PATIENT INFORMATION

Today's Date (mm/dd/yyyy) _____

PERSONAL INFORMATION

First Name: _____ Last Name: _____ MI: _____

Permanent Address: _____

City: _____ State/Province: _____ Zip Code: _____

Country (if outside US): _____ Date of Birth: _____

Phone 1: _____ Phone 2: _____

Local Address (if Different from permanent): _____

City: _____ State/Province: _____ Zip Code: _____

Marital Status: Married _____ Single _____ Divorced _____ Widowed _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Employer: _____ Phone: _____

Pharmacy: 1. _____ Phone: _____

Pharmacy: 2. _____ Phone: _____

Ethnicity: Latino/Hispanic _____ Other _____ Not reported/Refused _____

Race: Caucasian _____ Black _____ Hispanic _____ Asian _____ Other _____

Native American _____ Asian Pacific _____ Pacific Islander _____ White Non-Hispanic _____

Black Non-Hispanic _____ Native Hawaiian _____ Subcontinent Asian American _____

American Indian or Alaskan Native _____

Insurance Information (Please provide all current insurance cards at registration).

Primary Insurance Company: _____

Is this: Medicare _____ MedicareHMO _____

Group Number: _____ ID Number: _____

Secondary Insurance Company: _____

Is this: Medicare _____ MedicareHMO _____

Referral Information: (Please provide referral at registration)

Referred by: Insurance website _____ Insurance book _____ Referring physician _____

Newspaper/magazine ad _____ Friend/relative _____ Name of person referring you _____

Referring Physician: _____ Phone: _____

Primary Care Physician (if different): _____ Phone: _____

Patient's Name: _____ **DOB:** _____

EMERGENCY CONTACT INFORMATION

Spouse/Significant Other Contact Information:

Spouse's Name: _____

Spouse's Address (if different) _____

City: _____ State/Province _____ Zip Code _____

Country (if outside US): _____ Home phone: _____

Cell phone: _____ Pager: _____

Spouse's Occupation: _____

Spouse's Employer: _____ Work Phone: _____

Other Relative Emergency contact:

Name of nearest relative: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Pager: _____

IN CASE OF EMERGENCY, I HEREBY AUTHORIZE YOU TO CONTACT THE FOLLOWING EMERGENCY CONTACT(S):

Spouse/Significant Other: _____

Other nearest relative: _____

PLEASE BE AWARE IN CASE OF EMERGENCY I HAVE COMPLETED THE FOLLOWING DOCUMENTS THAT I WILL PROVIDE TO THIS PHYSICIANS OFFICE WITHIN 10 DAYS OF SIGNATURE BELOW. I AM AWARE THAT MY REQUESTS CAN NOT BE FOLLOWED UNLESS APPROPRIATELY SIGNED LEGAL DOCUMENTS ARE MAINTAINED IN THIS CHART OR PROVIDED AT THE TIME OF EMERGENCY.

Living Will _____ DNR/Do Not Resuscitate _____

_____ _____

Patient Signature Witness Signature

_____ _____

Patient Name Witness Name

Date: _____

Patient's Name: _____ **DOB:** _____

GYNECOLOGIC HISTORY

How old were you when you first started your period?	
How many days in between periods?	
How long does your period last?	
How many pads or tampons do you change in a day when you have a period?	
Date of last period? Does your bleeding impact the quality of your life?	
Have you ever had any of the following sexually transmitted diseases? If **Yes**, please circle: HIV HEPATITIS B HEPATITIS C GONORRHEA CHLAMYDIA HERPES VENEREAL WARTS TRICHOMONAS HPV (HUMAN PAPILLOMA VIRUS)	
Have you ever had any other gynecologic surgery? Please list.	
What was your most recent birth control method?	
Are you currently using birth control?	
Are you satisfied with your method?	
Are you interested in permanent birth control?	
Are you sexually active?	
Number of partners? (Lifetime) Partners are men _____ women _____ both _____	
Do you do Breast Self Exams?	
Have you ever had an ectopic (tubal) pregnancy?	
How many total pregnancies have you had? C/Section _____ Vaginal Delivery _____	
How many children do you have?	
How many miscarriages have you had?	
How many abortions have you had?	

Patient's Name: _____ DOB: _____

PATIENT MEDICAL HISTORY

CONDITION	YES	NO	SPECIFY (If applicable)
Chest Pain			
Shortness of Breath			
Hypertension (high blood pressure)			
Hyperlipidemia (high cholesterol)			
Myocardial Infarction (heart attack)			
Congestive Heart Failure			
Abnormal Heart Beat			
Lightheadedness / Passing Out			
Enlarged Heart			
Heart Murmur			
Rheumatic Fever			
Stroke			
Blood Clots			
Peripheral Vascular Disease			
Swelling or Aching in Legs			
CONDITION	**YES**	**NO**	**SPECIFY (If applicable)**
Other Vascular			
Excessive Fatigue			
Diabetes			
Gastrointestinal Problems			
Orthopedic Problems			
Asthma			
Emphysema			
Other Respiratory Problems			
Headaches			
OB/GYN Problems			
Thyroid			
Urinary / Kidney			
Hematological			
Immunological			
Psychological / Psychiatric			
Neurologic Problems			
Cancer			
Other			

Patient's Name: _____ **DOB:** _____

ABOUT YOU:

Have you ever smoked? _____ If so How Many Packs per day _____ for _____ years,

Current smoker? _____

Do you exercise? _____ How often? _____

Do you drink alcohol? _____ How much? _____ /month

Do you drink coffee? _____ How much? _____ /month

Do you use recreational drugs? _____ How much? _____ /month

Do you drink dairy products or take calcium supplements? _____

Have you been sexually abused, threatened or hurt by anyone?

