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

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 Kathy Harris, NP Eve Key, NP

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

Primary Care Provider: ____________________

Pharmacy: ____________________

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

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: _____________________

Policy Holder Employer & Occupation: __________________________ Relationship to Patient: _________________________

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#: _____________________________________

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

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 regards to my insurance coverage is correct. I will be prepared to present my correct insurance card at every visit. Greensboro OBGYN Associates charges $10.00 for your medical records.

CELL PHONE POLICY:

Greensboro OBGYN Associates requires you to mute or turn off your cell phones in our office. No cell phones and or video cameras are allowed in the Ultrasound Room. Failure to comply could cause your diagnostic study to be terminated immediately. The Ultrasound fee would then become your financial responsibility. Thank you for keeping us in compliance.

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 Piedmont Healthcare for Women 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.

Signature of Patient or Authorized Person: ______________________________ Date: ________________

GREENSBORO
OB-GYN ASSOCIATES
personalized care for every woman

HEALTH HISTORY

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

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:
None Withdrawal Condoms Pills Nuvaring IUD Nexplanon Essure Tubal Ligation Vasectomy

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

HEALTH HISTORY

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

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							

GREENSBORO
OB-GYN ASSOCIATES
personalized care for every woman

PRIVACY RELEASE OF INFORMATION

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

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 our 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.	____________	____________	____________
3.	____________	____________	____________

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

GREENSBORO OB-GYN ASSOCIATES
personalized care for every woman

REQUEST OF MEDICAL RECORDS

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

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:
(Please check all that apply)

- ☐ Pap Smear
- ☐ Mammogram
- ☐ Office Notes
- ☐ Lab Reports
- ☐ Pathology
- ☐ Bone Density
- ☐ Hospital Records
- ☐ Specific Dates: ____________________
- ☐ Other: ____________________

☐ 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