Obstetric & Gynecology
PHYSICIANS OF FLINT, PC

Patient Information Form:

Name: Date of Birth: Age:

Address: Home Phone:

City/State/Zip: Cell Phone:

Email: Social Security #:

Preferred Method of Contact (check one): Home Phone Cell Text to Cell Email

Employer: Occupation:

Work Address: Work Phone:

Primary Care Physician: Primary Care Phone:

Pharmacy:

Spouse Name: Spouse Phone: Spouse DOB:

Where did you hear about us?

Family Physician Another Patient Internet Search Other

Spouse Information

Name: Date of Birth: Social Security #:

Employer: Work Phone:

Insurance Information

Primary Insurance: Contact No.:

Insured Name on Card: Group No.:

Insured Date of Birth: Relationship to Patient:

Secondary Insurance: Contact No.:

Insured Name on Card: Group No.:

Insured Date of Birth: Relationship to Patient:

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Confidential Communications:

I authorize the practice of leaving a message on my answering machine/voicemail ☐ **Yes** ☐ **No**

I authorize the release of my protected health information over the phone to the following individuals:
(Note: The individual(s) listed below will be allowed to receive medical information about you and your care.)

Name: Relationship:

Home Phone: Work Phone:

Name: Relationship:

Home Phone: Work Phone:

Signature: Date:

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PHYSICIANS OF FLINT, PC

Registration Form

PATIENT INFORMATION

NAME:	Last	First	M.I.
Date of Birth:	Have you ever been seen by a Doctor under a previous name? ☐ NO ☐ YES If YES, please give previous name:		
Marital Status: M S W D	Email Address: **for office use only we NEVER share your email**		
Social Security Number:	Primary Care Physician/Location:		
Street Address:	City:	State:	Zip:
Phone:	Home	Cell	Work
Emergency Contact:	Name	Relation	Phone Number
If you are a dependent on your insurance policy please provide the name, date of birth and gender of the subscriber on the policy:			

DEMOGRAPHICS

Gender:	Gender Identity:	
Preferred Languages:	Primary	Secondary
Race: **Check all that apply**	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other Race: _____ ☐ Unknown ☐ Decline to Specify	
Ethnicity:	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline to Specify	

FOR OUR INFORMATION

What is your Preferred Pharmacy?	Name	Street/City
How did you hear about us?		
What is your preferred method of contact?	☐ Home Phone Call ☐ Cell Phone Call ☐ Mail ☐ E-Mail/Patient Portal Messaging	
Reminder calls/texts/emails are sent automatically from our system 1 week, 2 days and 90 minutes prior to appointments that have not been confirmed. A staff member will also call you 1 business day prior to your appointment if it has not been confirmed. **Do you wish to opt out of automated calls/texts/emails?** YES NO		

Please read, sign and date the reverse side of this form.

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Health Questionnaire

PATIENT INFORMATION

NAME:	Last	First	M.I.
Date of Birth:	Age:	Primary Care Physician/Location:	
Gender:		Gender Identity:	

GYNECOLOGICAL HISTORY

Date of Last Menstrual Period (First Day):	Age Period Began:	Length of Periods:	Length of Cycles (time between periods):

Are you sexually active? ☐ Yes, currently ☐ Never ☐ In the past but not now	Number of Sexual Partners:	Lifetime	Currently	Gender of Sexual Partners: **Circle All That Apply**	Female Male Trans Other: _____

What do you currently use for birth control:	
What have you used in the past for birth control:	
Date of Last Pap Smear:	Results:
Date of Last Mammogram:	Results:
Date of Last Colonoscopy:	Results:

Check any/all items below that you currently experience and/or have a history of:

☐ Abnormal Pap	☐ Infertility	☐ Hot Flashes	☐ Pelvic Pain
☐ Abnormal Periods	☐ Endometriosis	☐ Vaginal Dryness	☐ Nipple Discharge
☐ STI's	☐ Uterine Fibroids	☐ Mood Swings	☐ Ovarian Cysts
☐ PID	☐ Breast Disease	☐ Sexual Problems	☐ Pelvic or Bladder Prolapse
☐ Cervical cautery or freezing	☐ Female Cancer(s)	☐ Night Sweats	☐ Urinary Incontinence

