GREENSBORO
OB-GYN ASSOCIATES
a division of Piedmont Healthcare for Women, P.A.
personalized care for every woman

PATIENT REGISTRATION

510 North Elam Avenue, Suite 101 • Greensboro, NC. 27403
P (336) 854-8800 • F (336) 299-4308 • www.gsoobgyn.com

PATIENT INFORMATION:

Name: _____
Last First Middle Maiden

Address: _____
Street Apt #/ Suite

_____
City State Zip County

Home #: _____ **Work #:** _____ **Cell #:** _____

Date of Birth: _____ **Email Address:** _____

Social Security #: _____ **Sex:** M F **Marital Status:** S M Sep D W

Occupation: _____ **Student:** _____

Race: Asian Black/African American European Japanese Korean White
Other: _____

Ethnicity: Non- Hispanic/Latino Hispanic/Latino Decline

Preferred Language: English Spanish Other: _____

Interpreter Services Requested: Y N **If yes, language needed:** _____

Primary Insurance Information:

Employer: _____ Occupation: _____

Insurance Plan: _____ Policy #: _____ Group #: _____

Policy Holder Name: _____ Date of Birth: _____

Secondary Insurance Information:

Employer: _____ Occupation: _____

Insurance Plan: _____ Policy #: _____ Group #: _____

Policy Holder Name: _____ Date of Birth: _____

Preferred Provider: Thomas Henley, MD Todd Meisinger, MD Kathy Richardson, MD Jody Bovard, MD Cecilia Banga, D.O.
Kathy Harris, NP Eve Key, NP

Were you referred by a doctor? Y N **If yes, doctor name/practice:** _____

Primary Care Provider: _____

Pharmacy & Location: _____

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PARENT/SPOUSE INFORMATION:

Name: _____
Last First Middle Maiden

Address: _____
Street Apt #/Suite City State Zip

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship: _____ Contact #: _____

Name: _____ Relationship: _____ Contact #: _____

INSURANCE AUTHORIZATION AND FINANCIAL AGREEMENT

I understand that payment for all services is due at the time of visit, including copays. I understand it is my responsibility to know and understand my insurance benefits. If any visit requires an additional procedure I understand that my insurance may require I pay an additional fee. If I am unable to present a current insurance card, I will be classified as "self- pay." Payment for said visit will be due at the time of service. I give Greensboro OBGYN Associates permission to apply for benefits on my behalf, and authorize my insurance benefits to be paid directly to Greensboro OBGYN Associates. I authorize the release of pertinent medical information necessary to process my claims. I certify that the information provided by me in regards to my insurance coverage is correct. I will be prepared to present my correct insurance card at every visit. Greensboro OBGYN Associates charges $10.00 for your medical records.

Responsible Party (if other than yourself)

Name: _____
Last First Middle Maiden

Address: _____
Street Apt #/Suite City State Zip

Phone: _____ **Relationship to Patient:** _____

CELL PHONE POLICY

Greensboro OBGYN Associates requires you to mute or turn off your cell phones in our office. No cell phones and or video cameras are allowed in the Ultrasound Room. Failure to comply could cause your diagnostic study to be terminated immediately. The Ultrasound fee would then become your financial responsibility. Thank you for keeping us in compliance.

CONSENT FOR HEALTHCARE AND RELEASE OF MEDICAL INFORMATION

I voluntarily consent to healthcare treatment from the providers and staff at Greensboro OBGYN Associates. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of my treatment or examinations. I consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations. I have read this form. I have had the opportunity to ask questions and my questions/concerns have been answered.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice of Privacy Practices is available on our website under patient resources or you may receive a copy in office. The Notice describes how Piedmont Healthcare for Women may use and disclose of my healthcare information, and rights I may have regarding my protected health information. I am aware the Notice may be changed at any time. I may obtain a revised or additional copy at any time.

