

Patient Registration Form (eCW)

(Please Print)

PATIENT INFORMATION

Dr. Miss Mr. Mrs. Ms. Sir

Patient's Name (Last) (First) (MI) Previous Name

Address Line 1

City, State ZIP

Home Phone Cell No. Work Phone Ext.

Primary Care Provider (PCP) Referring Provider

Rendering Provider Name (this practice) E-Mail Address:

Date of Birth MM/DD/YYYY Sex F - Female M - Male Transgender

Race American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander Black or African American White Declined

Ethnicity Hispanic or Latino Not Hispanic or Latino Declined

Language English Spanish Indian Japanese Chinese Korean French German Russian Other

Marital Status Married Single Divorced Widowed Legally Separated Partner

Social Security Number Employer Name

Employment Status 1 - Full-Time 2 - Part-Time 3 - Not Employed 4 - Self-Employed 5 - Retired 6 - Active Military

Student Status F - Full-Time Student P - Part-Time Student N - Not a Student

Emergency Contact Last Name First Name

Phone Number Do you have a living will? Yes No

Emergency Contact Relationship to Patient Guardian

Address Line 1

City, State ZIP

Home Phone Work Phone Ext.

Referring Provider Name

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party Another Patient Guarantor Self Check here if information is same as patient

Responsible Party Name (Last) (First) (MI)

Guarantor Account Number Date of Birth MM/DD/YYYY

Social Security Number Telephone

E-Mail Address Sex F - Female M - Male

Address Line 1

City, State ZIP

Employer Employer Phone Number

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number

Name of Insured Patient Relationship to Insured

Subscriber ID (Policy Number) Group ID Copay Amount

Effective Date Termination Date Date of Birth MM/DD/YYYY

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number

Name of Insured Patient Relationship to Insured

Subscriber ID (Policy Number) Group ID Copay Amount

Effective Date Termination Date Date of Birth MM/DD/YYYY

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature Date

HCA Physician Services

Consultants in Obstetrics and Gynecology

**Patient Consent Form**

(Please Read and Sign)

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I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Consultants in Obstetrics and Gynecology** may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **Consultants in Obstetrics and Gynecology** will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

**MEDICARE PATIENTS:** I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **Consultants in Obstetrics and Gynecology**.

I acknowledge that I have been given **Consultants in Obstetrics and Gynecology** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: \_\_\_\_\_

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

\_\_\_\_\_  
Patient (or Responsible Party) Signature

\_\_\_\_\_  
Date

HIM.PRI.001

# How Can We Reach You?

## HealthONE Clinic Services PHONE MESSAGE CONSENT

Your provider will at times need to contact you. By filling out the information below we will be better able to serve you.

Name: \_\_\_\_\_

In an effort to protect your privacy, we will have developed a policy on leaving medical care messages:

- We will **NOT** leave messages with anyone except the patient or legal guardian.
- We will **NOT** leave any confidential information on an answering machine.
- We will **NOT** leave any messages on a voice mail.

### *UNLESS*

WE HAVE YOUR WRITTEN PERMISSION TO DO SO.

Please read below and consider carefully whom you authorize to have access to protected information regarding your care.

I, \_\_\_\_\_ give HealthONE my permission to speak with and/or leave messages regarding my medical care and/or billing with the following. I fully understand that this consent will remain valid until revoked in writing.

My **Home** answering machine: # \_\_\_\_\_ Initials: \_\_\_\_\_

My **Cell** voice mail: # \_\_\_\_\_ Initials: \_\_\_\_\_

My **Office/Work** voice mail: # \_\_\_\_\_ Initials: \_\_\_\_\_

### **Other Contacts:**

Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone#: \_\_\_\_\_ Initials: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone#: \_\_\_\_\_ Initials: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone#: \_\_\_\_\_ Initials: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Consultants in Obstetrics and Gynecology

HealthONE Clinic Services

I the undersigned authorize Consultants in Obstetrics and Gynecology to leave (circle one):

Detailed      or      General

Voicemail messages regarding future appointments, test results and personal information on the number I specify:

Phone Number: (\_\_\_\_) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_



### Obstetric Intake Patient Form

- Name: \_\_\_\_\_
- Age: \_\_\_\_\_
- Number of pregnancies: \_\_\_\_\_
- Number of living children: \_\_\_\_\_
- Current medical problems: \_\_\_\_\_  
\_\_\_\_\_
- Medications: \_\_\_\_\_
- Allergies: \_\_\_\_\_
- Problems during previous pregnancies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b>Do you have a history of:</b>	<b>Yes</b>	<b>No</b>	<b>Explanation:</b>
Preeclampsia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Growth restricted baby	<input type="checkbox"/>	<input type="checkbox"/>	_____
More than 2 miscarriages	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	_____
Herpes	<input type="checkbox"/>	<input type="checkbox"/>	_____

With whom do you live? \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How much per day? \_\_\_\_\_

Do you use drugs? \_\_\_\_\_

How many alcoholic beverages do you have per week? \_\_\_\_\_

## Consultants in OB/GYN

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Home phone: \_\_\_\_\_ Age: \_\_\_\_\_

Other phone: \_\_\_\_\_

Referred by: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Do you have:

Diabetes	yes	no
Hypertension	yes	no
Asthma	yes	no
Thyroid Dysfunction	yes	no
Cancer	yes	no
Other medical illness	yes	no

What surgeries have you had? \_\_\_\_\_

What medications are you allergic to? \_\_\_\_\_

What medications are you currently taking? \_\_\_\_\_

Are you pregnant? yes no

Do you plan to become pregnant in the next 2 years? yes no

How many times have you been pregnant? \_\_\_\_\_

How many children have you had? \_\_\_\_\_

Have you had a Cesarean section? yes no

Last menstrual period: \_\_\_\_\_

Birth control method: \_\_\_\_\_

Last pap and result: \_\_\_\_\_

Have you ever had an abnormal pap? yes no

If yes, have you had a LEEP? yes no

Have you had a sexually transmitted disease? yes no

Last mammogram and result: \_\_\_\_\_

Do you ever have leaking of urine? yes no

How many cigarettes do you smoke per day? \_\_\_\_\_

How much alcohol do you drink? \_\_\_\_\_

What is your sexual preference? Homosexual Heterosexual

Family history of major medical disorders: \_\_\_\_\_

medications BP -

pap WT -

mammogram UA -

blood work

ultrasound

dictated

