FOUR CORNERS OB/GYN PATIENT REGISTRATION

Patient Name: _____ "_____" Date of Birth: _Please call us_
LAST FIRST MI NICKNAME

Social Security # ___LAST 4 DIGITS ONLY -_____

Physical Address: _____City:_____State:_____Zip:_____

Mailing Address: _____City:_____State:_____Zip:_____

Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

May we leave a private message? ☐YES ☐ NO At Which Number(s)? ☐ HOME ☐ CELL ☐ WORK

Any other telephone numbers to reach you? (_____)_____-_____

Email: _____ Marital Status: Married _____ Single _____ Other_____

Preferred Language: _____

Responsible Party/Guardian Name: _____Social Security # ___LAST 4 only -_____

Responsible Party/Guardian Address: _____

EMERGENCY CONTACT _____ Relationship to you: _____

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

***Note: Advanced Directives and Living Will information available online.**

PRIMARY INSURANCE: _____SECONDARY INSURANCE: _____

FOUR CORNERS OB/GYN WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & NOTICE OF ELECTRONIC HEALTH INFORMATION EXCHANGE NOTIFICATION.

Notice of Privacy Practices are available at the front desk.

Electronic Health Information Exchange Notification

Four Corners OB/GYN endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the Four Corners OB/GYN HIE, or cancel an opt-out choice, at any time.

I _____, have been offered a copy of Four Corners OB/GYN's Notice of Privacy Practice, and understand that this practice participates in electronic HIE.

I hereby authorize the release of my medical records to any physician involved in my care, as well as any medical information necessary to process claims. I also authorize the notification of test results, reminders, and other messages regarding my care to be left by mail, courier, e-mail, and/or voicemail.

PATIENT'S SIGNATURE: _____DATE: _____/_____/_____

GUARDIAN'S SIGNATURE: _____DATE: _____/_____/_____

CONTINUED ON NEXT PAGE

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for costs incurred for my care. I understand that, as a courtesy, Four Corners OB/GYN will bill my insurance and that this does not transfer my financial obligation for services rendered to Four Corners OB/GYN. **Please read the following carefully and initial each paragraph, then sign where indicated to acknowledge your understanding and acceptance.** If you are a minor (under 18), your parent or legal guardian must accept financial responsibility on your behalf.

1. _____ I understand and accept I am financially responsible for all services provided to me by Four Corners OB/GYN. I understand and agree to pay for all services provided to me by Four Corners OB/GYN *at the time of service*, unless my services are covered by a contracted insurance.

2. _____ I understand and accept that I am responsible for the verification of my insurance coverage and benefit level for services rendered by Four Corners OB/GYN providers and providers to whom I am referred by Four Corners OBGYN.

3. _____ I understand and accept that my insurance company or health plan may require me to pay co-payments, co-insurance or deductibles. If I have a co-pay, I agree to pay in full *at the time of service*. **Co-Payments are collected upon check out.** I agree to pay any co-insurance or deductibles *within 30 days* of my first statement from Four Corners OB/GYN.

4. _____ I understand and accept that I will be assessed a $20.00 fee plus any additional charges allowed by CRS 13-21-109 for any returned check. Any payments thereafter must be made with cash or credit cards.

5. _____ I understand and accept that I will be charged a fee of $30.00 if I fail to keep my scheduled appointment(s) or fail to cancel my scheduled appointment(s) within 24 hours.

6. _____ I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Four Corners OB/GYN for any services furnished me by the physicians and practitioners in the office. I understand and accept that if, ***90 days*** after billing, my insurance has not paid, my account will be due and I will be responsible for payment in full of any outstanding balance.

7. _____ I understand and accept that in the event that my account becomes past due, my balance may accrue interest. If my account is sent to collections, I will be responsible for all collection costs, attorney fees, court costs and any other miscellaneous fees. I consent to have the collection agency obtain my credit report for the purposes of collection on my account. **I also understand my account at Four Corners OB/GYN will be locked, and no appointment(s) will be made until my debt is paid in full.**

8. _____ I understand and accept that if further action must be taken on my account, I may be discharged from this practice and Four Corners OB/GYN may require me to permanently seek further care elsewhere, in accordance with guidelines set forth by the Colorado State Board of Medical Examiners.

