate: _____ Date of last period (first day): _____

What is the purpose of your visit today? _____

_____

Gynecology History:

At what age did you get your first period? _____

How often do you get your period? Every _____ days

How long does your period last? _____ days

How many pads/tampons do you use on the **heaviest** day? _____

Is there any significant pain with periods?	Yes	No
Is there any significant pain at other times of your cycle?	Yes	No
Is there any spotting or bleeding after intercourse?	Yes	No
Is there any problem with sexual function?	Yes	No
Are there any breast masses or lumps?	Yes	No
Is there any breast discharge?	Yes	No
Are there any urinary complaints? (burning, loss of urine, urgency)	Yes	No
Have you ever had an abnormal pap smear result?	Yes	No
Have you ever had an abnormal mammogram?	Yes	No
Do you have a history of any sexually transmitted infections?	Yes	No
Do you have any other problems or concerns not mentioned above?	Yes	No

What is your current method of birth control? _____

If you answered yes to any of the above questions, please explain: _____

_____

_____

_____

Obstetrical History- please list all pregnancies, their outcomes and any conditions:

Year	Length of preg.	Vaginal/C-section	Complications
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

General Medical History- please indicate if you have any of the following:

	Anemia		Cancer		Heart failure		Neurologic disorders
	Anesthetic reaction		Type:		Heart murmur		Phlebitis/blood clot
	Angina/chest pain		Depression/anxiety		Hepatitis/liver disease		Seizures/convulsions
	Arthritis		Diabetes		High blood pressure		Skin disorders
	Asthma		Drug dependency		High cholesterol		Stroke/mini-stroke
	Bladder infections		Glaucoma		Irregular heart beat		Thyroid disease
	Bleeding problems		Headaches		Kidney problems		Ulcers
	Blood transfusion		Heart attack		Lung disease		Other:

Family History- please indicate if any family members (parents, grandparents, siblings, children) have the following:

Breast Cancer		Ovarian cancer		Diabetes	
Cervical Cancer		Uterine cancer		Thyroid Disease	
Colon cancer		Other cancer		Heart Disease	
Blood clots		Type:			

Surgical History/Hospitalizations- excluding childbirth

Year	Reason for Hospitalization/Surgery	Any Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Allergies- please also list the reaction

_____

_____

Current Medications (please include over the counter, strength, frequency and reason for taking)

_____

_____

_____

_____

_____

Personal Habits

Do you smoke? ____ How many per day _____ Do you drink alcohol? _____ How much per week?_____

Do you use recreational drugs?_____ What drugs & how often_____

Do you exercise regularly? _____ Activity & how often _____

Any concerns regarding your visit or health history not covered above please explain below:

_____

_____

_____