



Thank you for choosing OB/GYN Specialists, P.C. to provide your medical care. We consider it a privilege to be able to serve you. Our primary responsibility is to provide our patients with the highest quality medical services. We appreciate your confidence in selecting us for your obstetrical and gynecological care.

Please plan to arrive fifteen (15) minutes before your scheduled appointment time. This is so we are able to process the necessary paper work to expedite your appointment. We do work on an appointment basis, so if you find that you will be arriving late or are unable to keep your appointment, please call as soon as possible so that we may make whatever arrangements are necessary to serve you best. We ask for 24 hours notice if you are unable to make your appointment. Depending on the type of appointment, there may be a \$25-\$50 fee if proper notice is not given. Please remember to bring your insurance card with you.

Our office relies upon the prompt payment of fees by our patients. We ask for full payment at the time of service. We are participating physicians with many Baptist and Methodist insurance plans, and we will file insurance after the co-payment or deductible has been paid. For your convenience, we do accept cash/checks, Visa/MasterCard or Discover.

Please complete all forms provided through this link, and bring them with you to your appointment. It is important that we have the ability to contact you with test results in a confidential manner that follows HIPAA regulations. For that reason, please complete the Result Notification Release. This will provide your physician with the necessary information to initiate your care. Feel free to add any comments or other remarks as deemed necessary. Please be assured that all the information that you provide is confidential.

We are conveniently located in the PennMarc Centre at 6401 Poplar Ave., in Suite 530. Parking is in the rear of the building. Again, we thank you for selecting our practice and look forward to meeting you.

Please ask to speak to me or our administrator, Jeanne Distretti, if you have any questions during your visit.

Mary McKay  
Supervisor, Front Office

**NAME:**

**MR #**

**D.O.B.**



**THIS INFORMATION IS IMPORTANT AND CONFIDENTIAL. PLEASE BE FRANK. ANSWER THE QUESTIONS AS BEST YOU CAN. IF YOU NEED ASSISTANCE, ASK YOUR NURSE OR DOCTOR.**

Patient's Name \_\_\_\_\_ S/S # \_\_\_\_\_  
(last) (first) (middle)

Address \_\_\_\_\_  
(street) (city) (state) (zip)

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_ Status: M \_\_\_ S \_\_\_ D \_\_\_ Sep \_\_\_ W \_\_\_

Occupation \_\_\_\_\_ Where Employed \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_ Ext: \_\_\_\_\_

Person to Contact in Emergency (Other than Family Member) \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**PAST MEDICAL HISTORY**

(1) Past and Present Illnesses/Hospitalizations/Surgeries:

Illness	Year	Illness	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(2) Medications currently taking (prescription and non-prescription)

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(3) Allergic or bad reaction to medication

_____	_____	_____	_____
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**FAMILY HISTORY**

(4) Family Diseases:

Disease	Family Member	Disease	Family Member
<input type="radio"/> Heart Attack	_____	<input type="radio"/> High Blood Pressure	_____
<input type="radio"/> Diabetes	_____	<input type="radio"/> Ovarian, Uterine,	_____
<input type="radio"/> Breast Cancer	_____	<input type="radio"/> Cervical Cancer	_____
<input type="radio"/> Stroke	_____	<input type="radio"/> Other Cancers	_____
<input type="radio"/> Thyroid	_____		

**SOCIAL HISTORY**

(5) Smoking:

- Currently smoke? Packs per day: \_\_\_\_\_ Total years smoking: \_\_\_\_\_
- Stopped Smoking? How long ago: \_\_\_\_\_ Total years smoking: \_\_\_\_\_
- Never smoked.

