PATIENT DEMOGRAPHICS

NAME:_____ DATE OF BIRTH: _____/_____/_____ AGE:_____

ADDRESS: _____ **CELL** #: _____

CITY:_____APT#_____ HOME #: _____

STATE:_____ ZIP:_____ WORK #:_____

EMAIL:_____ OCCUPATION: _____

EMPLOYER: _____ SOCIAL SECURITY#:

PRIMARY CARE PHYSICIAN **NAME, ADDRESS & PHONE #** : _____

_____

*****PHARMACY NAME & ADDRESS***:** _____

MARITAL STATUS: _____REFERRED BY:_____

PLEASE CHOOSE ONE OPTION:

*_____ I AUTHORIZE BETHPAGE OB/GYN TO LEAVE A DETAILED MESSAGE AT THIS NUMBER:

( )_____-_____

*_____ PLEASE DO NOT LEAVE A DETAILED MESSAGE

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ **SECONDARY** INSURANCE: _____

ID#: _____ ID#: _____

GROUP #: _____ GROUP #: _____

POLICY HOLDER:_____ POLICY HOLDER:_____

RELATIONSHIP TO PATIENT: _____ RELATIONSHIP TO PATIENT: _____

DATE OF BIRTH: _____/_____/_____ DATE OF BIRTH: _____/_____/_____

EFFECTIVE DATE: _____ EFFECTIVE DATE: _____

EMERGENCY CONTACT

NAME:_____ PHONE #:_____RELATIONSHIP:_____

I will be responsible to inform this office of any changes in address, phone number, employment and insurance information by requesting and completing a new information form. Any outstanding balance such as co-pay/co-insurance, denials due to change in coverage or non-participating plans is patient responsibility. Related fees 60 days after date of service will be charged a late fee of 1.5% per month on any outstanding balance. Co-pays, which are not paid at the time of service and require a patient billing statement, will be charged an additional processing fee of $25.00.

PLEASE BE AWARE, NOT ALL TESTING MAY BE COVERED BY YOUR HEALTH PLAN. YOU ARE ADVISED TO CONTACT YOUR CARRIER PRIOR TO TESTING. BETHPAGE OB/GYN WILL NOT BE RESPONSIBLE FOR ANY BILLS YOU MAY INCUR. PLEASE BE AWARE THAT CERTAIN SEXUALLY TRANSMITTED DISEASE TESTING IS INCLUDED WITH YOUR PAP SMEAR IF YOU DO NOT WISH TO HAVE THIS TESTING PLEASE LET YOUR CLINICIAN KNOW.

By my signature, I affirm; all of the information included on this form is correct and accurate.

PATIENT'S SIGNATURE:_____ DATE: _____/_____/_____

RECEPTIONIST INITIALS: _____DATE: _____/_____/_____

Patient HIPAA Acknowledgement and Consent Form

Patient Name: _____ D.O.B:_____

_____ (Patient Initials) **Release of Information**. I hereby permit Bethpage OB/Gyn and the physicians/clinicians or other health professionals involved in the inpatient or outpatient care to release my Protected Health Information (PHI) for purposes of treatment, payment, or healthcare operation.

- Healthcare information regarding a prior admission(s) at other healthcare facilities may be made available to subsequent healthcare admitting facilities to coordinate Patient Care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other healthcare industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not limited to : Improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends, Family and/or Healthcare Providers
I give permission for my Protected Health Information (PHI) to be disclosed for purposes of communicating results, findings, and care decisions to the persons listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ I DO NOT WANT MY MEDICAL INFORMATION RELEASED TO ANYONE.

PATIENTS SIGNATURE: _____ DATE: _____

New Patient History Form ID No:_____ Today's Date:_____

Patient Identification (please print) Date of Birth: _____/_____/_____

Patient's Name: _____ Age: _____

Employer: _____ Marital Status: __S __M__W

Occupation: _____

Current Medications (Include Birth Control)
_____

Allergies ___None
List all medications you are allergic to:

_____ _____

Medical History (check appropriate space)

Have you ever had:

