- ☐ NEW PATIENT
- ☐ NEW OB
- ☐ NAME CHANGE
- ☐ ADDRESS CHANGE
- ☐ INS. CHANGE
- ☐ UPDATE

**Most insurance carriers require us to submit claims for patient services. For this reason, we request all patients to fill out completely and sign the registration form on an annual basis. If you are mailing this form please return ALL copies. THANK YOU**

**PRESS FIRMLY – 2 PART FORM** **PATIENT INFORMATION**

Patient's Legal Name ______________________ (Last / First / Middle) Birth Date ____________ S.S. # ____________

Address ______________________ (Street / City / Zip) Daytime Phone # (____) ____________ (Area Code) Marital Status ____________

Employer's Name ____________ Occupation (Indicate if Student) ____________ Business Phone # (____) ____________ (Area Code)

Patient's Primary Doctor ______________________ (Name / Street / City/St / Zip) Drs. Phone # (____) ____________ (Area Code)

Name, Address of Nearest Friend or Relative ______________________ Phone (____) ____________ (Area Code) Relationship ____________

**PARENT / SPOUSE INFORMATION**

Parent / Spouse Name ______________________ (Last / First / Middle) Birth Date ____________ SS# ____________

Address ______________________ (Street / City / Zip) Home Phone ____________ Business Phone ____________

Employer ______________________ Employer's Address ______________________

**PRESS FIRMLY – 2 PART FORM** **PRIMARY INSURANCE**

Ins. Company Name ______________________ Address ______________________ Phone # ____________

ID#/Policy # ______________________ Group # ____________ Effective Date ____________

Policy Holder's Name ______________________ Relationship to PT. ____________ Birthdate ____________

Policy Holder's Address ______________________ Home Phone ____________

**SECONDARY INSURANCE**

Other Insurance Co. ______________________ Address ______________________ Phone ____________

Other Insured (If other than patient) ______________________ Address ____________ Phone ____________

Birth Date ____________ Relationship to Patient ____________ ID #/Policy # ____________ Group # ____________

Other Insured's Employer ______________________ Address ______________________ Phone # ____________

**AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS**

I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted and I will be bound by the signature as though I personally signed the claim. I also authorize the release of any medical information necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees.
I have read and understand the office policy and procedures.

* ______________________ ______________________
Responsible Party Signature Date

POS® Reorder # 9317989

# Desert Sage
Obstetrics and Gynecology

Pt's Name ______________________________ Date of Birth______________ Age _______ Today's Date ________________________
Email:_______________________________________________________ Pharmacy #_______________________

**With whom may we discuss test results or therapies?** ____________________________________________________________

At what phone number can we leave a secured voice mail?___________________________

1. GYNECOLOGICAL HISTORY: Any gynecological problems since your last examination? ❒ Yes; ❒ No (If yes, please explain)

- First day of last period ___________________________________
- Duration of flow ___________________________________
- Time between periods ___________________________________
- Date of last Bone Density Scan ______________________________
- Colonoscopy? ❒ Yes; ❒ No If yes, when? ___________________
- Date of last Mammogram ___________________________________
- Date of last Pap Smear ___________________________________
- Are you sexually active? ___________________________________
- Do you use contraception? ❒ Yes; ❒ No (If yes, type?) _____________
- Are you done having children? ❒ Yes; ❒ No

2. MEDICAL HISTORY: Any medical problems since your last examination? ❒ Yes; ❒ No (If yes, please explain)

- Do you take calcium? ❒ Yes; ❒ No
- List current Medications with the dosages *(include vitamin and herbal supplements)* ___________________________________
- List any Allergies to Medication ___________________________________
- Any Surgeries/Hospitalizations since your last examination? (If yes, please explain):

3. FAMILY HISTORY: Any changes to your family history since your last examination? ❒ Yes; ❒ No (If yes, please explain)
*(For example, breast cancer, ovarian cancer, uterine cancer and/or colon cancer, > 10 polyps on colonoscopy?)*

- Ashkenazi / Jewish Ancestry? ❒ Yes; ❒ No

4. SOCIAL HISTORY: Any changes to your social history since your last examination? ❒ Yes; ❒ No

- Do you exercise regularly? ❒ Yes; ❒ No Current Occupation: ___________________________________
- Marital status? ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widow ❒ Same Sex Partner
- Do you smoke cigarettes? ❒ Yes; ❒ No If yes, at what age did you start?_____________ Packs per day?_________________
- Do you drink alcohol? ❒ Yes; ❒ No If yes, amount? _______ If yes, how often? ________
- Do you use drugs socially? ❒ Yes; ❒ No If yes, amount? _______ If yes, how often? ________
- Are you a victim of domestic violence or abuse in your present relationship? ❒ Yes; ❒ No Past Relationship? ❒ Yes; ❒ No
- Do you have a living will? ❒ Yes; ❒ No
- Do you have a medical power of attorney? ❒ Yes; ❒ No If yes, please supply a copy.

5. REVIEW OF SYSTEMS

**Abdomen:**
Diarrhea? ❒ Yes ❒ No Constipation? ❒ Yes ❒ No Other: ___________________________________

**Genitourinary:**
Frequent urination? ❒ Yes ❒ No Urinary Incontinence? ❒ Yes ❒ No Other: ___________________________________

**Skin/breast:**
Lumps in breast? ❒ Yes ❒ No Nipple discharge? ❒ Yes ❒ No Other: ___________________________________

**Any other problems?**

Completed by:___________________________________________________ Date:________________________

Reviewed by: ___________________________________________________ Date:________________________
(Signature of Provider)

**Acknowledgment of Receipt of Privacy Notice**

***Desert Sage***

By signing below, I acknowledge that I have been provided with a copy of Desert Sage Notice of Privacy Practices and have therefore been advised of how health information about myself may be used and disclosed by Desert Sage and how I may obtain access and control this information.

* ____________________________________________
(Signature of Patient or Guardian)

* ____________________________________________
(Print Patient name or Guardian)

* ____________________________________________
(Date)

* ____________________________________________
(Description of Guardian)

Please list who you want to have access to your pertinent medical information, (i.e.: family member, spouse)

1. ____________________________________________

2. ____________________________________________

3. ____________________________________________

May we leave a message on an answering machine? YES __ NO __

Preferred method of contact:

Home#____________________________________________

Cell# ____________________________________________

Work# ____________________________________________

# Desert Sage OB/GYN

**NOTICE TO OUR PATIENTS: Please be advised that if you are scheduled as a Well Woman Exam, the exam includes:**

- Breast exam
- Pelvic exam
- Pap smear (as per ACOG Guidelines)
- STI Screening
- Contraception
- Refills on maintenance medicine
- Orders for Routine Imaging

**What is not included in your Well Woman Exam:**

**Any problems such as:**

- Abnormal bleeding
- pelvic pain
- vaginal infections
- urinary tract infections
- infertility
- etc.

These will be billed outside the annual exam and may not be covered by your insurance at 100% a deductible, co-insurance or copay may apply.

## For our MEDICARE patients:

Medicare only pays for a portion of your Well Woman Exam every 24 months. You will be required to sign an Advanced Beneficiary Notice (ABN) which explains your financial responsibility.

## AUTHORIZATION AND AKNOWLEDGMENT:

I recognize and accept financial responsibility for all professional services rendered and further authorize the insurance company to pay benefits to the physician.

_______________________________________________ ___________________________________

Signature of Responsible Party Date