PATIENT REGISTRATION FORM

PATIENT INFORMATION:

LAST NAME ______________________ HOME PHONE ( ) ______________________

FIRST NAME ______________________ INITIAL ____ WORK PHONE ( ) ______________________

ADDRESS ______________________ CELL PHONE ( ) ______________________

CITY ______________ STATE ________ DATE OF BIRTH ______________________

ZIP CODE ______________ SOCIAL SECURITY # ______________________

OCCUPATION: ______________________ MARITAL STATUS: SINGLE ____ MARRIED ____

EMPLOYER/SCHOOL ADDRESS ______________________ WIDOW ______ DIVORCE ______

______________________ REFERRED BY ______________________

RELATIONSHIP TO RESPONSIBLE PARTY:

WIFE ____ CHILD ____ PARENTS ____ OTHER ______________________

RESPONSIBLE PARTY INFORMATION: EMPLOYER: ______________________

LAST NAME ______________________ HOME PHONE ( ) ______________________

FIRST NAME ______________________ INITIAL ____ WORK PHONE ( ) ______________________

ADDRESS ______________________ CELL PHONE ( ) ______________________

CITY ______________ STATE ________ DATE OF BIRTH ______________________

ZIP CODE ______________ SOCIAL SECURITY # ______________________

IN CASE OF EMERGENCY NOTIFY:

LAST NAME ______________________ CELL PHONE ( ) ______________________

FIRST NAME ______________________ INITIAL ____ WORK PHONE ( ) ______________________

ADDRESS ______________ CITY ______________ ZIP CODE ________ RELATIONSHIP ______________

AUTHORIZATION:
I hereby consent to any necessary medical treatment for myself or the minor named above for whom I am legally responsible.

ASSIGNMENT:
I permit payment directly to Drs. office for any benefits due for services rendered. I understand that I am responsible for all charges, whether or not covered by my insurance company.

MEDICAL RECORDS:
Authorization is hereby granted for release of any information required to process insurance claims. A copy of this authorization is as valid as the original. Regardless of any claim pending, you will receive periodic statements if your account has an outstanding balance. We cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

SIGNATURE ______________________________ DATE ______________________

+ Pharmacy + Address:

Gynecological Patient History Form

Please complete this form and bring it with you to your first visit. This record of your medical history is confidential and will not be given to anyone without your request or permission. By completing this form in advance you will have more time to discuss your gynecological issues and to ask questions of your doctor.

Today's Date:__________________ Appointment Date: ________________ Doctor:________________________

Name:____DOB: ____________________Age:__________

Street Address: ____________________________City:______________State:_________Zip Code:____________

Marital Status: ☐ Married ☐ Single ☐ Widowed   Occupation:____

Please list your phone numbers and check those at which we can leave messages and any other instructions so we can preserve your confidentiality.

Phone Numbers ☐ Home:__________________☐ Cell:____________________☐ Work:_________________

Special Instructions____

May we contact you by e-mail Yes_____ No______ Email Address:___________________________________

MENSTRUAL HISTORY

Present Symptoms or illness:

____

____

____

Describe your periods (check all that apply) ☐ Regular ☐ Irregular ☐ None ☐ Bleeding between periods

☐ Heavy ☐ Light ☐ Need medications to have period (which medications)_____________________________

Age at first menses?__________________ How many days do you bleed each month?___________________

Last menstrual period (date) ____________________ Previous menstrual period (date) ____________________

Approximate number of days between the start of one period to the start of the next?__________________

How painful are your periods? ☐None ☐ Mild ☐Moderate ☐ Severe What medications do you use for the pain?________________________________ Does the medication markedly reduce the pain? ☐Yes ☐ No

Check any premenstrual symptoms? ☐Back pain ☐ Bloating ☐ Cramps ☐Sore breasts ☐ Moodiness ☐ Other

____

____

GYNECOLOGIC HISTORY

Total pregnancies________________________ Premature__________ Stillborn____________ Miscarriages________

Total living children_______________________ Pregnancy complications_____________________________________

Vaginal discharge or irritation ____________________

Most recent Pap Smear (date)__________ Have you had an abnormal pap smear? ☐Yes ☐No

Have you had a mammogram within 12 mo? ☐Yes ☐No Result: ☐ Normal ☐ Abnormal

Present method of birth control ____________________

Difficulty with intercourse ____________________

Pelvic Pain ____________________

MEDICAL/SURGICAL HISTORY

List medications that you are currently taking ____________________

List any allergies to medications ____________________

Serious illnesses ____________________

Operations (date & hospital) ____________________

Other hospitalizations ____________________

IMMUNIZATIONS/INFECTIONS

Have you been immunized against:

Rubella ☐Yes ☐No **HPV** (cervical cancer)? ☐Yes ☐No **Hepatitis B** ☐Yes ☐No

Check any of these infections you have had?

