

Health History

Name: _____ Date of birth: _____ Height: _____ Weight: _____

Reason for visit today: _____

Do you smoke? Yes No If yes, how many packs per day? _____

Have you ever smoked? Yes No If yes, when did you quit? _____

Do you use alcohol? Yes No If yes, how many drinks per week? _____

Do you or have you used the following in the last three months? Marijuana Cocaine Heroin Crack Methamphetamine

Are you allergic to any medications? Yes or No (If yes, please list.)

Current Medications	Dosage

Previous Surgery	Date

Have you ever had any of the following? Circle all that apply: Asthma Stomach Problems Bladder problems Jaundice-Liver Gout Alcoholism Kidney Disease Prostate Skin Disease Joint Disease Stroke Epilepsy-Seizures Depression-Anxiety Thyroid Blood Clot High Blood Pressure Tuberculosis Diabetes Cancer Lung Disease Heart Disease Psychiatric Disorder

Do any of these conditions run in your family? Circle all that apply: Alcoholism Addiction Joint Disease Stroke Blood Clots Diabetes Psychiatric Disorder Heart Disease

Primary care physician information:

Name: _____ Phone number: _____

Address: _____

Pharmacy information:

Name: _____ Phone number: _____

Address: _____

How did you hear about us? Circle any that apply:

Website Family/Friend Internet Search

Former or current patient (please provide name so we can thank them!) _____

Physician (please specify): _____

Other Healthcare facility (please specify): _____

Insurance Network (please specify): _____

Other (specify): _____

METROPOLITAN OB/GYN PATIENT REGISTRATION FORM

PATIENT INFORMATION

(Please print)

Patient's Legal Name: (Last) (First) (MI)

Preferred Full Name (if different from above):

Address:

City, State, Zip:

Home Phone Number (landline): Cell: Work:

E-Mail Address: Date of Birth:

Gender Identity: Female Male Transgender Female to Male Transgender Male to Female Genderqueer Choose not to disclose Additional Gender category not listed

Race: American Indian/Alaska Native Asian Native Hawaiian/Pacific Islander Black/African American White Hispanic Chose not to disclose Other not listed

Ethnicity: Hispanic or Latino Not Hispanic or Latino Choose not to disclose

Preferred Language: English Spanish ASL Japanese Mandarin Korean French Indian: Hindi, Tamil, Gujarati etc Swahili Russian Arabic Vietnamese Haitian Creole Bosnian/Croatian/Serbian/Serbo-Croatian Albanian Burmese Tagalog Farsi-Iranian/Persian Portuguese Cambodian Other not listed

Patient Social Security Number:

RESPONSIBLE PARTY INFORMATION (If not self)

(Information used for patient balance statements)

Responsible party: Another patient Guarantor Self Check here if address and telephone information is same as patient Responsible party name: (Last) (First) (MI)

Date of birth: MM/DD/YYYY Sex: Female Male

Responsible Party Social Security Number: Phone number:

Address:

City, State: ZIP:

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) (First)

Phone number: Do you have a living will? Yes No

Emergency contact relationship to patient: Guardian

Address:

City, State: ZIP:

Home phone: Work hone: Ext.

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: Date:

Printed name of patient or personal representative: Relationship to patient:

Patient name: _____

Date of birth: _____

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, **METROPOLITAN OB/GYN** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge **METROPOLITAN OB/GYN** may use the services of a third-party business associate or affiliated entity as an extended business office (“EBO Servicer”) for medical account billing and servicing.

Assignment of Benefits. I hereby assign to **METROPOLITAN OB/GYN** any insurance or other third-party benefits available for health care services provided to me. I understand **METROPOLITAN OB/GYN** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **METROPOLITAN OB/GYN** agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII (“Medicare”) or Title XIX (“Medicaid”) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **METROPOLITAN OB/GYN** by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for **METROPOLITAN OB/GYN**, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **METROPOLITAN OB/GYN** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **METROPOLITAN OB/GYN** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: _____ **Date:** _____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

Spouse
Parent
Legal Guardian

Guarantor
Healthcare Power of Attorney
Other (please specify) _____

Metropolitan OB/GYN
HealthOne Clinic Services

We at Metropolitan Ob/Gyn care about you and your health; we encourage you at all times to discuss any health concerns with your physician.

If you are here for your **YEARLY ANNUAL EXAM** and problem issues are discussed, you and/or your insurance may be billed additional charges.

This may prompt a co-pay, deductible, or co-insurance expense, which you will be responsible for.

By signing below, I acknowledge that I have read and understand the above policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Patient (or Responsible Party) Signature

Date

Patient Printed Name

Metropolitan Ob/Gyn “No-Show” Policy

Our goal is to provide quality care in a timely manner. In order to do so we have had to implement a “No Show” appointment cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

Definition of “No-Show” Appointment

Metropolitan Ob/Gyn defines a “no-show” appointment as any scheduled appointment, in which the patient either:

- Does not show.
- Cancels with less than 24 hour notice.
- Arrives more than 15 minutes late and is consequently unable to be seen.

Metropolitan Ob/Gyn Expectations

When a patient schedules an office visit with us, we expect them to arrive at our practice 15 minutes prior to their scheduled visit. This allows time for the patient and our check-in staff to address any insurance or billing questions and/or to complete any necessary paperwork before the scheduled visit.

In order to be respectful of the medical needs of the Metropolitan Ob/Gyn community please be courteous and contact us promptly if you are unable to attend an appointment. This time will be reallocated to someone who may be in need of urgent treatment.

If it is necessary to cancel your appointment we ask that you call at least two (2) working days in advance. Appointments are in high demand, and your early cancellation will give another patient the possibility to have access to timely medical care.

While we ask that our patients avoid cancelling or rebooking a scheduled visit with less than 24 hour notice, we do realize that things come up. In this situation, we still ask that the patient contact our office as soon as they realize they need to cancel or rebook. ***It is always better to call rather than to “no-show/no-call”.*** The staff member handling the call will pass the information on to the Practice Coordinator so that appropriate action is determined.

By signing below, I acknowledge that I have read and understand the “No Show” policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Patient (or responsible party) Signature _____ Date ____/____/____

Patients Printed Name _____