Shrewsbury Obstetrics and Gynecology, PC

REGISTRATION FORM

___David A. Klein, MD
___Nicole K. Manning, NP

Date: _____

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 ID: _____

SHREWSBURY OBSTETRICS & GYNECOLOGY, PC

David A. Klein, MD
Nicole K. Manning, NP

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
Psychiatric Disease/ Anxiety/Depression		
Neurologic Disease		
Hypertension		
Heart Disease		
Lung Disease		
Breast Disease		
Kidney Disease/ UTIs		
Liver Disease/Hepatitis		
Thyroid Disease		
Diabetes		
Lupus, Rheumatoid Arthritis or Scleroderma		
Varicosities/ Phlebitis		
Bleeding Disorder		
History of Blood Transfusion		
Exposure to Tuberculosis		

	N Neg Y Pos	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
History of Genital Herpes		
Infertility		
Abnormal Pap Smear		
Sexually Transmitted Diseases: Gonorrhea, Chlamydia, HIV or Syphilis		
Uterine Abnormalities		
Major Injuries		
Violence (Domestic)		
Complications due to Anesthesia		
History of Relative with Cancer of the Breast, Uterus, Ovary or Colon		
History of Female Relative with Heart Attack before age 65 or Male Relative before 55		

PROCEDURES AND OPERATIONS

Year	Procedure or Operation

Shrewsbury Obstetrics and Gynecology, PC

Name: _____ Primary Language: _____

Husband/Partner's Name: _____ Age: ____ Husband/Partner's Occupation: _____

Husband/Partner's Race: ☐ White ☐ Black ☐ Asian ☐ Indian/Alaskan ☐ Pacific Islander ☐ Hispanic-Black ☐ Hispanic-White ☐ Other/Mutiracial

Ancestral Countries of origin: _____ Husband/Partners Ancestral Countries of origin: _____

GENETICS SCREENING & TERATOLOGY COUNSELING

(Includes patient, baby's father or anyone in either family unless where indicated)

	N Neg Y Pos	DETAIL POSITIVE REMARKS
Thalassemia (or Italian, Greek, Mediterranean or Asian Descent)		
Neural Tube Defect		
Congenital Heart Defect		
Down Syndrome		
Tay-Sachs (or Jewish, French Canadian or Cajun Descent)		
Sickle Cell Anemia (or African, Haitian or Central American Descent)		
Muscular Dystrophy		
Hemophilia		
Cystic Fibrosis		
Huntington's Disease		
Phenylketonuria (PKU) or any other metabolic disorders		

	N Neg Y Pos	DETAIL POSITIVE REMARKS
Mental Retardation or Autism		
Any other inherited disorders		
Patient or baby's father with a child with any birth defects not already listed		
Patient with more than 2 prior miscarriages or a stillbirth		
Family history of fraternal (non-identical) twins		
Has the patient had a rash or viral illness since her last period?		
Has the patient had or been vaccinated for the chicken pox?		
Is the patient Rh sensitized?		
Has the patient had any alcohol since her last period? If so, what kind, how much and how often?		
Does the patient smoke? If so, how much?		
Does the patient do any street drugs? If so, what kind?		

DIETARY HISTORY

Are you a vegetarian?		Do you consume dairy products daily?	
How many caffeinated beverages do you drink a day?		Do you regularly use laxatives?	
Are you on a special diet? If so, what kind?			

MEDICATIONS AND ALLERGIES

Please list the name and dosage of any medications that you are currently taking	
Please list any vitamins, herbs or dietary supplements that you are currently taking	
Do you have any known allergies? If so, please list.	

SOCIAL & ENVIRONMENTAL FACTORS

Do you or other members of your household ever go to bed hungry?		Do you do more than 3 hours a day of repetitive bending/lifting at work?	
Will you be moving during this pregnancy?		Do you work over 50 hours per week?	
Do you feel safe where you live?		Do you feel that you are under a lot of stress?	

_____

Signature *Date*