

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 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: ____ / ____ / ____

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# _____

Today's Date: _____

Patient's Name: _____

Date of Birth: _____

Employer: _____

Age: _____

Occupation: _____

Marital Status: _____

Current Medications (including birth control)

Allergies:(Including Medications)

Medical History:
 Have you ever had:

- | | | | |
|-----------------------------------|-----|-------------------|-----|
| Blood Transfusion | ___ | Migraines | ___ |
| High Cholesterol | ___ | Anemia | ___ |
| Heart Disease | ___ | Breast Problems | ___ |
| Rheumatic Fever | ___ | Breast Cancer | ___ |
| High Blood Pressure | ___ | Ovarian Cancer | ___ |
| Asthma | ___ | Chlamydia | ___ |
| Diabetes | ___ | Gonorrhea | ___ |
| Liver Disease | ___ | Herpes | ___ |
| Birth Defects / Inherited Disease | ___ | AIDS/ HIV | ___ |
| Sexual Abuse / Domestic Violence | ___ | Hepatitis (Type) | ___ |
| Infertility | ___ | Syphilis | ___ |
| Fibroids | ___ | Ovarian Cysts | ___ |

Other medical conditions: _____

Hospitalizations / Surgeries
(Do Not Include Pregnancies)

Month / Year	Illness / Operation

Substance Use: (Social, Occasional, Per Day, Rarely, None)	
Alcohol:	_____
Tobacco:	_____
Vape:	_____
Marijuana:	_____
Other drugs:	_____

Menstrual History

First day of last menstrual period: ___/___/___
 Approximate age of first period _____ years old
 # of days in between periods _____ days
 Length of period _____ days
 Are you experiencing : vaginal discharge / excessive bleeding / pain

Lifestyle:

Have you ever had a pap smear test? Yes / No
 Date of last pap ___/___/___
 Have you ever had an abnormal pap? Yes / No
 Were you ever told you had a positive HPV result? Yes / No
 Are you currently sexually active? Yes / No
 Have you ever been sexually active? Yes / No
 Do you experience pain or bleeding during intercourse? Yes / No
 Have you ever had a mammogram? Yes / No
 If Yes approx. date of last mammogram ___/___/___
 Do you perform monthly breast exams? Yes / No
 Have you ever had a colonoscopy? Yes / No
 If yes, approx. date of last colonoscopy ___/___/___

Contraception:

<input type="checkbox"/> None	<input type="checkbox"/> Condoms
<input type="checkbox"/> Condoms	<input type="checkbox"/> Depo-Provera
<input type="checkbox"/> Withdrawal	<input type="checkbox"/> Nuvaring
<input type="checkbox"/> Tubal Ligation	<input type="checkbox"/> Vasectomy
<input type="checkbox"/> Birth Control Pills	<input type="checkbox"/> IUD: Type _____
Name _____	Date inserted ___/___/___

Pregnancy History

Total # of pregnancies _____	# of full term births (after 37 weeks) _____
# of Preterm Births (before 37 weeks) _____	# of Miscarriages / Spontaneous Abortions _____
# of Terminations _____	# of Living Children _____

	Month / Year	Male / Female	Birth Weight	Delivery Type Vaginal / C-section	Complications
1					
2					
3					
4					