GREENSBORO
OB-GYN ASSOCIATES
personalized care for every woman

PATIENT REGISTRATION

510 N. Elam Avenue, Suite 101 Greensboro, NC 27403
P(336)854-8800 F(336)299-4308 www.gsoobgyn.com
Email: info@gsoobgyn.com

New patients MUST arrive 15 minutes prior to your scheduled appointment time, or you will be asked to reschedule. If you cancel or no show your first appointment, we are happy to reschedule; however, if you miss the following new patient appointment you will not be allowed to be reschedule with our office. Our office is NOT responsible for checking your benefits prior to scheduling. Please confirm your benefit coverage with your insurance plan prior to making an appointment.

Name: _____
Last First (Preferred Name) Maiden

Address: _____
Street Apt#/Suite

_____
City State Zip Code

Primary# (CELL or HOME): _____ **Alternate#**: _____
circle one

Date of Birth: _____ **Email Address:** _____

Social Security#: _____ **Relationship Status**: S M Sep D W

Gender: M F Transgender (Female to Male) **Preferred Pronoun**: He She

Sexual Orientation: Heterosexual (straight) Lesbian Bi-Sexual Other: _____

Race: Asian Black/African American European Japanese Korean White Other: _____

Ethnicity: Non-Hispanic/Latino Hispanic/Latino Decline

Preferred Language: English Spanish Other:_____

Interpreter Services Requested: Y N If yes, language needed: _____

Occupation: _____ **Student:** _____

Preferred Provider: Thomas Henley, MD Todd Meisinger, MD Kathy Richardson, MD Jody Bovard, MD
Cecilia Banga, DO Shanti Shivaji, MD Eve Key, NP

Were you referred by a doctor? Y N If yes, doctor name/practice:_____

Primary Care Provider: _____

Pharmacy: _____

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PRIMARY Insurance Information:

Insurance Plan: _____ Member ID: _____ Group#: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Policy Holder Employer & Occupation: _____ Relationship to Patient:

_____

SECONDARY Insurance Information:

Insurance Plan: _____ Member ID: _____ Group#: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

PARENT / SPOUSE INFORMATION:

Name: _____
Last First Relationship to Patient

Address: _____
Street Apt#/Suite City State Zip Code

Phone#: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ **Relationship**: _____ **Phone#:** _____

Name: _____ **Relationship**: _____ **Phone#:** _____

RESPONSIBLE PARTY:
(If other than yourself)

Name: _____
Last First Relationship to Patient

Address:

_____
Street Apt#/Suite City State Zip Code

Phone#: _____

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PLEASE READ AND INITIAL EACH SECTION:

INSURANCE AUTHORIZATION AND FINANCIAL AGREEMENT:

I understand that payment for all services is due at the time of visit, including copays. I understand it is my responsibility to know and understand my insurance benefits. If any visit requires an additional procedure, I understand that my insurance may require I pay an additional fee. If I am unable to present a current insurance card, I will be classified as "self-pay." Payment for said visit will be due at the time of service. I give Greensboro OBGYN Associates permission to apply for benefits on my behalf, and authorize my insurance benefits to be paid directly to Greensboro OBGYN Associates. I authorize the release of pertinent medical information necessary to process my claims. I certify that the information provided by me in regard to my insurance coverage is correct. I will be prepared to present my correct insurance card at every visit. Greensboro OBGYN Associates charges $15.00 for your medical records. _____

CONSENT FOR HEALTHCARE AND RELEASE OF MEDICAL INFORMATION:

I voluntarily consent to healthcare treatment from the providers and staff at Greensboro OBGYN Associates. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of my treatment or examinations. I consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations. I have read this form. I have had the opportunity to ask questions and my questions/concerns have been answered. _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

Notice of Privacy Practices is available on our website under patient resources or you may receive a copy in office. The Notice describes how Greensboro OB/GYN Associates may use and disclose of my healthcare information, and rights I may have regarding my protected health information. I am aware the Notice may be changed at any time. I may obtain a revised or additional copy at any time. _____

PATIENT RECORD SHARING (please circle):

Record sharing allows my clinical chart of Greensboro OB/GYN Associates to be available to other authorized providers for continuum of care. This allows care settings to connect my records so information can be accessed between treating providers. I **consent** to sharing my clinical documents and I am aware I have the right to opt-out at any time. _____

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HEALTH HISTORY

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REASON FOR VISIT:

_____

_____

GYN History:

Last PAP: ____/____/____ Abnormal PAP? Y N Any Procedures: _____

Last Mammogram: ____/____/____ Last Bone Density: ____/____/____ Last Colonoscopy: ____/____/____

STD:
Chlamydia Gonorrhea Herpes Syphilis
Trichomonas Genital Warts HPV HIV

Please choose current activity:
Sexually Active Abstinent Female Partner

Menses:
First Day of Last Period: ____/____/____ Regular Cycles? Y N How Often? _____

