FOUR CORNERS OB-GYN PATIENT REGISTRATION

Patient Name: ____ "________________" Date of Birth: _____/______/_____
LAST FIRST MI NICKNAME

Social Security # _________-_________-_________ Legal Sex ☐ Female ☐ Male

Physical Address: ____City:_____________State:_____Zip:_________

Mailing Address: ____City:_____________State:_____Zip:_________

Cell Phone: (______) ________-_________________ Work Phone: (______) ________-_________________

May leave a detailed message at your cell number? ☐ YES ☐ NO

Email: ____

Preferred Language ☐ English ☐ Other _______________________

Race ☐ White/Caucasian ☐ American Indian ☐ Black/African American ☐ Asian ☐ Pacific Islander ☐ Other ______________

Marital Status ☐ Married ☐ Single ☐ Significant Other/Partner ☐ Separated ☐ Divorced ☐ Widowed

Sexual Orientation ☐ Straight ☐ Gay or Lesbian ☐ Bisexual ☐ Other _________________

Gender Identity ☐ Identify as Female ☐ Identify as Male ☐ Transgender MTF FTM ☐ Other _________________

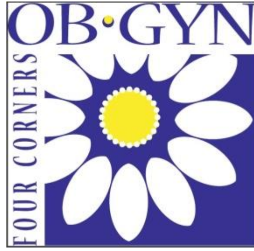
EMERGENCY CONTACT ____ Relationship to you: _________________________

Home Phone: (________)__________-_____________ Cell Phone: (________)__________-_____________ .

INSURANCE INFORMATION

Insurance Carrier ____ Guarantor on Plan _________________________

Responsible Party/Guardian Name (if other than patient listed above ____



FOUR CORNERS OB-GYN WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES, NOTICE OF ELECTRONIC HEALTH INFORMATION EXCHANGE NOTIFICATION, & NOTICE OF FINANCIAL RESPONSIBILITY

ELECTRONIC HEALTH INFORMATION EXCHANGE NOTIFICATION

Four Corners OB-GYN (FCOG) endorses, supports, and participates in Electronic Health Information Exchange (EHIE) as a means to improve the quality of your health and healthcare experience. EHIE 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 EHIE network. Using EHIE helps your health care providers to more effectively share information and provide you with better care. The EHIE 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 EHIE 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 FCOG EHIE, or cancel an opt-out choice, at any time.

I have been offered a copy of FCOG's Notice of Privacy Practice, and understand that this practice participates in EHIE.

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.

FINANCIAL RESPONSIBILITY & RELEASE OF BILLING INFORMATION

I agree to be financially responsible for costs incurred for my care. I understand that, as a courtesy, FCOG will bill my insurance and that this does not transfer my financial obligation for services rendered to FCOG. **Please read the following carefully, 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 FCOG. I understand and agree to pay for all services provided to me by FCOG *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 FCOG providers and providers to whom I am referred by FCOG.

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 in.** I agree to pay any co-insurance or deductibles *within 30 days* of my first statement from FCOG.

4. I understand and accept that I will be assessed a $30.00 fee plus any additional charges allowed by CRS 13-21-109 for any returned check.

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 FCOG for any services furnished me by the physicians and practitioners in the office. I understand and accept that if, **9*0 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 and/or 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 FCOG 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 FCOG 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.

CONSENT FOR PURPOSES OF TREATMENT & ASSIGNMENT OF BENEFITS

1. I hereby consent and authorize FCOG to diagnose and treat me based on their professional, medical opinion. I have the right to revoke this consent, in writing, at any time, except to the extent that the practice has taken action in reliance on this consent.

2. I consent to the use or disclosure of my protected health information by the medical providers at FCOG for diagnosing or providing treatment to me, obtaining payment from insurance companies or to conduct health care operations of the practice.

3. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of FCOG.

4. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

5. I hereby authorize and assign all payment and/or insurance benefits for medical services and/or surgical procedures to FCOG. I understand that I am responsible for all charges not covered by my insurance plan.

My signature below indicates that I have read and understand all the information above and a copy is available to me upon request.

PATIENT NAME (PRINTED) ____

PATIENT'S SIGNATURE: ____ **DATE:** ______/______/______

GUARDIAN'S SIGNATURE: ______________________________________ **DATE:** ______/______/______

FOUR CORNERS OB-GYN PATIENT MEDICAL HISTORY

NAME: ___________________________________**DOB:** _______________**TODAY'S DATE:** ___________

Reason for visit: ____

Pharmacy: ______________________________ Primary Care Physician: ________________________________

MEDICATION ALLERGIES:

Allergy:	Reactions:	Allergy:	Reaction:

MEDICATIONS

Name	Dose & Frequency	Name	Dose & Frequency

Date of last PAP Smear:_____________ ☐ Normal ☐ Abnormal____

Current form of birth control:____

Date of last Mammogram:___________________ ☐ Normal ☐ Abnormal ______________________________

Date of last Colonoscopy:__________________ ☐ Normal ☐ Abnormal ______________________________

First day of your last menstral period:______________________ Age of menopause:___________________

PREGNANCY HISTORY:

Total # of pregnancies:_______Miscarriages:_______Abortions:_______Preterm:________Full term:________

Birthdate	M/F	Name	Weight	Vaginal/ Cesarean	#Weeks at delivery	Complicaitons

FAMILY HISTORY:

Problem	Family member	Maternal /paternal	Problem	Family member	Maternal /paternal
Breast Cancer			Stroke		
Cervical Cancer			Diabetes		
Ovarian Cancer			Osteoporosis		
Uterine Cancer			Thyroid Problem		
Colon Cancer			Alzheimer's		
High Blood Pressure			Mental Illness		
Heart Attack			Other		

Tobacco use: ☐ Never ☐ Now ☐ Former Quit Date: _____________ Packs per day _______ How many years: _____

Blood transfusion in case of emergency: ☐ Yes ☐ No

Caffeine: ☐ Yes ☐ No Quanity per day: ________ Type:____

Alcohol: ☐ Yes ☐ No Quanity per week:____________ Type:____

Recreational Drugs: ☐ Yes ☐ No How often:____

Excersice: ☐ Yes ☐ No What type and how often:____

Gender Identity:______________________________ Pronouns:____

SURGICAL HISTORY:

Year	Surgery	Complications

PAST MEDICAL HISTORY:

Problem:	YES	NO	Problem:	YES	NO
Abuse/Domestic Violence			Heart Problems		
Anemia			Blood/Bleeding Disorders		
Anesthesia Complications			Hepatitis/Liver Disease		
Anxiety			High Cholesterol		
Asthma			History of Abnormal Pap		
Autoimmune Disease			History of Sexual Transmitted Infection		
Birth defects/Inherited Disease			Hypertension		
Bladder Problems			Kidney Disease		
Blood Transfusion			Lung Disease		
Breast Problems			Neurologic/Epillepsy/Seizure Disorder		
Cancer			Osteoporosis		
Deep Vein Thrombosis			Other		
Depression			Polycystic Ovary Syndrome		
Dermatologic Disorders			Psychiatric Illness		
Diabetes			Stroke		
Eating Disorder			Thyroid Problems		