Folsom Obstetrics & Gynecology Medical Group, Inc.

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Welcome

We are excited you have decided to come to our office for your care. You have downloaded a package of forms we would like you to fill out before you come in for your first visit. This information will allow our office to take better care of you.

These forms include:

1. Registration Form
2. Patient Family Medical History Form
3. Authorization to Share Your Medical Information with Others
4. Acknowledgement of Office Policies

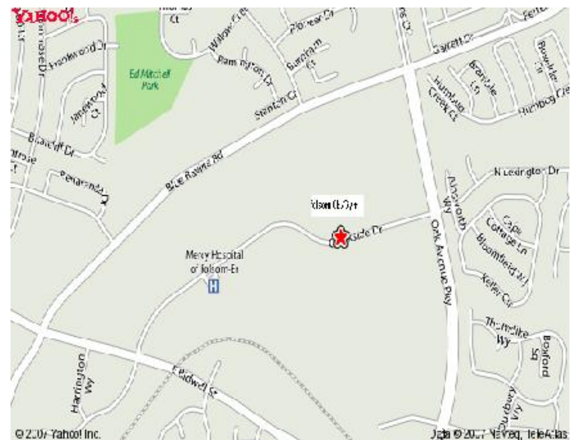
In addition to these forms, please bring the following to each appointment:

1. Current insurance card and required co-pay
2. Photo ID
3. List of current medications including dosage and how you take them (include vitamins and supplements)

It may also be helpful for you to arrange to have your prior medical records sent to our office from your past physicians. A form is available on our website (folsomobgyn.com) for this purpose.

Other forms and office policies are also available at our website.

We look forward to seeing you at your visit.
We are located at 1735 Creekside Drive in the Willow Creek Medical Office Park. We are directly across the street from The Falls apartments, between the Folsom Dog Park and Vintage Willow Creek Retirement apartment community.



Registration Information

*Please Print Clearly Date: ____/____/____

Name: ____
(Last) (First) (Middle)

Address: ________________________________ City: _______________________

State: ________ Zip Code: ____________ E-Mail _________________________

Home Phone: (_____) _____-_________ Cell Phone: (_____) _____-_______

Birth Date: ___/___/___ Age: ______ Maiden Name: _____________________

Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Social Security #: ______-______-_________ Drivers License #: ____________

Patient's Employer: ______________________ Occupation: __________________

Work Phone: (_____) _____-_________

Primary Care Physician: ____

Pharmacy: _______________________________ Location: __________________

Emergency Contact: _________________________ Relationship: ____________

Phone: (_____)_____-________ Alternate Phone: (_____)_____-________

Insurance Subscriber: Self ☐ Spouse ☐ Parent ☐ Other ☐ ________

Name of Subscriber: _________________________ Birth Date: ____/____/_____

Insurance Company: _____________________ ID #: _______________________

Secondary Insurance-
Insurance Subscriber: Self ☐ Spouse ☐ Parent ☐ Other ☐ ________

Name of Subscriber: _________________________ Birth Date: ____/____/_____

Insurance Company: _____________________ ID #: _______________________

<u>**PLEASE COMPLETE ENTIRE FORM**</u>

Folsom Obstetrics & Gynecology's
New Patient Personal & Family History

Name: ______________________________ Date: __________________

Age: ________________

Who referred you to our office? ____

What is the reason for your visit today? __________________________________

____

____

If time allows, is there anything else you would like to address during your appointment? ____

____

Please list any medication, severe food, or environmental allergies: __________

____

____

Please list any medications you are taking: ______________________________

____

Have you had any of the following problems?

- ☐ Heart/Cardiovascular Disease
- ☐ Coronary Artery Disease/MI
- ☐ Diabetes Type I
- ☐ GERD (Reflux)
- ☐ Irritable Bowel Syndrome
- ☐ Attention Deficit disorder
- ☐ Incontinence
- ☐ Fractures
- ☐ Parkinson's Disease
- ☐ Allergies
  Seasonal ☐ Year Round ☐
- ☐ Triglycerides
- ☐ Hypertension
- ☐ Diabetes Type II
- ☐ Hepatitis
- ☐ Alzheimer's
- ☐ Infertility
- ☐ Fibromyalgia
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Headaches
  Type: __________
- ☐ Elevated Cholesterol
- ☐ Gall Bladder Disease
- ☐ Colon Polyps
- ☐ Thyroid Disorder
- ☐ Kidney Disease
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Anemia
- ☐ Lupus
- ☐ Cancer
  Type: ____________

Have you been diagnosed by a physician for any diseases or medical conditions that are not listed above? ____

Pregnancy History (please indicate number if each)

____ Full Term ____ Premature Deliveries ____ Abortions ____ Miscarriages

Any complications during your pregnancies? ________________________

____

Gynecological History

First day of last menstrual period: _____________ Are periods regular? Y / N

Are you having any problems with your menstrual cycles? ___________________

What is your current form of **Birth Control**? _______________________________

How old were you when you had your first period? _________________________

If you have gone through **menopause**, how old were you when you had your last period? ______________

When was your last **pap smear**?________ History of abnormal Pap? Y / N
If yes, what was the outcome of the follow up testing? _________________

When was your last **mammogram**? ______History of abnormal Mammo? Y / N
If yes, what was the outcome of the follow up testing? _________________

When was your last **Dexa Scan** (bone density)? __________________
What were the results? ____

When was your last **Colonoscopy**? __________________
What were the results? ____
When is your next one due?____________________

Please list surgeries you have had and when they were performed

Surgery	Date
_______________________________________	____________________
_______________________________________	____________________
_______________________________________	____________________

Family History
Please check any diseases that a member of your family has been affected by, and list which members were affected.