PREGNANCY HISTORY

Are you currently pregnant?		Are you trying to get pregnant?	
Number of:	Pregnancies	Miscarriages	Abortions

Please list each delivery: **if you need more room, please use the space at the end of this packet**

Type of Delivery (Vaginal or C-Section)	*Year*	*Any Complications*

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Health Questionnaire

MEDICAL HISTORY

Do you experience: **Check all that apply**

☐ Depression/Anxiety	☐ Blood in Urine	☐ Weight Loss	☐ Painful Urination
☐ Sleep Interruptions	☐ Heart Palpitations	☐ Bowel Changes	☐ Persistent Cough
☐ Temp. Intolerances	☐ Chest Pain	☐ Rectal Bleeding	☐ Sinus Problems
☐ Fainting Spells	☐ Swelling of Ankles	☐ Vomiting Blood	☐ Easy Bruising

Do you or have you ever had: **Check all that apply**

☐ Blood Transfusions	☐ Heart Disease	☐ High Blood Pressure	☐ Urinary/Bowel Problems
☐ Epilepsy/Seizures	☐ Heart Murmur	☐ Psychological Issues	☐ Pulmonary Embolism
☐ Lung Disease	☐ Migraines	☐ Thyroid Disease	☐ Arthritis/Back Problems
☐ Varicose Veins	☐ Kidney Disease	☐ Gallbladder Disease	☐ Stroke
☐ Diabetes	☐ Lupus	☐ Bleeding Problem	☐ Asthma
☐ Cancer	☐ Sickle Cell Trait	☐ Blood Clots	☐ Neuro. Disease (Aneurysm)

Allergies:	
Allergen	Reaction

Medications:			
Medication	Dose	Medication	Dose

Surgeries: **excluding deliveries listed on the previous page**		
Procedure/Reason	Year	Facility

Please print your First and Last name and Date of Birth: _____

This ensures all pages are loaded to the correct patient

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Health Questionnaire

SOCIAL HISTORY

Who lives with you?				
Marital Status: M S W D		Family Problems? Y N	Spousal Problems? Y N	
Occupation				
Occupational Concerns: **Circle** Stress Hazardous Substances Heavy Lifting Other_____				
Please tell us about your use of the following:				
Tobacco	☐ Current ☐ Past	Type:	Amount:	How Long:
Alcohol	☐ Current ☐ Past	Type:	Amount:	How Long:
Drugs	☐ Current ☐ Past	Type:	Amount:	How Long:

In the last 12 months have you had issues with any of the follow? **Check all that apply**

☐ Having enough food for yourself/family ☐ Homelessness/Housing ☐ Transportation

☐ Paying for Necessities (ie. Utilities, Diapers, Feminine Products, etc.) ☐ Physical/Emotional/Sexual Abuse

If so, would you like a referral to resources? Y N What is your most urgent issue?

FAMILY HISTORY

Condition	**Father**	**Mother**	**Mother's Parents**	**Father's Parents**	**Brothers/ Sisters**	**Aunts/ Uncles**	**Your Children**
Heart Disease							
High Blood Pressure							
Stroke							
Diabetes							
Thyroid Disease							
Menopause Problems							
Mental Illness							
Cancer							

Use this box to tell give details of the items you checked above, please make sure to list types of cancer and ages of diagnosis if known:

Please print your First and Last name and Date of Birth: _____

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PHYSICIANS OF FLINT, PC

Health Questionnaire

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? *Circle*				
	Not at all	**Several days**	**More than half the days**	**Nearly every day**
Little Interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have notices. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
If you experienced any of the above, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
For provider use			**TOTAL:**	

Please use this space for anything you could not fit in the spaces provided or for any other pertinent issues/ history you would like to discuss with your provider:

Patient Signature: _____ **Date:** _____

Reviewed By: _____ **Date:** _____

Please print your First and Last name and Date of Birth: _____

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PHYSICIANS OF FLINT, PC

Patient Financial Policy

It is a goal of OBGYN Physicians of Flint to provide the best care on your behalf. It is also our desire to assist you in the financial arrangements related to your care. Therefore, it is important for you to fully understand our patient, insurance, credit, and collections policies. **We ask that you initial next to each number and sign this statement once you have carefully read the following information.**

Thank you for your cooperation!

