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 & OBSTETRICIANS, P.C. rev. July 2015 QuestionnNewPt

INITIAL GYNECOLOGY HISTORY RECORD AND PATIENT QUESTIONNAIRE

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

MEDICAL HISTORY

Have any of your ***blood relatives*** had any of the following conditions? Circle "YES" or "NO" & list Relation & their Age

Breast Cancer	YES	NO
Ovarian Cancer	YES	NO
Colon Cancer	YES	NO
Uterine Cancer	YES	NO

Have YOU had any of the following conditions? Circle "YES" OR "NO"

Cancer; What kind?_____	YES	NO
Diabetes	YES	NO
Gallbladder/Gastrointestinal/Liver	YES	NO
Heart Problems/High Blood Pressure	YES	NO
Thrombophlebitis/Blood Clots	YES	NO
High Cholesterol	YES	NO
Last Cholesterol Date _____ Result, if known_____		
Sickle Cell Anemia/Blood Disorders	YES	NO
Blood Transfusion	ES	NO
Thyroid Disease	YES	NO
Migraine/Vascular Headaches	YES	NO
Epilepsy/Neurological Problems	YES	NO
Rheumatic Fever as a Child	YES	NO
Infection of Fallopian Tubes	YES	NO
Recurrent Urinary Tract Infection	YES	NO
Kidney Problems	YES	NO
Asthma/TB	YES	NO
Hepatitis	YES	NO
Sexually Transmitted Disease	YES	NO

if yes, circle (herpes/genital warts/ gonorrhea/chlamydia/syphilis)

Mitral Valve Prolapse OR Any heart condition requiring antibiotics before surgery/dental procedures? YES NO

Psychological Problems	YES	NO
Serious Injuries	YES	NO
Drug Use	YES	NO
Do you smoke?	YES	NO
If yes, how many per day? _____		
Do you drink alcohol?	YES	NO
If yes, how many drinks per day/week? _____		
Do you exercise regularly?	YES	NO
Loss of urine with coughing?	YES	NO
Urinary Urgency?	YES	NO
Constipation?	YES	NO

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? YES NO

HOSPITAL/SURGICAL HISTORY

_____
_____
_____

PRIMARY CARE PHYSICIAN

_____

PREGNANCY HISTORY (enter numbers)

Pregnancies _____ Abortions _____
Live Births _____ Stillborn _____
Miscarriages _____ Now Living _____
Age at time of first child _____

PAP SMEAR HISTORY

Last PAP smear date _____
Results: Normal ___ Abnormal___
Abnormal PAPs in past _____
If yes, what tests/treatment: _____
_____

Date of Last mammogram? _____
Where?_____

MENSTRUAL HISTORY

At What age did periods begin? _____
Interval between periods (first day to first day)__
How long do periods last? _____
Amount of flow? Light __ Moderate__Heavy__
Cramping? Light __ Moderate___Heavy___
LMP (1st day of last period) _____
At what age did you go through menopause? _____

CONTRACEPTIVE METHOD USED NOW

_____
_____
_____

Which pharmacy do you use?
_____

Reviewed by: _____

Your Name:_____ **Date of Birth:**_____

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

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

Revised 09/13

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****

Revised 01/14