9. _____ I understand and accept that specimens obtained in our office will be sent to outside laboratories for testing. I understand that there will be other outside services including but not limited to labs, pathology and diagnostic imaging that will be **billed separately**. Any questions regarding bills for laboratory, pathology and diagnostic imaging should be directed to the testing facility.

PATIENT NAME (PRINTED) _____

PATIENT'S SIGNATURE: _____ **DATE:** _____/_____/_____

GUARDIAN'S SIGNATURE: _____ **DATE:** _____/_____/_____

FOUR CORNERS OB/GYN PATIENT MEDICAL HISTORY

The following questions are confidential but if any of the questions below are uncomfortable for you, you may leave them blank.

Name: _____ **DOB**: _____ **Today's Date:** _____

Primary reason for visit today: _____

_____

GYNECOLOGIC HISTORY

First day of last menstrual period: _____

Are your periods usually: ☐ Regular ☐ Irregular ☐ No longer menstruating Date of Menopause: _____

Bleeding is: ☐ Heavy ☐ Moderate ☐ Light Do you have cramps/pain with your periods? ☐ Yes ☐ No

Do you have pain or bleeding with intercourse? ☐ Yes ☐ No Is your partner: ☐ Male ☐ Female ☐ Both (bi-sexual)

PERSONAL MEDICAL HISTORY: **Check all that apply**

Problem:		**Comment:**	**Problem:**		**Comment:**
Abnormal Paps			Osteoporosis		
Bladder leaking			Pituitary disease		
Blood disorder			Psychiatric history		
Blood transfusion			Seizure disorder		
Cancer			Sexual dysfunction		
Depression			STD exposure		
Diabetes			Thyroid disease		
Heart problems			Uterine fibroids		
Hemorrhoids			Vaginal problems		
Hepatitis A, B, or C			Other		
High blood pressure					
High cholesterol					
Lung problems					
Menstrual					

MEDICATION ALLERGIES:

ALLERGY:	**ALLERGIC REACTION:**	**ALLERGY:**	**ALLERGIC REACTION:**

CONTINUED ON NEXT PAGE

NAME: _____ DATE OF BIRTH: _____

FAMILY HISTORY: *Please write which family member and on what side of the family (Ex. Maternal/Paternal Grandmother).*

PROBLEM:	FAMILY MEMBER:	PROBLEM:	FAMILY MEMBER:	PROBLEM:	FAMILY MEMBER:
Breast Cancer		High blood pressure		Thyroid	
Cervical cancer		Heart Attack		Alzheimer's	
Ovarian cancer		Stroke		Mental Illness	
Uterine cancer		Diabetes		Other:	
Colon cancer		Osteoporosis			

SOCIAL HISTORY:

Tobacco use: □ Never □ Now:
Packs per day: _____ How many yrs.: _____/□ Past: Packs per day: _____How many yrs.? _____ Date quit: _____
Alcohol use: Drinks per week: _____ Type: _____ Marijuana use: How much: _____How often: _____
Caffeine use: Quantity per day: _____ Type: _____
Do you exercise? □ Yes, □ No. If yes, how often and what type?_____

CONTRACEPTIVE HISTORY:

Current method of birth control:_____
Have you ever had a problem with any of the above contraceptives? □ Yes □ No. If yes, state which method and what the problem was: _____

CURRENT MEDICATIONS, SUPPLEMENTS, VITAMINS, OR HERBALS:

Med/Sup/Herbal	Dose & Frequency	Med/Sup/Herbal	Dose &Frequency

PREGNANCY HISTORY:

Total # of pregnancies: _____Miscarriages: _____ Abortions: _____Preterm deliveries: _____Term deliveries: _____

Year		Vaginal or Cesarean	# Weeks at delivery	M/F	Birth Weight	Complications

SURGICAL HISTORY:

Year	Type of surgery	Complications

SCREENINGS: *Please specify month and year*

Last Pap smear date: _____ (Normal/Abnormal)_____ **PCP:**_____
Last mammogram date: _____(Normal/Abnormal)_____
Last colonoscopy date: _____(Normal/Abnormal)_____