_____ 1. Payment Responsibility: The patient or legal guardian is responsible for all charges that are incurred, not covered by insurance. Payment is expected at the time of each office visit. All co-pays are dure at the time of service; this is the law. Deductibles that have not been met are also due at the time of each visit. Failure to pay these co-pays, fees or deductibles could result in an additional $5.00 charge to my account.

_____ 2. I hereby authorize direct payment of surgical/medical benefits to Obstetric & Gynecology Physicians of Flint for services rendered by them in person or under their supervision.

_____ 3. Insurance Contract: Your insurance contract is an agreement between you and your insurance carrier. As a courtesy to you, our office is able to file your insurance claims for you. Your doctor's bill is an agreement between you and this office. You are ultimately responsible for payment of your bill regardless of the status of your insurance claim.

_____ 4. Insurance Verification: Your insurance is verified prior to your appointment. If the policy is inactive, the patient is responsible for all charges incurred. All information is subject to verification.

_____ 5. Partial Insurance Coverage: If your insurance only covers a portion of a service, you are responsible for the difference (please refer to number 1.)

_____ 6. Assignment of Benefits: Our office will bill your insurance if you supply all necessary information such as proof of identification and insurance cards. It is the patient's responsibility to know what their insurance benefits cover. If you have an HMO insurance we can assist you in acquiring a referral from your Primary Care Physician. If they refuse to issue one, or the referral is not finalized by your appointment date, you will not be seen.

_____ 7. Discounts: By Federal Law and Managed Care Contract Laws, we are required to collect all co-pays and deductibles for each service. Therefore, accounts cannot be reduced or discounted.

_____ 8. Refunds: Overpayments will be refunded once all active and past dues accounts are paid in full. Refunds of less than $5.00 will not be processed unless specifically requested.

_____ 9. Outstanding Balances: Patients with outstanding balances will be required to pay on their account PRIOR to being seen. Patients with a balance exceeding $200.00 will not be permitted to schedule future appointments until the balance has been paid to below $200.00.

_____ 10. Delinquent Accounts: Patients that have unpaid delinquent accounts and/or accounts that have been sent to collections may be discharged for financial negligence at the discretion of office management.

_____ 11. Referral for Outside Collection: If we do not receive payment in full by 90 days from the date of service or you do not maintain a payment arrangement as outlined by a staff member and signed by you, we reserve the right to refer your account to an outside collections agency for a fee of $100.00, at which point you will be responsible for all collection and attorney fees.

_____ 12. Missed Appointments: If you miss an appointment or fail to give 24 hours' notice, your account will be charged $40.00 for each appointment.

_____ 13. Payment Methods: We accept cash, check, and money orders. Any payments made by credit/debit card via phone or mail will be charged a $2.00 processing fee. After your card information is used for payment processing it is destroyed and NEVER given out to third parties.

_____ 14. Lab Billing: All lab work billing issues must be initially addressed with Quest Diagnostics. If you require lab work to go to a different lab than Quest Diagnostics you must let the staff know prior to having blood drawn, a Pap smear, culture collection or biopsy completed, if you do not inform a staff member and your labs are sent to Quest Diagnostics, YOU ARE RESPONSIBLE FOR ALL CHARGES INCURRED!

Obstetric & Gynecology
PHYSICIANS OF FLINT, PC

Patient Consent/Authorization

We ask that you initial next to each number and sign this statement once you have carefully read the following information.

Thank you for your cooperation!

