Gynecologic Surgeons & Obstetricians, PC

Patient Registration Information

(Please complete or correct all missing or incomplete information)

PATIENT INFORMATION				
Last Name	First Name	M.I.	Date Of Birth	Age
Street Address	Additional Address	City	State	Zipcode

SSN	Marital Status		Phone Numbers H: C:

Your E-Mail Address:

CURRENT EMPLOYER	
Employer / Job Title	Work Phone: Ext

SPOUSE, SIGNIFICANT OTHER, OR PARENT INFORMATION			
Last Name	First Name	Date Of Birth	Sex

Phone Numbers H: C:	Employer
SSN:	Work Phone:

EMERGENCY CONTACT	
Name & Relationship:	Phone:

PRIMARY INSURANCE INFORMATION	
Insurance Name	
ID/Certificate Number	Group ID/Number

Policy Holder (Subscriber) Name	Relation To Patient	Subscriber Birth Date	Subscriber Sex

SECONDARY INSURANCE INFORMATION	
Insurance Name	
ID/Certificate Number	Group ID/Number

Policy Holder (Subscriber) Name	Relation To Patient	Subscriber Birth Date	Subscriber Sex

Physician you normally see at Gynecologic Surgeons & Obstetricians	
GSO Physician	How did you learn about our office?

Payment for services is due in full on the day of your visit unless insurance coverage is in effect. You may have a copay. Payment may be made by cash, check, or credit card. Financial arrangements should be made with our Accounting Department prior to surgical or obstetrical care. I understand that:

- My insurance coverage is a contract between me and my insurance company.
- I am responsible for payment of copays, deductibles, and charges for services or items not considered covered benefits.
- I am responsible for obtaining any referrals or authorizations required by my insurance company.
- I am responsible for unpaid balances.

My signature below authorizes my consent for treatment. I have received a copy of Gynecolgic Surgeons and Obstetricians, P.C.'s Notice of Privacy Practices, which describes how my health information may be used or disclosed. I assign benefits and authorize payment directly to Gynecologic Surgeons & Obstetricians, P.C. for any medical or surgical services.

Date: _____ Signature: _____

Gynecologic Surgeons and Obstetricians, P.C.

PATIENT QUESTIONNAIRE

Since your last visit to our office, your life may have changed and this may affect your health. Please help us to provide the best health care for you by completing this short questionnaire. Thank you!

	CIRCLE ONE	IF YES, PLEASE SPECIFY
Have you changed your address or phone numbers?	No Yes	_____
Has there been a change in your periods?	No Yes	_____
First day of your Last Period:		
Do you use a method of contraception?	No Yes	Circle the type: Pills IUD Tubal Condoms Vasectomy Natural/Rhythm Sponge Spermicide Diaphragm Other
Date of your last PAP test _____ (if not at this facility)		
Date of your last mammogram		
Do you smoke cigarettes?	No Yes	How many per day?
Do you drink alcohol?	No Yes	How many per day/week?
Are you exercising?	No Yes	How often and what type?
Have you had any new illnesses in the last year?	No Yes	

Circle all that pertain: Asthma Hepatitis Diabetes Thyroid High blood pressure Blood Clots Heart diease Mitral Valve Prolapse Rheumatic Heart Disease Other_____

Have you ever had a cholesterol test?	No Yes	When?_____Result
Have you been pregnant since last seen?	No Yes	
Have you been treated for any female infections since last seen?. . . .	No Yes	If yes, what?_____
Have you had any operations since last seen?	No Yes	If yes, what & when?_____
Have any blood relatives developed breast, ovarian, or colon cancer since you were seen last?	No Yes	If yes, what kind & who?_____
Because abuse and violence are so common in women's lives, we have begun to ask routinely, are you in a relationship in which you have been physically hurt or threatened by your partner?	No Yes	_____
Do you wear seat belts?	No Yes	
When was your last tetanus vaccine? _____		
Do you receive an annual influenza vaccine?	No Yes	
After age 65, have you received the pneumonia vaccine at least one time?	No Yes	
Do you have smoke detectors in your home?	No Yes	
Do you feel that you need to urinate too frequently?	No Yes	
Do you ever leak urine?	No Yes	

Which pharmacy do you use?_____

Who is your primary care physician?_____

Is your visit today for ___your annual exam, ____pregnancy, or ___a problem? If a problem what is it?_____

Do you have any other questions or concerns that you would like to discuss today?