Blood Transfusion	__	Anemia/Blood Disorder	__
High Cholesterol	__	Allergies	__
Heart Disease	__	Breast Problems	__
Rheumatic Fever	__	Breast Cancer	__
High Blood Pressure	__	Ovarian Cancer	__
Asthma	__	Chlamydia	__
Diabetes	__	Gonorrhea	__
Thyroid Probs.	__	Herpes (HSV)	__
Liver Disease	__	Syphilis	__
Birth Defects/ Inherited Diseases	__	AIDS/HIV	__
Sexual Abuse/Domestic Violence	__	Hepatitis (type__)	__
Infertility	__	Other Medical Probs.	__

Medical History (continued)

Hospitalizations/Surgeries (Do not include pregnancies)

Month/Year	Illness or Operation
/	
/	
/	

Substance Abuse (Check only those you use)

Alcohol__ Type____Amt/Day___ Non-Prescribed Pills__Type____Amt/Day___

Tobacco__ Type___Amt/Day___

Pregnancy History (Complete all Info.)

# of Pregnancies	# of Premature Births	# of Miscarriages	# of Spontaneous Abortions	# of Induced Abortions	# of Living Children
# of Term Births	Born: Mon/Yr	Baby's Sex	Birth Weight	Type of Delivery	Complications Yes/No
1	/		lbs oz		
2	/		lbs oz		
3	/		lbs oz		
4	/		lbs oz		

Menstrual History

First day of last menstrual period: ___/___/___

Menarche (age at first period) _____years old

Interval (# days in between periods)_____days

Length of Period _____days

Abnormalities __Discharge __Excessive Bleeding __Pain __None

Contraceptive History

Type_____

Dates Used_____

Sterilization: __male __female

Lifestyle

Have you ever had a pap test? Yes/No

Date of last pap ___/___/___

Have you ever had an abnormal pap result? Yes/No

Are you sexually active? Yes/No

Do you experience pain during intercourse? Yes/No

Do you exercise on a regular basis? Yes/No

Have you ever had a Mammogram? Yes/No

Date of last Mammogram ___/___/___

Do you perform a monthly breast exam? Yes/No

Have you ever had a Colonoscopy? Yes/No

Date of last Colonoscopy___/___/___

PROVIDER'S COMMENTS:

Today's Date: _____

Name: _____ Date of birth: _____

Bethpage OB/GYN
4277 Hempstead Tpke Ste 102
Bethpage, NY 11714

Please answer the following questions to the best of your ability. Circle YES for any of the cancers in your family.

The Following Relatives Should Be Considered:

(1) Mother, Father, Brother, Sister, Children, (2) Paternal & Maternal Aunts/Uncles, Half Siblings, Nieces/Nephews, Maternal/Paternal Grandparents, (3) 1st Cousins, Great Aunts/Uncles, Great Grandparents

(1) 1st degree (2) second degree (3) third degree

Cancer History Description	Circle	YOURSELF or Relatives (see list above)	Paternal/ Maternal	Ages
Colon Cancer before the age of **50** (1st, 2nd degree)	**YES**			
Uterine/Endometrial cancer before the age of **50** (1st, 2nd degree)	**YES**			
Three or more of the following cancers (circle): colon, endometrial, gastric, ovarian, brain, pancreatic, small bowel, hepatobiliary tract, renal, or sebaceous adenomas (1st, 2nd & 3rd degree)	**YES**	.		
Breast Cancer diagnosed at or before the age of **50** (1st, 2nd degree)	**YES**			
Ovarian Cancer (1st, 2nd degree)	**YES**			
Male Breast Cancer (1st, 2nd degree)	**YES**			
Three or more breast cancers on the same side of the family (1st, 2nd & 3rd degree)	**YES**			
Three or more of the following cancers on the same side of the family: prostate, pancreatic or breast (1st, 2nd & 3rd degree)	**YES**			
Any relative diagnosed with breast cancer **twice or in both breasts** (1st, 2nd degree)	**YES**			
Are you **Ashkenazi Jewish** and have a diagnosis of breast, ovarian, pancreatic cancers in any family members listed above at any age (circle the cancer)	**YES**			
Have you or any of your family members been tested for the BRCA gene? If no, why not?				
If your family history does not match the above criteria, check here ☐				

OFFICE USE ONLY

Patient Meet Criteria for testing? Yes ☐ No☐ Discussed Genetic Testing? Yes ☐ No☐ Schedule appointment for counseling? Yes ☐ No☐

If no, state reason: _____

Patient Accepted Yes ☐ No☐ If patient denies, state reason: _____

Patient Signature: _____ MD signature: _____ Date: __/__/__

Notes: