

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:					
<p>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.</p>					
_____ Patient/Guardian's Signature			_____ Date		
_____ Printed Name of Signer			_____ Relationship to patient		

StarCare Gynecology and Obstetrics, LLC

New Obstetric Patient Questionnaire

Name:	Date of Birth: / /	Age:	Date of Visit: / /
Date of last period: <input type="checkbox"/> Unsure / /	Number of days between period: _____ <input type="checkbox"/> Regular <input type="checkbox"/> 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						

N o.	Date (mm/dd/yy)	Wks Gest	Labor hours	Baby's Weight	Gender	Delivery Type (Vag or C/S)	Pain Meds	Complications
1								
2								
3								
4								

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
High Blood Pressure	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	Migraines	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	HIV	<input type="checkbox"/>
Autoimmune disease	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	Other	<input type="checkbox"/>

SURGICAL HISTORY

Date	Operation	Indication	Complications

FAMILY HISTORY – Does anyone in your family have:

	Yes	No	Family Member		Yes	No	Family Member
Birth Defects				Hypertension			
Genetic disease				Diabetes			
Other				Heart Disease			

SOCIAL HISTORY

Marital Status	Married	Single	Other
Smoke	No	Yes	
Alcohol	No	Yes	
Drugs	No	Yes	
Exercise	No	Yes	
Occupation			

Patient's signature: _____

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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:

- o Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- o Obtain payment from third-party payers.
- o 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