Current Contraception:

Medications:
Medication, Dose, Frequency

Allergies:
Medication & Reaction
LATEX? Y N

Tobacco Usage:
Have you ever? Y N How much? _____

Currently? Y N How much? _____

Alcohol Usage: Y N How much? _____

Other Drug Usage: Y N What & How much? _____

Will you accept a blood transfusion in the event of a life-threatening emergency? Y N

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MEDICAL HISTORY:

Medical Problems:

Surgeries:

Pregnancy History

DATE OF DELIVERY	MISCARRIAGE/ABORTION	WEEKS CARRIED	TYPE OF DELIVERY (VAGINAL or C-SECTION)	SEX	WEIGHT	COMPLICATIONS (DIABETES, HIGH BLOOD PRESSURE, PRETERM LABOR, TOXEMIA, ETC)

Family History:
(please check all that apply)

	MOTHER	FATHER	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	OTHER
BREAST CANCER							
OVARIAN CANCER							
UTERINE CANCER							
COLON CANCER							
HEART DISEASE							
HIGH BLOOD PRESSURE							
DIABETES							

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PRIVACY RELEASE OF INFORMATION

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In order to serve you better, please complete this form allowing us to communicate with a list of people with which we may discuss your health information. Those noted on your list must provide your date of birth in order to receive any information.

Patient Name _____ Date of Birth _____

I hereby give my permission to the person(s) listed below to receive PHI, which can include medical and financial information about the care of the above mentioned patient.

	NAME	RELATIONSHIP	PHONE NUMBER
1.	_____	_____	_____
2.	_____	_____	_____

APPOINTMENT REMINDERS:

☐ I give Greensboro OB-GYN Associates permission to remind me of my appointment(s) via email/text.

☐ I **DO NOT** give Greensboro OB-GYN Associates permission to remind me of my appointment(s) via email/text.

RESULTS:

☐ I give Greensboro OB-GYN Associates permission to remind leave NORMAL lab/test results on my voicemail. Please provide best contact number _____

☐ I **DO NOT** give Greensboro OB-GYN Associates permission to remind leave NORMAL lab/test results on my voicemail.

EMAIL COMMUNICATION:

☐ I give Greensboro OB-GYN Associates permission to communicate with me via email at my request. Please provide email address, if not already provided _____
I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communication as selected. INITIAL _____

☐ I **DO NOT** give Greensboro OB-GYN Associates permission to communicate with me via email.

Optional: To protect your health information, you may provide a password of your choosing: _____
Anyone calling the office, including yourself, on your behalf **MUST** provide your password before any information can be discussed. Thank you.

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or receive a copy of the protected health information disclosed, as described in this document***. I understand*** that a revocation is not effective in cases where the information was already disclosed, but will be effective going forward. ***I understand*** the information used or disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law. ***I understand*** that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____
Signature of Patient or Authorized Person Date

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REQUEST OF MEDICAL RECORDS

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PATIENT INFORMATION:

Name: _____ **Date of Birth**: _____

Address: _____
Street Apt # / Suite

_____
City State Zip Code

Phone Number: _____

I do hereby authorize: _____ **Phone Number**: _____

Facility Address:

To Release:
(Note: We are not a PCP provider, please do not request your complete chart to be sent to our office, only necessary records. i.e. labs, pathology, mammogram, last 3 years of office notes)

- ☐ Pap Smear
- ☐ Mammogram
- ☐ Office Notes
- ☐ Lab/Ultrasound Reports
- ☐ Pathology
- ☐ Bone Density
- ☐ Specific Dates: _____
- ☐ Date Range: _____

☐ I do
☐ I do not

Authorize release of information related to AIDS (acquired immunodeficiency syndrome) or HIV (human immunodeficiency virus) infection, sexually transmitted disease(s), psychiatric care and/or psychological assessment and/or treatment for alcohol and/or drug abuse.

Purpose of Disclosure:

- ☐ Referral to specialist
- ☐ Disability
- ☐ PCP/Internist
- ☐ Other: _____
- ☐ Insurance
- Personal
- Worker's Compensation
- ☐ Legal Issue
- ☐ Change of Provider

SEND RECORDS TO:

Facility Name: Greensboro OB-GYN Associates **Phone Number**: (336) 854-8800 **Fax Number**: (336) 299-4308
Address: 510 N. Elam Avenue, Suite 101 Greensboro NC 27403

I do hereby authorize disclosure of the health information for the above named patient. The authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with a written notification, but it will not affect any information released prior to cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by this release. I understand the medical provider to whom this authorization is furnished may not condition its treatment on me on whether or not I sign the authorization.

_____ _____
Signature Date