StarCare Gynecology and Obstetrics, LLC
NEW PATIENT REGISTRATION

Today's Date:

Patient's Last Name	**First Name:**		**Mid. Initial:**
Date of Birth Age:	Sex: F M	**Marital Status:** S M D W	
Patient's Social Security Number	Driver's License No.		
Home/Mailing Address	**City**	**State**	**Zip**
Home Phone #:	**Work Phone #:**		
Cell Phone #:	**Preferred Contact Methods: Cell Home Work E Mail**		
E mail Address:			
Occupation	Employer:		
Spouse Name	Employer:		
PRIMARY CARE DOCTOR:	**Referred by:**		

NOTIFY IN CASE OF EMERGENCY

Name	**Relationship**		
Address	City	State	Zip
Home Telephone	**Work Telephone**		

INSURANCE INFORMATION:

Primary Insurance Company:	**Insurance ID #**	
Subscriber's Name	**Subscriber's Date of Birth**	**Subscriber's SSN#:**
Address	City State	Zip
Secondary Insurance Company:		
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#

Authorization to Pay Benefits and Release Information:

I request that payment of authorized medical benefits be made directly to StarCare Gynecology and Obstetrics, LLC for any services furnished me by that Practice. I authorize any holder of medical information about me to release (mail, email, telephone or FAX) to my insurance company and its' agents any information needed to determine these benefits. In making this assignment to StarCare Gynecology and Obstetrics, LLC, I understand and agree that I will be responsible for any unpaid balance not covered by my insurance policy and by my insurance plan. I agree to accept full financial responsibility. In the event the unpaid balance is turned over to a collection agency and/or attorney, I agree to pay all collection cost, attorney's fees and any other cost associated with the collection of any sum owed. I also authorize StarCare Gynecology and Obstetrics, LLC to fax/mail or request all relevant medical records/films to any physician in order for me to be evaluated and receive the necessary medical treatment.

_____ _____

Patient/Guardian's Signature Date

_____ _____

Printed Name of Signer Relationship to patient

3301 Woodburn Rd · Suite 102 · Annandale · VA · 22003 Telephone: 703·698·9668 · Fax: 703·698·8998
106 Elden St · Suite 13 · Herndon· VA ·20170
4208 Evergreen Ln· Suite 213· Annandale· VA 22003 Telephone: 703·642·7522 · Fax: 703·642·6699

StarCare Gynecology and Obstetrics, LLC

Estabalished Gynecology Patient Questionnaire

Name:	Reason for Visit:	Date of Visit: / /
Date of Last Pap Smear:	Date of Last Mammogram:	Date of Birth: / /
Name of Primary Care Doctor:	Date of Last Bone Density Scan:	Age:
Preferred Pharmacy:		

MENSTRUAL HISTORY:

Date of last period:	____/_____/_____ ☐ Unsure ☐ Menopausal: Age of Menopause:_____
Number of days between period: _____ ☐ Regular ☐ Irregular	
Flow (check applicable): ☐Light ☐ Normal ☐ Heavy ☐ Clots ☐ Bleeding between periods	
Days of bleeding:_____	Menstrual cramps/pain: Mild / Moderate / Severe / None
Pelvic pain	☐ None ☐ Before period ☐During period ☐ All the time ☐ Painful Sex

Have you had any change of the following?

	Yes	No	Date		Yes	No	Date
Abnormal Pap Smear				Chronic pelvic pain			
Recent change in menstrual cycle				Painful sex			
Recent change in menstrual flow				Vaginal relaxation			
Bleeding after menopause				Leaking of Urine			
Bleeding after sex				Pelvic prolapse			
Urinate more than 3 times a night				Other:			

Do you have any change in Medical and Surgical history? ☐ No ☐ Yes

If yes, please list the changes below:

New pregnancies			
New medical problems			
New surgeries			
New allergies			
Changes in medication			

Patient's signature:_____