

# Shrewsbury Obstetrics and Gynecology, PC

## REGISTRATION FORM

Date: \_\_\_\_\_  David Klein, MD  
 Nicole Manning, NP

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Insurance Subscriber: \_\_\_\_\_ Their Date of Birth: \_\_\_\_\_

Email address: \_\_\_\_\_

Who may we thank for referring you?: \_\_\_\_\_

### Authorization for treatment and promise of payment

I hereby consent for medical treatment by B. Dale Magee, MD or David Klein, MD.  
I hereby understand I am responsible for fees not covered by my insurance

Signature of Patient or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

### Release of information and direct Payment to Physician

I hereby authorize B, Dale Magee, MD or David Klein, MD to release medical information necessary to process my claim to my insurance company for services rendered. I also authorize my insurance company to pay benefits directly to Shrewsbury Obstetrics and Gynecology.

Signature of Patient or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

### Notification of Privacy Practices

I have received a copy of the Notice of Privacy Practices prior to signing this consent. By signing this form, I am consenting to Shrewsbury Ob-Gyn's use and disclosure of my Private Health Information (PHI) to carry out Treatment, Payment & Healthcare Operations (TPO). With my consent, Shrewsbury Ob-Gyn **may call my home or other designated location, mail to my home or other designated location, and call my home or other designated location and leave a message on voice mail or with a person for me to return a call to this office** in reference to any appointment reminders, insurance items and any call pertaining to my clinical care. If I do not sign this consent, Shrewsbury Ob-Gyn may decline to provide treatment to me.

I have the right to request that Shrewsbury Ob-Gyn restrict how it uses or discloses my PHI to carry out TPO, however, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. Shrewsbury Ob-Gyn reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Shrewsbury Ob-Gyn Privacy Officer at 555 Main Street, Shrewsbury, MA 01545.

Signature of Patient or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

***Patient Financial Responsibility Disclosure Statement***

Your signature below forms a binding agreement between Shrewsbury OB/Gyn, P.C. and the Patient who is receiving medical services, or the Responsible Party for minor patients. Responsible Party is the individual who is financially responsible for the payment of medical bills.

All charges for services rendered are due and payable at the time of service.

**MEDICAL INSURANCE:** We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for **any reason**.

The person signing on behalf of themselves or the Patient as the Responsible Party must:

- Inform our office with changes to contact information
- Present all **current** insurance cards prior to each visit
- Pay any required co-pay at the time of the visit
- Call your insurance company to find out whether the MD you are seeing is a contracted provider with your health plan and if you have any additional costs such as co-pays, co-insurance and/or deductibles
- Pay any additional amount billed after the services were rendered with in 30 days unless a payment agreement is set up between the Practice & the Responsible Party
- Contact Quest Diagnostics with any lab service fee questions

**SELF PAY PATIENTS:** We offer discounted prices to Patients with out active insurance coverage that pay in full on the date of service. Any lab fees will be applied separately from Quest Diagnostics.

**Non-Payment on the Account will result in collection proceedings.**

By signing below, you agree to accept full financial responsibility as a Patient who is receiving medical services or as the Responsible Party for a minor patient. Your signature verifies that you have read the above disclosure statement, understand your responsibility and agree to the terms.

*Signature of Patient or Responsible Party:* \_\_\_\_\_

*Date:* \_\_\_\_\_

# Shrewsbury Obstetrics and Gynecology, PC

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_ Highest Level of Education: \_\_\_\_\_

Race:  White  Black  Asian  Indian/Alaskan  Pacific Islander  Hispanic-Black  Hispanic-White  Other/Mutiracial

Do you prefer a chaperone for your exams? YES NO Preferred Language: \_\_\_\_\_ Ethnicity: Hispanic OR Non-Hispanic

## MENSTRUAL & PREGNANCY HISTORY

Date of last menstrual period: \_\_\_\_\_ Menses occur every: \_\_\_\_\_ days Menses length: \_\_\_\_\_ days Any bleeding between periods? \_\_\_\_\_ Age of onset of periods: \_\_\_\_\_

### Deliveries

Year	Hospital	Duration of Preg.	Length of Labor	Type of Delivery	Type of Anesthesia	Weight of Infant	Gender	Problems

### Miscarriages

Year	Weeks Pregnant	D&C?

### Abortions

Year	Weeks Pregnant	Facility

## PAST MEDICAL HISTORY

	N Neg Y Pos	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT		N Neg Y Pos	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
Psychiatric Disease/ Anxiety/Depression			History of Genital Herpes		
Neurologic Disease			Infertility		
Hypertension			Abnormal Pap Smear		
Heart Disease			Sexually Transmitted Diseases: Gonorrhea, Chlamydia, HIV or Syphilis		
Lung Disease			Uterine Abnormalities		
Breast Disease			Major Injuries		
Kidney Disease/ UTIs			Violence (Domestic)		
Liver Disease/Hepatitis			Complications due to Anesthesia		
Thyroid Disease			History of Relative with Cancer of the Breast, Uterus, Ovary or Colon		
Diabetes			History of Female Relative with Heart Attack before age 65 or Male Relative before 55		
Lupus, Rheumatoid Arthritis or Scleroderma					
Varicosities/ Phlebitis					
Bleeding Disorder					
History of Blood Transfusion					
Exposure to Tuberculosis					

## PROCEDURES AND OPERATIONS

Year	Procedure or Operation