☐ Hypertension ____________________

☐ Heart Disease ____________________

☐ Intestinal Disease ____________________

☐ Osteoporosis ____________________

☐ Lupus ____________________

☐ Arthritis ____________________

☐ Diabetes ____________________

☐ Alzheimer's ____________________

☐ Stroke ____________________

☐ Parkinson's disease ____________________

☐ Cancer (please indicate type) ____________________

Social History

Occupation: ____________________

Marital Status: ____________________

Number of children and ages: ____________________

Hobbies: ____________________

Exercise (please indicate type and frequency): ____________________

Do you smoke? Y / N If yes, how much? ____________________

If you smoked in the past when did you quit? ____________________

Do you drink Alcohol? Y / N If yes, how much? ____________________

Do you use other drugs? Y / N If yes, how much? ____________________

Do you live in a safe/ supportive home? Y / N

If no, please explain: ____

Do you now, or have you ever suffered from any psychiatric disorders? (i.e. anxiety disorders, eating disorders, depression)? Y / N

If yes, please explain: ____

Do you now, or have you ever had any sexually transmitted diseases? Y / N

If yes, please explain: ____

Do you now, or have you ever had any communicable diseases? (i.e. hepatitis, Lyme disease, tuberculosis)? Y / N

If yes, please explain: ____

Is there anything else you would like the doctor to know about you?

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Folsom Obstetrics & Gynecology
Authorization To Share My Medical Information

In accordance with Personal Health Information (PHI) privacy laws, we are no longer allowed to release information to family members, leave information on voicemail systems, or take treatment requests from family members without your written consent. Please complete the following information.

☐ **I DO NOT** want any of my PHI released to any one except myself for any reason. Please keep my PHI completely confidential and allow only me to make appointments of request prescription refills.

OR

Please list all individuals who ARE authorized to receive your health information.

Name Relationship

1.____________________________ ____________________________

2.____________________________ ____________________________

3.____________________________ ____________________________

Please list all individuals who may request treatment for you or may call with medical complaints (i.e. medication refills, referrals, treatment for illnesses).

Name Relationship

1.____________________________ ____________________________

2.____________________________ ____________________________

3.____________________________ ____________________________

Are we allowed to leave information on your home answering machine? Y / N
Are we allowed to leave information on your work voicemail system? Y / N
Is there an email address you would like us to use instead? Y/ N
If Yes, ____________________@__________.__________

Are there any specific topics of information that you would like us NOT to release to anyone other then you, including the aforementioned names? Y / N
- If yes, please list these topics

____

____

Name ________________________________ Signature ________________________________

Print Name ____

FOLSOM OBSTETRICS & GYNECOLOGY'S
FINANCIAL RESPONSIBILITY & OFFICE POLICIES

OB PATIENTS FINANCIAL RESPONSIBILITIES

We will inform you on your second appointment with us what your maternity benefits are. You will be given a break down of those benefits showing any co-payment, co-insurance and deductible you will be responsible for. We will expect payment for these deductions by your 28th week of pregnancy, we collect these payments up front as Folsom ObGyn is the first to bill your insurance company for service rendered which makes our charges the first to be applied to your deductible.

Please Initial:______________

AFTER 90 DAYS

In the event an outstanding balance is not paid by your insurance company, you are personally responsible for the payment of all charges due. In addition, if your insurance company has not paid the submitted charges within 90 days, you will be responsible for the amount charged and you will pursue payment yourself by contacting your insurance company directly.

Please Initial:______________

THREE STATEMENTS

You are responsible to pay any billed amount upon receipt of a statement from Folsom ObGyn. Failure to pay any outstanding amount upon receipt of a third statement will subject your account to be forwarded to our collection agency, with any additional fees charged by the collection agency added to the original amount owed.

Please Initial:______________

RETURNED CHECKS

A $30.00 fee will apply for all returned checks, in addition to the amount originally owed. In the event of a returned check, your privilege to pay by check during future visits may be terminated.

Please Initial:______________

Print Name ____

PRESCRIPTION REFILLS

The best time to request prescription refills is during an office visit. The task of faxing and calling pharmacies for refills can be very time consuming. It is YOUR responsibility to be aware of how many refills you have left, and contact your pharmacy to refill your current Rx. All requests from the pharmacy for expired prescriptions will take 24-48 hours to process. Additionally, any refill requests received after 11am on Fridays will NOT be filled until the following Monday.
THERE WILL BE NO EXCEPTIONS TO THESE POLICIES.

Please Initial:_____________

DISABILITY FORM COMPLETION

All paper disability and family leave forms will require FIVE business days to complete. There will be a $10.00 form completion fee for the patient and an additional $10.00 fee for husband's family leave forms.

Please Initial:_____________

AUTHORIZATION TO RELEASE INFORMATION

I agree that my physician and staff may give out written or verbal information concerning my medical records to any insurance carrier or agent that is authorized to have access to make copies of my medical records.

Please Initial:_____________

NO CHILDREN POLICY

I have read the copy of the No Children Policy provided for me at folsomobgyn.com. I understand that Folsom OBGYN is a potentially hazardous environment for my child and will leave them at home where they are safe. I understand that bringing my child to the office will result in my appointment being rescheduled.
THERE WILL BE NO EXCEPTIONS TO THIS POLICY.

Please Initial:_____________

I, the undersigned, certify that I have read the foregoing, receiving a copy thereof, if requested, and that I am the patient or am authorized by the patient's general agent to execute the above and accept its terms.

Signature ____ Date ___________________