River City OB/GYN, P.C.
Patient Registration Form

PATIENT INFORMATION

Patient Name: _____ _____ _____
(First) (Middle) (Last)

Sex: ☐ Female ☐ Male Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Domestic Partner ☐ Widowed

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Mobile Number: (_____) _____-_____ Email Address: _____

Home Number: (_____) _____-_____ Work Number: (_____) _____-_____

Home Address: _____

City: _____ State: _____ Zip _____

How did you hear about River City OB/GYN: _____

ETHNICITY/ RACE : ☐ Hispanic or Latino ☐ Asian ☐ White or Caucasian
☐ American Indian or Alaska Native ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ Patient declines to specify

Emergency Contact:

Name: _____ Relationship to patient: _____

Phone: _____

RESPONSIBLE PARTY (if other than patient)

Guarantor's Name: _____ Phone Number: (_____) _____-_____

Address: _____ City: _____ State: _____ Zip _____

(If different from Above)

Patient Relation to Guarantor: _____ Guarantor's Employer: _____

Employer Address: _____

City: _____ State: _____ Zip _____

Guarantor Social Security #: ___ ___ ___-___ ___ -___ ___ ___ ___ Guarantor D.O.B _____/_____/_____

Insurance Information (you may leave blank if you can present your card to the receptionist)

PRIMARY

Name of Insurance Company _____ Policy Holder: _____

ID Number: _____ Group Number: _____

SECONDARY

Name of Insurance Company _____ Policy Holder: _____

ID Number: _____ Group Number: _____

I hereby authorize River City OB/GYN, P.C., to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to River City OB/GYN, P.C of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original.

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

Patient's signature (or responsible party) _____ Date: _____

PATIENT ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I hereby authorize River City OB/GYN, P.C., to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to River City OB/GYN, P.C of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original.

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

_____ Date: _____
Patient's signature (or responsible party)

_____ _____
Printed Name of Patient or Personal Representative Relationship to Patient

SPECIFIC INFORMATION RELEASE (If applicable)

I request and authorize River City OB/GYN, P.C. to disclose protected health care information to the individual(s) listed below.

Name _____ Contact # _____

Name _____ Contact # _____

Name _____ Contact # _____

NOTICE OF PRIVACY PRACTICES (HIPAA)

I acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

_____ Date: _____
Patient's signature (or responsible party)

_____ _____
Printed Name of Patient or Personal Representative Relationship to Patient

CONSENT FOR USE OR DISCLOSURE OF PATIENT INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I hereby consent to River City OB/GYN, P.C. using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to River City OB/GYN, P.C. using or disclosing my protected health information for treatment activities provided by another provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operation including quality assessment and reviewing the competence of health care professionals.

_____ Date: _____
Patient's signature (or responsible party)

_____ _____
Printed Name of Patient or Personal Representative Relationship to Patient

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received from the Group a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth this Group's privacy practices and my rights regarding privacy of my protected health information.

_____

Patient's Printed Name

_____ _____

Signature Date

River City OB/GYN Cancellation / No Show Policy

1. Cancellation / No Show for Scheduled Appointment:
   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a Thirty Five Dollar ($35) fee; this will not be covered by your insurance company. This appointment will also be marked as a No Show since adequate cancellation notice was not given. We will limit the number of No Shows or late cancellations allowed per patient. If you are a No Show three (3) times, we will no longer schedule appointments for you at our practice.

2. Late Arrival for Scheduled Appointments:
   We understand that delays can happen; however we must try to keep the other patients and doctors on time. If a patient arrives 15 minutes past their scheduled time we will have to reschedule the appointment.

_____
Printed Name

_____
Patient Signature or Guardian Signature

____/____/_____
Date

Medical History

Patient Name: _____ DOB: ___/_____/_____AGE: _____

Marital Status: □Single □In a Relationship □ Married □Widowed □Divorced

Sexual Orientation: □Heterosexual □Homosexual □Bisexual □Transgender

Spouse/Partners Name: _____

Family Physician or Primary Care Provider: _____

Your Employment/Occupation: _____

Preferred Pharmacy: _____

Medication Allergies: _____

List all Current Medication and the dosage (including over the counter):

_____

_____

_____

_____

Past Medical History:

Do you have, or have you ever had: (Please check all that apply)

Acid Reflux/Gerd	Chronic Kidney Disease	Herpes, Type:	Osteopenia
Asthma/ Emphysema/ Lung Disease	Crohns/Ulcerative Colitis	High Cholesterol	Osteoporosis
Anemia	Depression	HIV	Pelvic Inflamm. Disease
Anxiety	Diabetes	Hypertension	Seasonal Allergies
Arthritis	Endometriosis	HPV/genital warts	Seizure Disorder
Autoimmune Disorder-	Fibroids	Irritable Bowel Syndrome	Stroke
Bleeding or Clot Disorders	Gonorrhea	Leukemia/Lymphoma	Syphilis
Blood Transfusion	Heart Attack	Liver Disease	Thyroid Disorder
Cancer-What Kind?	Heart Disease	Migraines	Urinary Incontinence
Chlamydia	Hepatitis, Type:	Mitral Valve Prolapse	Varicella or Vaccine (Chicken Pox)

Other: _____

Date of last Well Women's Health Exam/ Pap Smear: _____

Do you have a history of an abnormal pap: □ No □Yes, If history of abnormal pap:

- When? _____
- Type of abnormality? _____
- Was there any treatment? □LEEP □Laser □Cone Biopsy

Have you had a:	Date of last:
Mammogram	
Bone Density	
Colonoscopy	
HPV/Gardasil Vaccine	Is series completed: □Yes □ No
Cholesterol check Results? □Normal □High	

Social History:

Tobacco Use: □Never □Current, how much_____ □Former, Quit at age_____

Alcohol Use: □Never □YES, average number of drinks per week_____

Recreational Drug Use: □No □Yes, What and how often_____

History of Sexual Abuse/Assault: □No □Yes History of Physical Abuse/Assault: □No □Yes

Reproductive History:

Date of Last Menstrual Cycle: _____/_____/_____ If Menopausal, age of menopause: _____

Method of Contraception: □None □Pill □Vasectomy □ Condoms □Rhythm Method □NuvaRing
□Depo Provera □ IUD □Nexplanon □Tubal Ligation

Obstetrical History: (please list all that apply and how many of each)

□Pregnancies: _____ □Miscarriages: _____ □Elective Abortions: _____

□Fetal Demise: _____□Ectopic: _____ □Multiples (Twins): _____ □Living Children: _____

Birthdate	Weeks	Baby's weight	Sex	Type of Delivery	Anesthesia	Complications	Location

Past Surgical History:

Year	Description	Year	Description

Family History: (Please check all that apply)

Condition:	Relation to you:	Condition:	Relation to you:
Asthma		Melanoma	
Breast Cancer	Age:	Mental Health Disorder	
Colon Cancer	Age:	Osteoporosis	
Diabetes		Ovarian Cancer	Age:
Heart Disease		Pancreatic Cancer	Age:
High Blood Pressure		Stroke	
High Cholesterol		Uterine Cancer	Age:

Other: _____