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 *New 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:_____
Age of first period:	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 (Circle applicable)
Pelvic pain	☐ None ☐ Before period ☐During period ☐ All the time ☐ Painful Sex

Have you ever had any of the following?

	Yes	No	Date		Yes	No	Date
Abnormal Pap Smear				Gyn Cancer			
Recent change in menstrual cycle				Chronic pelvic pain			
Recent change in menstrual flow				Painful sex			
Bleeding after menopause				Uterine fibroids			
Bleeding after sex				Endometriosis			
Vaginal relaxation				STD/Pelvic infection			
Leaking of Urine				Ovarian cyst			
Urinate 3 times or more at night				Infertility			
Pelvic prolapse				Others			

PREGNANCY HISTORY

	Total Pregnancy	Term Birth	Preterm Birth	Miscarriage	Abortion	Living Children
Number						
Number of Cesarean delivery						

MEDICATIONS

Medication	Dosage	Indication	Medication	Dosage	Indication

ALLERGIES ☐ **No Known Drug Allergies**

Medication	Reaction	Medication	Reaction

MEDICAL HISTORY – Have you ever had any of the following?

	Yes		Yes		Yes		Yes
Asthma		Epilepsy		Hypertension		Lung problems	
Blood Clots		Gall bladder problems		High Cholesterol		Migraines	
Breast disease		Gastrointestinal reflux		Intestinal problems		Osteoporosis	
Diabetes		Heart Disease		Kidney Stones		Thyroid disease	

SURGICAL HISTORY

Date	Operation	Indication	Complications

FAMILY HISTORY – Does anyone in your family have:

	Yes	No	Family Member		Yes	No	Family Member
Breast Cancer				High Cholesterol			
Ovarian Cancer				Hypertension			
Uterine Cancer				Diabetes			
Colon Cancer				Heart Disease			

SOCIAL HISTORY

Marital Status	Married	Single	Other
Sexual partners	Male	Female	Both
Smoke	No	Yes	
Alcohol	No	Yes	
Drugs	No	Yes	
Exercise	No	Yes	
Occupation			Retired

Patient's signature:_____

StarCare Gynecology and Obstetrics, LLC

Notice of Privacy Practices Acknowledgment & Patient Consent Form

I understand that under the Health Insurance Portability & Accountability Act of 1996 HIPAA90,
I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a description of the uses and disclosures of my health information prior to signing this consent. I understand StarCare Gynecology and Obstetrics, LLC has the right to change its Notice of Privacy Practices and that a current Notice will always be available in this office.
As stated in your Notice of Privacy Practice I have the right to request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment and health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.
I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name 1:_____

Name 2:_____

Name 3:_____

Consent for Photographing or Other Recording for Security and/or Health Care Operations

_X_____I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the hospital's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside of the practice without a specific written authorization from me or my legal representative unless otherwise required by law.

Consent to Receive Text Messages or Emails about Appointment Reminders:

Patients in our practice may be contacted via email or text messaging to remind you of an appointment.

_X_____ I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive appointment reminders. I understand that this request to receive text messages will apply to all future appointment reminders unless I request a change in writing.

The **cell phone number** that I authorize to receive text messages for appointment reminders is

__(_____)__ _____-_____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

The **E mail** that I authorize to receive emails for appointment reminders is

_____@_____ .

Revocation: I hereby revoke my request for future communications via email and/or text.

_____ *I hereby revoke my request to receive any future appointment reminders via text messages.*

_____ *I hereby revoke my request to receive any future appointment reminders via email.*
NOTE: This revocation only applies to communications from this practice.

_____ _____/_____/__
Patient Name Date

_____ _____
Patient/Patient Representative Signature Relationship to patient