_____ 1. **CONSENT TO TREATMENT** I hereby voluntarily request, consent to and authorize Obstetric & Gynecology Physicians of Flint (OBGYN Physicians) and its physicians, employee(s), their associates, assistants, or other practitioners under their orders to treat me at OBGYN Physicians office, and to provide medical and surgical treatment, including, but not limited to, diagnostic procedures, x-rays, and administration of medications, as is deemed necessary and advisable. In cases of birth, this consent shall extend to my child/children. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments and examinations in OBGYN Physicians office.

_____ 2. **PATIENT'S PERSONAL POSSESSIONS** OBGYN Physicians is not responsible for any patient's clothing, valuables or other personal belongings left with/by patient. I hereby release OBGYN Physicians from any liability for any and all personal possessions which I choose to keep with me during my office visit.

_____ 3. **APPOINTMENT VERIFICATION/TEST RESULTS** I understand that OBGYN Physicians of Flint contacts patients at their home to confirm appointments and/or to discuss test results. If the patient is not at home to take the call, an office associate will leave a message, if available, regarding the appointment date and time, or instructing the patient to return a call to the office.

_____ 4. **PATIENT IDENTITY VERIFICATION** I understand that lab and test results will only be released to the patient and requires verification of identity for those results to be discussed over the phone.

_____ 5. **RELEASE OF INFORMATION** I hereby authorize OBGYN Physicians, or its designee, to release information, in written form, by phone, or facsimile machine, contained in the patient's medical records. I specifically authorize the release of drug and alcohol abuse records in accordance with Federal regulations and or communications made by me to a social worker or psychologist and/or records pertaining to communicable diseases. I further specifically authorize the release of information regarding: Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), Acquired Immunodeficiency Related Complex (ARC) to:

(a) any third party payor, employer, or insurance company (including but not limited to Medicare, Medicaid, maternal and infant health, Blue Cross/Blue Shield, commercial health insurers, automobile no fault insurers, workers' disability compensation insurers and health maintenance organizations) which are responsible in whole or in part for paying the patient's bill so that OBGYN Physicians may receive payment or reimbursement for the services provided to the patient.

(b) any health care facility, physician, durable medical equipment supplier or other ancillary services provider to which the patient is referred or transferred or to which referral transfer is contemplated for the purpose of facilitating continuity of the patient's health care, and

(c) any independent auditors hired or retained by any and all third party payors, private health insurers and or any employer providing health insurance benefits to the patient, applicable to the patient's office visit, for the purpose of enabling these independent auditors to analyze charges made for services rendered to the patient.

(d) The release authorization shall be effective only so long as is necessary to accomplish the purpose for which it is given. With respect to substance abuse information (if any), this consent may be revoked at any earlier time unless OBGYN Physicians has release information in reliance upon it.

Patient Name: _____

Patient's Signature: _____ Date: _____

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Obstetric & Gynecology
PHYSICIANS OF FLINT, PC

Edilberto A. Moreno, M.D. Lavanya Cherukuri, M.D., F.A.C.O.G Erin Weisler-Zatorski, PA-C

We, the providers of Obstetric & Gynecology Physicians of Flint, P.C., believe in the transfusion of blood or blood products when needed to save the lives of our patients.

_____ I, _____ ,**Consent to transfusion of blood or blood products**
(X) (Printed Patient Name)

_____ I, _____ ,**Refuse to transfusion of blood or blood products**
(X) (Printed Patient Name)

(I am aware that **if I refuse to consent** to the transfusion of blood or blood products, then **I must seek care with another provider.**)

Date:
Patient Signature

Edilberto Moreno, M.D. Date:

Lavanya Cherukuri, M.D. Date:

HIPAA Notice of Privacy Practices Acknowledgement

I understand under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge I have received or have been given the opportunity to receive a copy of your HIPAA Notice of Privacy Practices. I also understand that this practice has the right to change its HIPAA Notice of Privacy Practices, and that I may contact the practice at any time to obtain a current copy.

Date:
(Printed Patient Name) (Patient/Parent/Guardian Signature)