

WELCOME TO EMANUEL OB/GYN

PATIENT INFORMATION:

Name: (as appears on your insurance card)

Last: _____ First: _____ Middle: _____

Birthdate: ____/____/____ SS#: _____ Marital Status: Single Married Other

Address: (Street) _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____

Occupation: _____ Employer: _____ Work #: _____

Primary Care Physician: _____ Phone #: _____

Pharmacy Name: _____ Phone #: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Secondary Insurance: _____

Relationship to Insured: _____ Relationship to Insured: _____

Date of Birth of Insured: _____ Date of Birth of Insured: _____

ID #: _____ ID #: _____

Group #: _____ Group #: _____

OTHER INFORMATION:

Emergency Contact: _____ Relationship to Patient: _____ Phone #: _____

(For Patients who are Minors)

Parents Name: _____ Phone #: _____

*****PLEASE PRESENT INSURANCE CARDS TO THE RECEPTIONIST*****

- I hereby authorize and request the medical treatment necessary for the care of the above named patient.
 - I authorize the release of all medical records to the referring family physicians and to my insurance company, if applicable. I allow the fax transmittal of my medical records, if necessary.
 - I acknowledge full financial responsibility for services rendered by Emanuel OB/GYN. If I am uninsured I understand payment is due at the time of service, unless other definite financial arrangements have been made prior to treatment. I understand that I am responsible for any un-met deductibles and co-insurance fees.
 - I further authorize and request that insurance payment be made directly to Emanuel OB/GYN, for services rendered.
- I have read and fully understand the above consent for treatment, release of medical information, financial responsibility, and insurance authorization.

Patient/Parent Guardian (Please Print)

Patient/Parent Guardian Signature

Date

Name: _____ DOB: _____ Age: _____

Current Medications: (Please list all medications you are currently taking):

Medication	Strength	Dosage

Drug Allergies: Yes No List Allergies: _____

◆ MENSTRUAL HISTORY ◆

Last Menstrual Period (first day): _____

Menses: Age of onset: _____ Length of flow: _____ Interval between periods: _____

◆ PREGNANCY HISTORY ◆

Total number of pregnancies: _____ Miscarriages: _____ Total number of living children: _____

Birthdate	Weight at birth	Baby's sex	Weeks pregnant	Type of Delivery (Vag/C-sect)
1. _____				
2. _____				
3. _____				
4. _____				
5. _____				

◆ PAST MEDICAL HISTORY ◆

Medical Problems: _____

Surgeries: _____

◆ HABITS ◆

Tobacco Use: Cigarettes (packs per day): _____ Smokeless (type): _____

Alcohol: Drinks per day or week: _____ Caffeine (cups per day): _____

Recreational Drug Use: _____

Emanuel OB-GYN
Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI)

I wish to be contacted in the following manner (check all that apply)

- Home Telephone _____
 - O.K to leave message with detailed information
 - Leave message with callback number only

- Work Number _____
 - O.K to leave message with detailed information
 - Leave message with callback number only

- Cell Phone _____
 - O.K to leave message with detailed information
 - Leave message with callback number only

- Written Communication
 - O.K. to mail to my home address _____
 - O.K. to mail to my Office/Work _____

- O.K. to fax to this telephone number _____

You may leave messages with, discuss my treatment, appointment or other scheduling that may occur or give other information as necessary with the following family, friends or personal representatives. I understand that Emanuel OB-GYN will refuse to discuss my information with anyone not listed below except in an emergency situation. I also understand that this consent does not apply to my referring physician/medical provider.

Please Print

1. _____
2. _____
3. _____
4. _____
5. _____

Patient's Signature

Date of Birth

Today's Date _____