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 *Established Obstetric Patient Questionnaire*

Name:	Date of Birth: / / Age:	Date of Visit: / /
Date of last period: ☐ Unsure / /	Number of days between period:_____ ☐Regular ☐ Irregular	
Name of Primary Care Doctor:		Date of Last Pap Smear: / /
Preferred Pharmacy:		

PREGNANCY HISTORY

	Total Pregnancy	Term Birth	Preterm Birth	Miscarriage	Abortion	Living Children
NO:						
Number of Cesarean delivery						

Last Delivery

	Date (mm/dd/yy)	Wks Gest	Labor hours	Baby's Weight	Gender	Delivery Type (Vag or C/S)	Pain Meds	Complications /Reason for CS
1								

MEDICATIONS

Medication	Dosage	Indication	Medication	Dosage	Indication

ALLERGIES ☐ No Known Drug Allergies

Medication	Reaction	Medication	Reaction

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

If yes, please list the changes below:

Changes in Medical History			
Changes in Surgical History			
Changes in Social History			
Changes in Family History			

Patient's signature:_____