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: ________________
ID#: ______________________________

GROUP #: ______________________________

POLICY HOLDER:______________________

RELATIONSHIP TO PATIENT: ____________
DATE OF BIRTH: ______/______/______

EFFECTIVE DATE: ______________________

SECONDARY INSURANCE: ________________
ID#: ______________________________

GROUP #: ______________________________

POLICY HOLDER:______________________
RELATIONSHIP TO PATIENT: ____________
DATE OF BIRTH: ______/______/______

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 or denials for services rendered will be the patient's responsibility. Any denials due to change in coverage or non-participating plans will also be the patient's 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. PLEASE BE AWARE THAT BETHPAGE OB/GYN USES QUEST, SUNRISE, GYNECOR, AND SEMA4 AS OUR PRIMARY LABORATORIES. IF YOU WOULD LIKE TO USE A DIFFERENT LAB PLEASE LET YOUR PROVIDER KNOW. WE ARE NOT RESPONSIBLE FOR ANY OUT-OF-NETWORK COSTS.
By my signature, I affirm; all of the information included on this form is correct and accurate.

PATIENT'S SIGNATURE:______________________________ DATE: ______/______/______

RECEPTIONIST INITIALS: ______________________________DATE: ______/______/______

BETHPAGE
Ob-Gyn

Obstetrics–Gynecology

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: ________________

4277 Hempstead Turnpike • Bethpage, New York 11714 Suite 102
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NEW PATIENT HISTORY FORM

ID #:_______________

Today's Date: _____________

(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 ____

High Cholesterol ____

Heart Disease ____

Rheumatic Fever ____

High Blood Pressure ____

Asthma ____

Diabetes ____

Thyroid Issues ____

Liver Disease ____

Birth Defects/ Inherited Diseases _____

Sexual Abuse/ Domestic Violence _____

Infertility _____

Medical history (Continued)

Migraines _____

Anemia/Blood Disorder ____

Allergies _____

Breast Problems _____

Breast Cancer _____

Ovarian Cancer _____

Chlamydia _____

Gonorrhea _____

Herpes _____

Syphilis _____

AIDS/HIV _____

Hepatitis (Type __) _____

Other Medical Problems (Please list below)

____

Hospitalizations/Surgeries (Do not include Pregnancies)

Month/ Year	Illness or Operation
/	
/	
/	

Substance Abuse (Check only those you use)

Alcohol _____Type________Amount/Day____

Non- Prescribed Pills ___Type___Amount/Day____

Tobacco ___Type_______Amount/Day_____

Pregnancy History (Complete all Info.)

Total # of Pregnancies	# Of Term Births	# of Preterm Births	# of Miscarriages/ Spontaneous Abortions	# of Terminations	# of Living Children
Pregnancy #	Born Mon/Year	Sex of Baby	Birth Weight	Delivery type Vaginal/C-sect.	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 of first period)______ years old

Interval (# of days in between periods)______ days

Length of Period ______ days

Abnormalities ___ Discharge__Excessive Bleeding___Pain____None

PLEASE CHECK YOUR CURRENT FORM OF CONTRACEPTION

- ☐ NONE
- ☐ CONDOMS
- ☐ WITHDRAWAL
- ☐ BIRTH CONTROL PILL- NAME_________________
- ☐ NUVARING
- ☐ DEPO-PROVERA
- ☐ IUD- Type_________________ Date Inserted_________________
- ☐ STERILIZATION- MALE OR 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

If so with Men___Women___Both___

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 monthly breast exams? Yes/No

Have you ever had a Colonoscopy? Yes/No

Date of last colonoscopy____/____/____