Specialists in Obstetrics and Gynecology

PATIENT REGISTRATION FORM (Please Print)

[Type here]

☐ Mr. ☐ Mrs. ☐ Ms.

Patient's Name (Last)_____ (First)_____ (Middle)_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Race ☐ White ☐ African American or Black ☐ Asian ☐ American Indian ☐ Native Hawaiian or other Pacific Islander

Ethnicity ☐ Hispanic or Latin American ☐ Not Hispanic or Latin American

Language ☐ Arabic ☐ Chinese ☐ English ☐ French ☐ Spanish ☐ Other

Social Security Number _____-_____-_____ ☐ Female ☐ Male Date of Birth_____/_____/_____

E-Mail Address_____

Phone Numbers Work_____ ☐ Day ☐ Evening Home_____ ☐ Day ☐ Evening

Cellular_____ Pager_____

Address_____

City, State, ZIP_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Occupation_____

Emergency Contact Name_____ Phone Number_____

Emergency Contact Relationship to Patient_____

Referring Provider Name_____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last)_____ (First)_____ (Middle)_____

Social Security Number _____-_____-_____ ☐ Female ☐ Male Date of Birth_____/_____/_____

Phone Numbers Work_____ ☐ Day ☐ Evening Home_____ ☐ Day ☐ Evening

Address_____

City, State, ZIP (+4)_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Employer Phone Number_____

Patient Relationship to Responsible Party_____

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

Name of Insured_____ Patient Relationship to Insured_____

Insurance Name_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ ☐ Female ☐ Male

Insured Date of Birth_____/_____/_____ Insured's Social Security Number _____-_____-_____

Insurance Company Address_____

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***_____

Specialists in Obstetrics and Gynecology

Last Name First Name Middle Initial

Medication Allergies:

_____

_____

Other Allergies:

_____

Current Medications:

_____

_____

_____

Please circle any symptoms you are experiencing: CURRENTLY

Constitutional	***Respiratory***	***Musculoskeletal***
Fatigue	Cough	Joint Pain
Weight Loss	Wheezing	Joint Swelling
Weight Gain	Shortness of Breath	

Head, Ears, Nose, Throat	***Gastrointestinal***	***Endocrine***
Headache	Nausea/vomiting	Hair Loss
Sore Throat	Diarrhea	Temperature Intolerance
Decreased Hearing	Constipation	Abnormal Hair Growth
	Abdominal Pain	

Breast	***Skin/Hair***	***Preventive Care (MM/YY)***
Breast Lumps	Rash	Last Pap Smear _____
Breast Tenderness	Skin Lesions	Last Mammogram _____
Nipple Discharge		Last Bone Density Scan_____
		Last Colonoscopy_____

Cardiovascular	***Neurologic***
Chest Pain	Seizures
Irregular Heartbeat	Tingling
	Numbness

No Symptoms to Report

Pharmacy Name: _____

Address: _____

Phone: _____

Reproductive History

Last menstrual period _____ Are periods regular? _____ Any problems with periods? _____
_____
At what age did your periods begin? _____

Yes No Are you currently sexually active? Any difficulties or discomfort? _____
Yes No Are you trying to get pregnant? _____
Yes No Are you on any type of contraception? _____
Do you want to change? Yes No To What? _____
When was your last Pap smear? _____
Yes No Have you ever had an abnormal Pap or HPV test? Treatment? _____
Yes No Have you ever had an abnormal mammogram or exam? Treatment? _____
Yes No Do you perform breast self-exams? Any changes or concerns? _____
Yes No Any vaginal discharge atypical for you? Itching? _____ Odor? _____
Yes No Any bladder leakage? Explain. _____
Yes No Have you ever had any sexually transmitted infections? What? _____
(Ex. Herpes, Gonorrhea, Chlamydia, Trichomonas, HIV, Hepatitis B or C, Syphilis, HPV)
Postmenopausal)
What age did you go through menopause? _____
Yes No Are you taking any hormone replace therapy medication? _____
Yes No Have you ever used hormone replacement therapy? If yes, total number of years: _____

Social History

Yes No Do you smoke? _____ Never ____ Former ____ Current
Yes No Do you drink alcohol? If yes, how often? Daily Weekly Monthly Rarely
Yes No Do you use drugs? If yes, which ones? _____
Yes No If yes, how often? _____
Yes No If yes, how much? _____
Yes No Leakage of urine when coughing/sneezing?
Yes No Painful Intercourse?
Yes No Vaginal Dryness?
Yes No Spotting After Intercourse?

Obstetrical History

Please list all pregnancies, including miscarriages, abortions, ectopics. Include full birthdates.
Pregnancies? _____ # Miscarriages? _____ # Abortions? _____
Ectopic? _____ Living Children ____
Complications: pre-eclampsia, diabetes, bleeding, pre-term labor, postpartum depression, high blood pressure
List pregnancies in chronological order:

Birthdate	Weeks	Baby's Weight	Sex	Type of Delivery (Vaginal or C/S)	Hours in Labor	Anesthesia	Complications	Child's Name	Name of Hospital

Past Medical History

Please circle any that you have had in the past.

Diabetes	Anemia	Irregular Heart Rate	Fibromyalgia	HIV/AIDS
Stroke	Seizures	Hepatitis (A, B, or C)	High Blood Pressure	Stomach Ulcers
Heart Murmur	GERD	Heart Attack	Thyroid Problems	Emphysema/Asthma
Depression	High Cholesterol	Migraines	Asthma	Bronchitis
Cardiovascular Disease	Blood Clots	Kidney Infections	Crohn's Disease	IBS
Anxiety	Bipolar Disorder	History of Blood Transfusion	Cancer Type:	

Other Medical Conditions:

Past Surgical History

Please circle any surgical procedures you have had in the past.