PAST SURGERY AND HOSPITALIZATIONS

Surgery / Hospitalization	Reason	Date (mm/dd/yyyy)

Patient's Name: _____ **DOB:** _____

FAMILY HISTORY

Relative	Age (or age at death)	History of ovarian cancer, uterine cancer, cervical cancer, breast cancer (please specify)	History of Heart Disease	History of High Blood Pressure	History of Heart Attack	History of Diabetes	History of Stroke	If deceased, list cause of death
Mother								
Brother								
Brother								
Sister								
Sister								
Father								
Grandmother Father's side								
Grandfather Father's side								
Grandmother Mother's side								
Grandfather Mother's side								
Other (Specify)								

Patient's Name: _____ **DOB:** _____

***Email Address:** _____
(this information is not released and is for our office use only to enable us to share health news and alerts)

HIPAA/PATIENT PRIVACY

Acknowledgement of receipt of Privacy Notice and Release of Protected Health Information. I have been presented with a copy of Albany Obstetrics and Gynecology's Notice of Privacy Policies detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request that the following be adhered to regarding my Protected Health Information.

I **DO** want the following individual(s) to have access to the information checked below (ie family members, spouse) _____

_____

	YES	NO
All information		
Financial Information		
Prescription Information		
Appointment Information		

I wish to be contacted in the following manner (please mark ONLY ONE NUMBER for first attempt at contact):

Home phone: Cell phone: Work phone:		
With detailed message? With call back number?		
Email with detailed message		

LIFETIME INSURANCE AUTHORIZATION

I authorize the release of any medical information necessary to process my insurance claims. I request that all payments be made on my behalf and that all benefits are assigned for physician service to Albany Obstetrics and Gynecology. I authorize this request to apply to all services provided after the date below. I understand I am responsible for payment of any balance not paid by my insurance company as outlined in my schedule of benefits and as applicable under law.

Signature: _____ Date: _____

Patient's Name: _____ **DOB:** _____

CURRENT MEDICATIONS, OVER THE COUNTER MEDICATIONS VITAMINS AND HERBS

PHARMACY NAME AND PHONE NUMBER _____

Name of Medication	Dosage (mgs)	Times per day

ALLERGIES/REACTIONS: _____

_____

HIV TESTING:
We are required by New York State Law to offer HIV testing. Are you interested in counseling and HIV testing?
YES _____ NO _____

HEPATITIS C TESTING:
We are required by New York State Law to offer Hepatitis C testing if you are born between the years of 1945-1965. Are you interested in counseling and Hepatitis C testing?
YES _____ NO _____

CHAPERONE:
Would you like a nurse/chaperone present at the time of your exam:
YES _____ NO _____

_____

Patient Signature Patient Name Date

GENERAL INFORMATION

HOURS

Our office is open from 8:30-5:00pm Monday through Thursday and from 8:30 to 11:30am on Fridays. For urgent matters and emergencies, we are always available after hours by dialing our regular office number.

APPOINTMENTS

We pride ourselves in being able to see our patients quickly. If there is an urgent problem, we will do our best to see you the same day or the same week.

We ask that if you need to change your appointment time, we prefer a 24 hour notice so that we may offer that appointment time to another patient.

PRESCRIPTIONS

We ask that you call for prescription refills during regular office hours because the on-call physician will not be able to refill prescriptions for you.

FINANCIAL

If you have insurance, you will be responsible only for that portion of the bill that your insurance indicated belongs to you.

Copayments are due at the time of your visit.

If we do not participate with your insurance, any additional balances due after receipt of the insurance payment will be billed to you. It is your responsibility to understand the coverage benefits in your contract.

If payment is not received or financial arrangements are not made, the balance will be forwarded to a collection agency. Any fees incurred during that process will be your responsibility.

It is your responsibility to inform our office of any change in your insurance coverage.

Payment options: We accept cash, check, MasterCard and Visa.

Special arrangements may be made in case of financial hardship through our billing representative.

Our fees are based on the usual and customary fees charged in this area.

I have read and understood the above information and agree to the terms outlined above.

Patient Signature: _____ Date: _____

Patient Name: _____ Patient DOB: _____

Patient's Representative's Signature and Name: _____

If patient is unable to sign or is a minor, please sign as authorized person and indicate relationship to patient.