Most testing is sent to outside lab, you will receive a separate bill from that lab for these services.

Your Name:_____ Reviewed by: _____

Date of Birth:_____

Medical Information Release Form for Gynecologic Surgeons & Obstetricians, P.C.

HIPAA RELEASE FORM

AUTHORIZATION WHEN PATIENT REQUESTS DISCLOSURE OF PROTECTED HEALTH INFORMATION

☐ I hereby authorize Gynecologic Surgeons & Obstetricians, P.C. to disclose any or all medical information concerning my injuries, disabilities, and physical condition, including all medical records and radiographs, pictures, or other information including any condition or care related to any drug and/or alcohol dependency, psychological diagnosis, or HIV or AIDS status to:

☐ Spouse_____

☐ Significant Other_____

☐ Parent(s)_____

☐ Child(ren)_____

☐ Other_____Relation:_____

☐ My personal health information is NOT to be released or disclosed to anyone.

This authorization expires upon written notice from me. I understand I have a right to revoke this authorization in writing except to the extent Gynecologic Surgeons & Obstetricians, P.C. has taken action or has relied upon the authorization. This authorization may be revoked in writing delivered to Gynecologic Surgeons and Obstetricians, P.C.

The information used or disclosed under this authorization may be subjected to redisclosure by the recipient and no longer protected by federal privacy laws.

_____	_____	_____
Date Signed	Patient Signature	Date of Birth
_____	_____	_____
Date Signed	Signature of Personal Representative of Patient	Relationship

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Gynecologic Surgeons and Obstetricians, PC
MEDICATION AND ALLERGY LIST

Patient Name:_____ Date of Birth:_____

Are you allergic to latex/rubber gloves? _____yes _____no

Do you have Allergies to Medicine: _____yes _____no

If yes, please list medication and reaction(s): _____

_____

Medication Name and Dosage (including over the counter, supplements, vitamins, etc……)

Drug Name	Dosage and Directions for use	Prescribing Physician

Patient Signature:_____ Date Signed:_____

For Office Use: These medications and allergies were reviewed and there are no changes.

WOMEN'S HEALTH CARE CENTER
of Williamsburg

6050 Village Drive, Lincoln, NE 68516
(402) 421-8581
FAX: (402)421-8594

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Authorization to Consent to Medical Services for a Minor Child
Under 19 years of age

I, _____, certify that I am the parent or legal guardian of

_____, date of birth _____, a minor and that I am authorized to provide informed consent for any medical treatment provided to my child by Women's Health Care Center. I hereby choose to exercise my right to consent to medical treatment for said minor child as follows:

_____ (initial)

Option 1: I hereby give Women's Health Care Center consent to provide all medical services required for, or requested by, the minor child and no further consent from me will be required to provide such medical services at any time after the date of this document.

_____ (initial)

Option 2: I hereby give Women's Health Care Center consent to provide the following medical services required for, or requested by, the minor child as reflected by my initials and no further consent from me will be required to provide such medical services at any time after the date of this document:
(please check mark which of the following)

_____Office visits including pelvic exam
_____Pap Smear
_____Lab Tests, including blood tests or cultures
_____Office Procedures, including Colposcopy, Cryotherapy, Ultrasounds, etc
_____Prescriptions/Injections, including birth control, antibiotics, immunizations, etc.
_____The placement and/or removal of intrauterine or implant device for birth control
_____Obstetrical Services

_____ (initial)

Option 3: Any medical services provided to the minor child shall require my consent at the time such services are provided. I understand that I must be present at every visit to provide my consent for services.

I understand that I am financially responsible for any medical services provided by Women's health Care Center to the minor child. I further understand that my consent to treat will remain in effect until the minor child reaches the age of majority (19) or I provide written notice to the clinic that I am revoking my consent.

_____

Printed name of Parent or Legal Guardian of DNF DNF

_____

Signature of Parent or Legal Guardian Date

****If the Legal Guardian, you must provide the office with Letters of Guardianship****

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