(6) Exercise:

- Regularly exercise? Type: \_\_\_\_\_ How often: \_\_\_\_\_

(7) Weekly alcohol consumption: Beer: \_\_\_\_\_ Wine: \_\_\_\_\_ Hard liquor: \_\_\_\_\_

(8) Drugs used regularly:

- Marijuana  Barbituates  Amphetamines  Opiates  Cocaine

(9) Weight a year ago: \_\_\_\_\_ Present weight: \_\_\_\_\_

**MEDICAL SYSTEM REVIEW**

1. Venereal Diseases:

Year

- Gonorrhea \_\_\_\_\_
- Herpes \_\_\_\_\_
- Syphilis \_\_\_\_\_
- Chlamydia \_\_\_\_\_

2. Urinary problems

- Kidney stones
- Bladder or kidney infection
- Painful or burning urination
- Too frequent urination
- Urine loss
- Blood in urine

3. Blood Disorders

- Low blood count (anemia)
- Easy bruising
- Sickle cell disease
- Bleeding problems with surgery or injury
- Family members with bleeding problems
- Other: \_\_\_\_\_

4. Lungs

- Asthma
- Other

5. Heart

- MVP
- Murmur
- Other

6. Stomach and Intestinal Problems

- Constipation
- Vomiting Blood
- Indigestion
- Diarrhea
- Bloody or black bowel movement
- Other: \_\_\_\_\_

7. Liver Problems:

- Hepatitis
- Gall bladder trouble
- Jaundice
- Other: \_\_\_\_\_

8. Menstrual History

- Age period started: \_\_\_\_\_
- Age period stopped: \_\_\_\_\_
- Age period stopped naturally: \_\_\_\_\_
- Age at time of hysterectomy: \_\_\_\_\_
- Problems with your periods
- Excessive bleeding
- Excessive cramping or pain
- Bleeding between periods
- Bleeding with or after intercourse
- Vaginal discharge

11. Date of last pap smear: \_\_\_\_\_

12. Date of last mammogram, if ever: \_\_\_\_\_

Who may we thank for this referral?

\_\_\_\_\_

9. Method of Birth Control

- Birth control pill
- Diaphragm
- Bilateral tubal ligation
- Intrauterine device
- Condom
- Vasectomy
- Vaginal foam or jelly
- Rhythm
- Not satisfied with method
- Other: \_\_\_\_\_

10. Pregnancy History:

Total number of pregnancies: \_\_\_\_\_

Number of miscarriages: \_\_\_\_\_

Number of abortions: \_\_\_\_\_

Living children: \_\_\_\_\_

Pregnancy Problems

- Excessive weight gain
- Vaginal bleeding
- High blood pressure
- Problems with delivery
- Toxemia



PATIENT #
DATE
DOCTOR

PLEASE PRINT

**PATIENT REGISTRATION**  
Please complete all blanks

**PATIENT**

NAME LAST	FIRST	M.I.	AGE	DATE OF BIRTH	RACE	ARE YOU PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO
ADDRESS		CITY	STATE	ZIP	PHONE	
SOCIAL SECURITY NUMBER	MARITAL STATUS <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	HAVE YOU BEEN TREATED BY THESE PHYSICIANS BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO	UNDER WHAT NAME		DATE	
OCCUPATION		NAME OF EMPLOYER				
EMPLOYER'S ADDRESS		CITY	STATE	ZIP	PHONE	
IN CASE OF EMERGENCY NOTIFY SOME PERSON OTHER THAN A FAMILY MEMBER	NAME	STREET ADDRESS, CITY, STATE, ZIP			PHONE	

**LIST HUSBAND - IF MINOR OR STUDENT LIST FATHER AND MOTHER**

HUSBAND/FATHER	ADDRESS	DATE OF BIRTH	PHONE		
SOCIAL SECURITY NO.	OCCUPATION	NAME OF EMPLOYER			
EMPLOYERS ADDRESS		CITY	STATE	ZIP	PHONE
MOTHER	ADDRESS	DATE OF BIRTH	PHONE		
SOCIAL SECURITY NO.	OCCUPATION	NAME OF EMPLOYER			
EMPLOYER'S ADDRESS		CITY	STATE	ZIP	PHONE

**INSURANCE**

INSURANCE CO. NAME	MAIL FORM TO:	STREET ADDRESS	CITY	STATE	ZIP	PHONE
POLICY HOLDER (IF GROUP, EMPLOYER)	INSURER'S NAME	<input type="checkbox"/> GROUP <input type="checkbox"/> PRIVATE	POLICY OR I.D. #	GROUP OR OTHER #		
INSURANCE CO. NAME	MAIL FORM TO:	STREET ADDRESS	CITY	STATE	ZIP	PHONE
POLICY HOLDER (IF GROUP, EMPLOYER)	INSURER'S NAME	<input type="checkbox"/> GROUP <input type="checkbox"/> PRIVATE	POLICY OR I.D. #	GROUP OR OTHER #		