_____ _____
Signature of Patient or Authorized Person Date

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HEALTH HISTORY

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NAME: _____ **DATE OF BIRTH:** _____

REASON FOR VISIT
Problems you wish to discuss

MEDICAL HISTORY
Medical Problems:

Surgeries:

Pregnancy History:

DATE	WEEKS CARRIED	MISCARRIAGE/ ABORTION	TYPE OF DELIVERY (Vaginal or C-Section)	SEX	WEIGHT	COMPLICATIONS (diabetes, high blood pressure, preterm labor, toxemia, etc)

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Gyn history:
Abnormal Pap? Y N Any Procedures: _____
Last pap: _____ /_____ /_____

STD:
Chlamydia Gonorrhea Herpes Syphilis Trichomonas Genital Warts HPV HIV

Menses:
First Day of Last Period? _____ /_____ /_____
Regular Cycles? Y N How often? _____
Vaginal Bleeding Between menses? Y N Painful menses? Y N

Contraception:
None Pills IUD Condoms Tubal Ligation Vasectomy Nuvaring Withdrawal Essure Nexplanon
Other _____

Medications: medication, dose and frequency:

_____

_____

Allergies: medication and reaction:

_____

_____ Latex? Y N

Tobacco Use: Y N How much? _____
Have you ever? Y N How much? _____

Alcohol Use: Y N How much? _____

Other Drug Use: Y N What and how much? _____

Family History (mother, father, maternal grandparents, paternal grandparents, other close relatives):

	Mother	Father	Maternal	Paternal	Other
Breast Cancer					
Ovarian Cancer					
Uterine Cancer					
Colon Cancer					
Heart Disease					
High Blood Pressure					
Diabetes					

Will you accept a blood transfusion in the event of a life-threatening emergency? Y N

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PRIVACY RELEASE OF INFORMATION

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In order to serve you better, please complete this form allowing us to communicate with a list of people with which we may discuss your health information. Those noted on your list must provide your date of birth in order to receive any information.

Name of Patient _____ Date of Birth _____

I hereby give my permission to the person(s) listed below to receive PHI, which can include medical and financial information about the care of the above mentioned patient.

	Name	Relationship	Phone Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Appointment Reminders:

☐ I give Greensboro OBGYN Associates permission to remind me of my appointment(s) by email/text.

☐ I **DO NOT** give Greensboro OBGYN Associates permission to remind me of my appointment(s) by email/text.

Results:

☐ I give Greensboro OBGYN Associates permission to leave normal lab/test results on my voicemail.
Please provide best contact number _____

☐ I **DO NOT** give Greensboro OBGYN Associates permission to leave normal lab/test results on my voicemail.

Email Communication:

☐ I give Greensboro OBGYN Associates permission to communicate with me by email at my request. Please provide email address if not already provided _____
I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communication as selected. Initial _____

☐ I **DO NOT** give Greensboro OBGYN Associates permission to communicate with me by email.

Optional:To protect your health information you can provide a password of your choosing: _____
Anyone calling the office, including yourself, or on your behalf **MUST** provide us your password before any information can be discussed. Thank you

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. ***I understand*** that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. ***I understand*** that information used or disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law. ***I understand*** that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative Date

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REQUEST OF MEDICAL RECORDS

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Fee for release of records to patient: $15.00

PATIENT INFORMATION:

Name: _____ **Date of Birth:** _____

Address: _____
Street Apt #/ Suite

_____
City State Zip County

Phone Number: _____

I do hereby authorize: _____ **Phone Number:** _____

Facility Address: _____

To Release:

- ☐ Entire Record
- ☐ Pap Smear
- ☐ Mammogram
- ☐ Office Notes
- ☐ Lab Reports (specify, if needed)
- ☐ Pathology
- ☐ Bone Density
- ☐ Hospital Records
- ☐ Specific Date(s): _____
- ☐ Other: _____

☐ I do
☐ I do not

Authorize release of information related to AIDS (acquired immunodeficiency syndrome) or HIV (human immunodeficiency virus) infection, sexually transmitted disease(s), psychiatric care and/or psychological assessment and/or treatment for alcohol and/or drug abuse.

Send Records to: *Greensboro OB/GYN Associates*
Name of Facility
510 Elam Avenue, Suite 101
Street Apt #/ Suite

Greensboro	*NC*	*27403*	*Guilford*
City	State	Zip	County

Purpose of Disclosure:

- ☐ Referral to specialist
- ☐ Disability
- ☐ PCP/Internist
- ☐ Other: _____
- ☐ Insurance
- ☐ Personal
- ☐ Worker's Compensation
- ☐ Legal Issue
- ☐ Change of Provider

I do hereby authorize disclosure of the health information for the above named patient. The authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with a written notification, but it will not affect any information released prior to cancellation. I understand that the information used or disclosure may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by this release. I understand the medical provider to whom this authorization is furnished may not condition its treatment on me on whether or not I sign the authorization.

_____ _____
Signature Date

_____ _____
Witness Signature (office use) Date