Please present your insurance card and photo ID to the receptionist along with this completed form. Thank You!

Garden Ob/Gyn

DATE_____

PATIENT NAME_____

***** Please fill out name as it appears on the insurance card*****

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

ADDRESS_____

(APT #) (CITY) (STATE) (ZIP)

CONTACT INFORMATION:

HOME PHONE: (___)_____ CELL PHONE: (____)_____

WORK PHONE: (___)_____ _____ **EMAIL**:_____

EMERGENCY CONTACT:_____

RELATION:_____ PHONE #: (___)_____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

HOW DID YOU FIND US?

__FAMILY/FRIEND ___INSURANCE COMPANY ____MALL EVENT ___ZOC DOC _____GOOGLE/INTERNET

WHO REFERRED YOU TO OUR PRACTICE? _____

TYPE OF INSURANCE_____ MEMBER ID #_____

NAME OF POLICY HOLDER_____ DOB_____

POLICY HOLDER SOCIAL SECURITY #_____

PRIMARY PHYSICIAN NAME/PHONE #:_____

ADDRESS_____

(CITY) (STATE) (ZIP)

PHARMACY NAME_____**PHARMACY PHONE #**_____

PHARMACY ADDRESS_____

I HEREBY AUTHORIZE GARDEN OBGYN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION AND/OR TREATMENT TO MY INSURANCE COMPANY. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO BETHPAGE MEDICAL PLLC FOR SURGICAL AND/OR MEDICAL BENEFITS, IF ANY ARE DUE UNDER THE TERMS OF MY INSURANCE POLICY. I HEREBY AUTHORIZE A PHOTOCOPY OF THIS TO SERVE AS THE ORIGINAL.

SIGNATURE_____ DATE_____

HIPAA (Health Insurance Portability and Accountability Act) PROVIDES PATIENTS WITH REASSURANCE THAT THEIR INFORMATION IS PRIVATE. WE GIVE YOU THE RIGHT TO PUT RESTICTIONS ON YOUR PERSONAL INFORMATION. PLEASE ANSWER THE FOLLOWING QUESTIONS TO ALLOW US TO PROVIDE YOU WITH THE MEDICAL CONFIDENTIALITY YOU WANT AND DESERVE.

1. I WISH TO BE CONTACTED IN THE FOLLOWING MANNER REGARDING APPOINTMENT CONFIRMATIONS, INSURANCE PROBLEMS AND/OR TEST RESULTS: (PLEASE CHECK ALL THAT APPLY)
   □ HOME PHONE □ CELL PHONE □ WORK PHONE

2. IN REGARDS TO THE QUESTION ABOVE, MAY WE LEAVE A MESSAGE WITH THE ABOVE INFORMATION, EITHER MACHINE OR WITH A PERSON, EVEN IF THE MESSAGE MAY INCLUDE A DIAGNOSIS OR OTHER MEDICAL INFORMATION?
   □ YES, A MESSAGE IS FINE □ NO, PLEASE DO NOT LEAVE MESSAGES
   □ YES, BUT PLEASE DO NOT LEAVE A DIAGNOSIS

3. WHEN YOU ARE IN THE WAITING ROOM, HOW WOULD YOU LIKE TO BE CALLED IN FOR YOU EXAMINATION?
   □ FIRST AND LAST NAME □ FIRST NAME □ LAST NAME

4. PLEASE LIST BELOW ANY FAMILY MEMBERS OR FRIENDS WHO YOU ALLOW TO HAVE CERTAIN ACCESS TO YOUR PROTECTED HEALTH INFORMATION.
   (I.E. CALLING OUR OFFICE TO MAKE AND/OR CONFIRM AN APPOINTMENT FOR YOU, CALLING FOR RESULTS, PICKING UP A PERSCRIPTION)
   □NAME_____ RELATION_____

   □NAME_____ RELATION_____

   □NAME_____ RELATION_____

   □ I WOULD PREFER NO OUTSIDE ACCESS

PATIENT NAME_____

SIGNATURE _____ DATE_____

WITNESS_____ DATE_____

NOTICE OF HIPAA PRIVACY POLICY

ACKNOWLEDGMENT OF RECEIPT

□ PATIENT SIGNATURE_____
(ACCEPT HIPAA PRIVACY)

□ PATIENT SIGNATURE_____
(DECLINE HIPAA PRIVACY)

PRINT NAME_____ DATE_____