German measles__________ Hepatitis B__________ Hepatitis C __________ Chlamydia__________

Genital herpes__________ Gonorrhea__________ Genital warts(HPV)__________

NUTRITIONAL SUPPLEMENTS, VITAMINS AND HERBAL PREPARATIONS

Please list any nutritional substances, vitamins or herbal preparations you are currently using.

LIFE STYLE

Do you exercise? ☐Yes ☐ No If yes, describe ____________________

How many caffeinated beverages (coffee, tea, soda) so you drink each day? ______ ☐None

Do you smoke cigarettes? ☐Yes ☐No If yes, how many each day? ______

Do you drink alcohol? ☐Yes ☐No If yes, how many drinks each day? ______

FAMILY HISTORY

Do you have a family history of breast, ovarian or bowel cancer? ☐Yes ☐No If yes, who and at what age?

____

Please list any illnesses or diseases (past or present)

Father:	Alive? ☐ Y ☐ N	Age:	
Mother:	Alive? ☐ Y ☐ N	Age:	
Sister:	Alive? ☐ Y ☐ N	Age:	
Brother:	Alive? ☐ Y ☐ N	Age:	
Other Family:			

REVIEW OF SYSTEMS

Please check any current health problems and comment.

	No	Yes	List and describe any specific problems
Nervous system *Dizziness, numbness, weakness, headache, blurred vision, visual loss*			
Ear, nose and throat *Abnormal vision, hearing, swallowing*			
Gastrointestinal *Appetite, pain, indigestion, constipation, diarrhea, abdominal pain, GERD*			
Emotional *Eating disorder, bipolar disease, depression, anxiety, OCD, ADHD, schizophrenia*			
Lungs: *Asthma, chronic cough, allergies*			
Heart: *Shortness of breath, chest pain, irregular heartbeat, high blood pressure*			
BREAST: *Pain, lump, tenderness, discharge*			
URINARY: *Loss of urine, frequent infections, blood in urine, kidney stones*			
SKIN: *Rashes, persistent sores, worrisome moles, lumps, pigmented patches on skin or in skin folds, easy bruising*			
Bones, joints and muscles *Sore joints, weakness*			
ENDOCRINE: *Excessive hair growth, hair in abnormal location, weight gain/loss, skin pigment changes, thyroid problems, lack of regular cycles, diabetes, glucose intolerance*			
GLOBAL: *Fatigue, sleep disturbance, feeling of loss of well-being, anemia, elevated cholesterol or triglycerides*			
OTHER:			

Are there other current health complaints or worries about any particular disease?			

EXPECTATIONS AND QUESTIONS

What are your expectations from your visit and what questions do you want answered?

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____

FEMI D. IWALOYE, M.D

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

I, ______________________________, hereby acknowledge that I have

(Print your name here)

received a copy of the NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES of Femi D. Iwaloye, M.D.

Signature:____________________________

Date:________________________________

** A copy of this acknowledgment will be kept on file in your medical record.

CANCELATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointments. It is therefore requested that if you must cancel your appointment you provide more that 24 hour notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. Whit cancellations made less than 24 hour notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24 hour notification may be subject to a **$30.00** cancellation fee. Procedure cancellations require 3-5 business day advance notice, without notification they may be subject to a **$50.00** cancellation fee.

Patients who do not show up for their appointments without a call to cancel an office appointment or procedure appointment will be considered as a NO SHOW. Patients who no show two(2) or more times in a 3 month period may be dismissed from the practice and they will be denied any future appointments. Patients may also be subject to a **$30 fee for office appointment no show and $50.00 procedure no show fee.**

The cancellation and no show fees are the sole responsibility the patients and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication.

Please sign that you have read, understand and agree to this Cancelation and No Show Policy.

____

Patient Name (Please print)

____ ________________________

Signature of Patient or Patient Representative **Date**

Dr. Femi D. Iwaloye MD PA
(915)595-5439

INSURANCE AND ELIGIBILITY WAIVER AND CONSENT

Due to the increased amount of paper work in our attempt to serve our patients financial needs with the upmost importance we have now implemented a $10.00 charge for each claim submitted and processed by any insurance as a secondary with the knowledge of any patient not providing their primary insurance. In the event that your secondary insurance pays as primary and is later determined that you as a patient knowingly had a commercial insurance as a primary insurance and you do not notify us at the time of being seen you will be held responsible for this charge on each individual claim that must be processed once again.

I ________________________, am completing this Acknowledgement and Waiver of Liability in connection with my proof of insurance and eligibility to any and all active and eligible insurance coverage that I may have. I hereby acknowledge and agree that I will provide proof of health insurance coverage that covers me for all office visits that are in accordance with my insurance coverage whether it be primary or secondary.

I ________________________, herby authorize and consent to being held responsible in the event that I did not provide proof of any active and eligible insurance information at the time of my scheduled visit to be seen with Dr. Femi D. Iwaloye.

________________________ ____________

Patient Signature Date