Healthy Woman
Obstetrics Gynecology

Patient Registration Form

Today's Date: ___ /___ /_____ Email Address: _____

Last Name:_____ Legal First Name:_____ Middle:_____

Address:_____APT#_____

City_____ State:_____ Zip_____

Home Ph: (_____) _____ Work Ph: (_____) _____ Other Ph: (_____)_____

SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth: _____ / _____ / _____ Age:_____

Status: Single Married Widow Divorced Sex: Male Female Occupation:_____

Employer: _____ Employer Phone:(_____) _____

Emergency Contact Person: _____ Phone: (_____) _____

Pharmacy Name: _____ Location: _____ Phone: (_____) _____

Email: _____

Insurance Information

(If insurance information is incorrect or incomplete, the patient will be responsible for bill)

Primary Insurance Name:_____Phone: (_____) _____

Address: _____ City/State _____ Zip_____

Subscriber Name:_____ Employer:_____

SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth: ____ / ____ / ____ Relationship to patient_____

ID#:_____ Group #:_____

Secondary Insurance Name:_____Phone: (_____) _____

Address: _____ City/State _____ Zip_____

Subscriber Name:_____ Employer:_____

SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth: ____ / ____ / ____ Relationship to patient_____

ID#:_____ Group #:_____

Guarantor Information (patients age 18 and under)

Last Name:_____ First Name:_____ Middle:_____

Address:_____APT#_____

City_____ State:_____ Zip_____

Home Ph: (_____) _____ Relationship to Patient:_____SSN:

___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth: _____ / _____ / _____

Status: Single Married Widow Divorced Sex: Male Female Occupation:_____

Employer: _____ Employer Phone:(_____) _____

Consent/Release/Authorization

The insurance information listed on page one is current and correct. If any information is incorrect, I understand that I will be held responsible for any unpaid balance. I also understand and I agree that I will be responsible for any collection or legal fees associated with the collection of overdue balances that are my responsibility. It is my responsibility to notify Healthy Woman of any changes that occur in my insurance coverage.

I authorize Healthy Woman to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physicians all payment for medical services rendered to myself or my dependants. I understand that I am responsible for any amount not covered by insurance. In order to evaluate my present health status, I hereby consent, voluntarily, to undergo examination and necessary treatment by Healthy Woman. I authorize Healthy Woman to disclose my health information for treatment, payment and health care operations. I have read and understand the above and hereby, voluntarily give my consent and authorization.

Patient Signature_____ Date _____ / _____ / _____

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How did you hear about our practice? _____

Primary Care Physician's information: Name:_____

Address:_____

Phone:_____ Group Name:_____

Medical Problems: (chronic or serious illness, past or present)_____

Past surgeries or hospitalizations:_____

_____

Medications you are presently taking:

_____

_____

List Allergies:

Allergies to Medication: _____Other allergies (food, seasonal, etc.)_____

Ob/Gyn History:

Date of your last menstrual period:_____ / _____ / _____ Menstrual Problems? _____

Number of Deliveries_____ Miscarriages: _____

Social History:

Do you use tobacco now?:_____ In the past?:_____ How much?:_____

Do you use alcoholic beverages?:_____ Weekly amount?:_____

Family History:

Yes	No	Diabetes	Yes	No	Tuberculosis	
Yes	No	Kidney Disease	Yes	No	Cancer	Type:_____
Yes	No	Heart Disease	Yes	No	Skin Disorder	
Yes	No	Stroke	Yes	No	Glaucoma	
Yes	No	High Blood Pressure	Yes	No	Thyroid Disorder	

Present Complaint:

_____

_____

_____

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Obstetrics Gynecology

Joseph Cipriano, M.D. FACOG
Rebecca Cipriano, M.D. FACOG
Susan Pacana, M.D. FACOG
Neeti Misra, M.D. FACOG
Elizabeth Scheff, M.D. FACOG
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Authorization for Release of Protected Health Information

I authorize the staff and/or physicians at Healthy Woman to discuss my healthcare, diagnosis, test results, procedures, prognosis, insurance and billing information with the following person(s) for the purpose of my treatment or payment of services rendered *:

Name of designated person _____ Relationship to patient _____

Name of designated person _____ Relationship to patient _____

☐ **I DO NOT wish to designate any person(s) ***

Please note for children under 18 years of age, information will be released to the parent or legal guardian.

I authorize the release of my Protected Health Information to the following physician(s) or facility(s) upon request of the physician(s) or facility(s) for the purpose of my treatment:

Name of designated Physician or Facility _____ Type of Physician or Facility _____

Name of designated Physician or Facility _____ Type of Physician or Facility _____

☐ **I DO NOT wish to designate any physician(s) or facility(s)**

I understand that in order to ensure continuation of care, the staff and/or physicians at Healthy Woman may need to leave messages on the answering machine at my home or with any individual(s) who may answer my home phone. These messages may include but are not limited to: appointment confirmations, lab results, radiology results, pathology results, etc.

☐ **I DO wish to have messages left** ☐ **I DO NOT wish to have messages left**
☐ **I DO NOT wish to have email sent**

I also understand that by designating the above individual(s) or facility(s), I am allowing my Protected Health Information (medical records/ information) to be discussed or released to them. I know that this is my personal choice and I have not been forced to designate any individual(s) or facility(s) if I have chosen not to.

Patient Printed Name _____ X _____ Patient Signature

___/___/_____
Date

Privacy Practices Acknowledgement

I have reviewed / received the Notice of Privacy Practices for Healthy Woman

Patient Printed Name _____ X _____ Patient Signature

___/___/_____
Date

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Patient Name: _____ Phone: _____

Email: _____ Age: _____

Health Questionnaire

MENSTRUAL CYCLE

1. Do you experience heavy periods? ☐Yes ☐No

If you are done having children, you may be a great candidate for cryoablation, a 12- minute procedure (no pain or recovery time) done right here in our office. Ninety (90%) percent of woman who have had a cryoablation experience a lighter cycle post- procedure. Would you like your doctor to tell you more about it?

☐Yes ☐No

HEALTH &FITNESS

1. Are you happy with your weight? ☐Yes ☐No

2. Can we contact you about our medically-supervised, personalized weight loss program that has already helped lose over 30,000 pounds-and keep it off?

☐Yes ☐No

BEST PART? You can safely lose up to 20 pounds in one month.

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Medical Services Waiver

I understand that I am presenting myself in the office today for medical services to be performed. While many insurance companies cover the services that may be performed such as an annual exam (including pap smear, breast exam, other age appropriate screenings), biopsies, colposcopies and injections, I have been informed that some insurance companies do not. If my insurance company does not pay Healthy Woman for the services performed today I understand that any charges incurred during my exam will be my financial responsibility.

I understand that I will also be responsible for any copay or coinsurance payment due to Healthy Woman at the time of service, per the requirements of my health insurance plan contract.

I also understand that I will be responsible for payment of charges in full if I do not have any health insurance coverage.

Lastly, I understand that if I require a referral or preauthorization for Healthy Woman's services or any additional services recommended by Healthy Woman (including but not limited to radiology and lab work), I am responsible for either obtaining the correct referral OR notifying the office within 48 hours of the date of service to obtain an authorization. If I fail to do so, I will be responsible for the balances billed by Healthy Woman or outside parties for these services.

X _____ _____

Patient Signature Patient Printed Name

If patient is under 18:

X _____ _____

Parent / Guardian Signature Patient Printed Name

____/____/_____

Date