Gallbladder	Plastic Surgery	Thyroid
Hernia Repair	Joint Replacement	Heart Surgery
Wisdom Teeth	Back Surgery	Pacemaker
Tonsils/Adenoids	Cataract Removal	Appendectomy
Tubal Ligation	D &C	Laparoscopy
Hysterectomy	Oral Surgery	Mastectomy
Breast Biopsy	Hernia Surgery	Tonsillectomy
C-Section	Abdominal Surgery	Heart Cath

Other Surgeries: _____

Were there bleeding or anesthetic complications with any of your surgical procedures? If yes, please explain.

Family Medical History

Please circle any that are present in your family.

No Significant Family History	Anemia	Irregular Heart Rate	Fibromyalgia	HIV/AIDS
Diabetes	Seizures	Hepatitis (A, B, or C)	High Blood Pressure	Stomach Ulcers
Stroke	GERD	Heart Attack	Thyroid Problems	Emphysema/Asthma
Depression	High Cholesterol	Migraines	Asthma	Bronchitis
Cardiovascular Disease	Blood Clots	Kidney Infections	Crohn's Disease	IBS
Anxiety	Bipolar Disorder	History of Blood Transfusion	Cancer Type:	Family History Unknown or Adopted

Family History:

Heart Disease? Y / N relationship: _____
Diabetes? Y / N relationship: _____
Breast Cancer? Y / N relationship: _____
Ovarian Cancer? Y / N relationship: _____
Colon Cancer? Y / N relationship: _____
Osteoporosis? Y / N relationship: _____
Hypertension? Y / N relationship: _____
Mental Illness? Y / N relationship: _____
Other: _____

Specialists in Obstetrics and Gynecology
Sebastian Faro, MD
Connie Faro, MD
Wyntrea Cunningham, MD
Jonathan Faro, MD
Stephanie Meyers, WHNP

Assignment of Benefits

I hereby assign to Specialists in Obstetrics and Gynecology any insurance or other third-party benefits available for health care services provided to me. I understand that Specialists in Obstetrics and Gynecology has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Specialists in Obstetrics and Gynecology, I agree to forward to Specialists in Obstetrics and Gynecology all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

Signature of Patient/Legal Guardian: _____ Date: _____

Authorization for Release of Information

I authorize Specialists in Obstetrics and Gynecology to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare or any other third-party payers. I authorize Specialists in Obstetrics and Gynecology to release all medical information to my referring physician and my primary (family) physician. I authorize Specialists in Obstetrics and Gynecology to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Specialists in Obstetrics and Gynecology.
I agree that these provisions will remain in effect until I provide written revocation to Specialists in Obstetrics and Gynecology.

Signature of Patient/Legal Guardian: _____ Date: _____

Specialists in Obstetrics and Gynecology: 7400 Fannin, Suite 1200 ▪ Houston, TX 77054 ▪ office 713-383-9579 ▪ fax 713-383-9369 ▪ fax 713-799-9233

Specialists in Obstetrics and Gynecology
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Financial Policy

As your physician, we are committed to giving you the best possible medical care. To achieve this goal, we need your assistance and understanding of our payment policy.

Managed Care Plans: As providers we ask that the co-pay and deductibles (if applicable) be paid in full at the time of your visit. We accept assignment for services covered and will bill the insurance. Any balance outstanding, following payment from the insurance, will be billed to you.

Medicare: We are participating Medicare providers, and will file your medical claims to Medicare for you. Services routinely not covered by Medicare (i.e., Preventive/Routine Exams) will require payment at the time of service. We also request payment for the 20% co-insurance of the allowable Medicare charges and any deductible (if applicable) that has not been met at the time of your visit.

Financial Agreement: We will be glad to discuss your proposed treatment and the cost of those services. If you have questions as to if your insurance will cover a medical service, we will be glad to try to find out if the plan will cover those services. HOWEVER, please be aware that your insurance is a contract between you, your employer (if applicable) and the insurance company. We are not a party to your contract. Unfortunately, not all services are covered benefits in all contracts.

We must emphasize that as your physicians, our relationship and concern is with you and your health, not with your insurance company. All charges for services are your responsibility at the time of service. Collection action will be taken for any balance on your account that is over 90 days old. We realize that emergencies do arise and may effect timely payment of your account. If such extreme cases do occur, please contact our office promptly for assistance in management of your account.

If you have any questions regarding the above or any uncertainty regarding insurance coverage or request for payment; please do not hesitate to ask. We are here to assist you.

I understand and agree to the financial policy for Specialists in Obstetrics and Gynecology.

_____ _____
Patient/Legal Guardian Signature Date

_____ _____
Witness Date

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following:

- 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
- 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, the undersigned, acknowledge that Specialists in Obstetrics and Gynecology will use and disclose my information for the purposes of treatment,

payment, and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which the judgment of the attending physician or their assigned designees, may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to Specialists in Obstetrics and Gynecology or benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized person to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury, to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

This consent specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases including but not limited to blood-borne diseases.

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

If there is an exposure, and the patient's test is positive, the attending physician will notify the patient, any person exposed, and the Public Health Department and appropriate counseling will be offered.

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 **Specialists in Obstetrics and Gynecology.**

I acknowledge that I have been given the **Specialists 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. .

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name: _____

Name: _____

_____ _____

Patient (or Responsible Party) Signature **Date**