**PLEASE READ AND SIGN**

**ASSIGNMENT AND RELEASE:** I hereby authorize OB/GYN Specialists, P.C. to furnish information to insurance carriers concerning treatment, and hereby assign to the doctor all insurance benefits otherwise payable to me for these services. I understand that I am financially responsible for all charges not covered by my insurance. I also understand that I am responsible for reasonable collection costs and/or attorney fees incurred for the collection of this account. I agree to follow all office policies set by OB/GYN Specialists, P.C. I agree to provide any information requested by OB/GYN Specialists, P.C. concerning my account. I understand and agree to fill out the requested forms and updates when requested by OB/GYN Specialists, P.C. without delay and I understand that if I do not provide updates, forms and new insurance information I will be responsible for all charges to my account. I also understand that the information provided by me will be provided to an OB/GYN Specialists, P.C. outside collection agency should my account become past due by 90 days or 3 billing statement cycles for collection procedures.

**PLEASE NOTE:** There will be a \$25.00 charge for returned checks. Twenty-four (24) hour notice is required for cancellation of appointment. Failure to give 24 hour notice may result in a \$25.00 fee.

Responsible Party Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

Date: \_\_\_\_\_ Reviewed by Staff Member: \_\_\_\_\_

This form will remain in effect for 1 year from the date signed or until any information on this form/account changes at which time I agree to fill out a new form with the correct information without delay. I also agree to provide new insurance cards within 2 weeks of receiving them. I understand that if I delay in providing new insurance information my claims may be denied for timely filling limit and that I will be solely responsible for the affected charges. Initials: \_\_\_\_\_

Signature: \_\_\_\_\_



**Result Notification Release**

**Patient** \_\_\_\_\_

It is important that we are able to contact you regarding test results or other aspects of your care. Please complete the following information:

1. Cell Phone # \_\_\_\_\_  
(Unless otherwise indicated, we will leave messages on your cell phone voice mail.)

Comments \_\_\_\_\_

2. Home # \_\_\_\_\_

May we leave a message for you to call us on your home answering machine? \_\_\_\_\_ Yes \_\_\_\_\_ No N/A

May we leave a message for you to call us with a family member? \_\_\_\_\_ Yes \_\_\_\_\_ No N/A

*Please specify name/s of family member* \_\_\_\_\_

May we discuss test results with a family member. \_\_\_\_\_ Yes \_\_\_\_\_ No N/A

*Please specify name/s of family member* \_\_\_\_\_

3. Work # \_\_\_\_\_ ext \_\_\_\_\_

May we call you at work? \_\_\_\_\_ Yes \_\_\_\_\_ No N/A

May we leave a message on your work voice mail? \_\_\_\_\_ Yes \_\_\_\_\_ No N/A

**There are numerous Walgreens, Walmarts, & Rite-Aids. To ensure that we call your medications to the correct pharmacy, please give us that name and number.** \_\_\_\_\_

Are there any special instructions we should know about? \_\_\_\_\_

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Date*

I authorize the doctors of OB/GYN Specialists, P.C. to fax/send lab/test results to any physician I am referred to for consultation. Only results that would be pertinent to my consultation are to be sent.

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Date*



## **OFFICE POLICY ON MANAGED CARE INSURERS**

OB/GYN Specialists, P.C. has enrolled in numerous managed care insurance programs to accommodate the needs of our patients.

With each insurance program, there are many individual requirements of the plans having different stipulations regarding what services are covered and how often they may be performed.

Unfortunately, if you do not inform us of special requirements in your insurance contract such as lab work, preventative care, hospitalization, and/or out-patient procedures that are not covered or must go to a specific location, or the need for a referral from your primary care physician, we have no choice but to bill you directly for those charges. Payments for those charges are then your responsibility.

Please check with your insurance provider if you have any questions relating to the services that we provide. We want you to receive all of the benefits offered to you.

I have read and understand the office policy stated above and agree to accept responsibility as described.

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SIGNATURE

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DATE