Welcome to OBGYN Associates.

We are happy you have chosen our practice for your specific medical needs. Please fill out the enclosed forms and bring them with you to your appointment. *We do ask that you please arrive at our office at least twenty minutes before your scheduled appointment time, this enables us to complete our registration process.*

The charge for your initial appointment will be approximately $237 to $316, any additional services will be charged accordingly. Fees are to be paid at the time of service. We accept cash, personal check, Visa, MasterCard and Discover for payment. If you have one of the following insurance carriers we will file this charge with your insurance company on your behalf. If you do not have your current insurance card with you at your appointment you will need to pay at the time of service and file for reimbursement.

Advantage HMO	Community Health Alliance
Sagamore	Cigna PPO
Medicare	United HealthCare
Blue Cross/Blue Shield/Anthem	Aetna PPO
Select Health Network	Private HealthCare Systems (PHCS)

Indiana Medicaid MHS, Anthem or MDWise SHN

WE DO NOT ACCEPT MICHIGAN MEDICAID

Many insurance companies are now requiring their members to use a preferred laboratory. Please inform us if you need to use a lab other than the South Bend Medical Foundation.

If you need a referral from your primary care physician, it is your responsibility to obtain the referral prior to your appointment. If you are unsure if you need a referral or if you have any questions regarding your benefits, please contact your insurance company.

Thank you.

Just a reminder that your appointment is scheduled for _____/_____/_____ @ ____:____ am pm

Please bring a list of your current medications including strengths and dosages.

OB GYN
ASSOCIATES OF NORTHERN INDIANA, P.C.

6301 University Commons, Suite 310
South Bend, Indiana 46635
574-232-1417 Fax 574-232-0741

PATIENT INFORMATION

Last Name_____ **First Name**_____ **Init**_____

Nickname (if applicable) _____

SS#____-____-____ **Date of Birth**_____ **Age**_____

Address_____

City_____ **State**_____ **Zip**_____

Phone Number_____ **Cell**_____ **Work**_____

Email Address:_____

Preferred Contact: Home Cell Work

Preferred Method of Preventative Care Reminder: Email _____ Other _____

Primary Language: English _____ Other: _____

Race:_____ **Ethnicity:**_____

Marital Status: Married Single Divorced Separated Widowed

Patient Employer_____ **Occupation**_____

Who may we thank for referring you? Internet/Insurance Co./Physician/Patient recommendation//Other

Referring Physician:_____ **Family Physician**_____

Emergency Contact:_____ **Phone**_____ **Relationship**_____

PRIMARY INSURANCE

Name of Policy Holder_____ Date of Birth_____

Social Security #____-____-____ Relationship to Patient_____

Address (if different from patients)_____ City_____ State____ Zip_____

Insurance Co._____ ID#_____ Group#_____

PLEASE COMPLETE BOTH SIDES OF FORM

SECONDARY INSURANCE

Name of Policy Holder_____ Date of Birth_____

Social Security #____-___-_____ Relationship to Patient_____

Address (if different from patients) _____City_____State_____ Zip_____

Insurance Co._____ID#_____Group#_____

Parent(s) /Guardian Information
(If patient is a minor)

Name_____ Relationship_____
First Middle Last

Address_____City_____Sate_____Zip_____

Social Security #_____-_____-_____ Date of Birth _____/_____/_____

As parent/guardian, I give my permission to consult and/or treat: _____

Parent/Guardian Signature: _____

Notice to Our Patients

As required by the HIPAA Privacy Regulations, all patients who received health care service in our office must:

- Receive the attached "Notice of Privacy Practices" form; and
- Sign the "Acknowledgement" form below.
- A complete list of this policy is available in our office at your request.

Please note that the attached notices are not a consent form. This form must be read in full by the patient and signed before treatment can be provided; rather, the Notice provides each patient with a summary description of:

How our office will use and disclose their medical information for legitimate business purposes.
How each patient can exercise their rights with regard to this medical information.

IN ORDER FOR US TO REMAIN HIPAA COMPLIANT PLEASE LIST ANY PERSON(S) OR COMPANIES THAT YOU GIVE YOUR PERMISSION TO OBTAIN WRITTEN OR VERBAL INFORMATION ON YOUR BEHALF: (DO NOT LIST YOURSELF OR OTHER PHYSICIANS)

_____
Name Relationship Phone Number

_____
Name Relationship Phone Number

OBGYN Policies and Procedures

- You must allow five to seven business days for completion of all forms. There will be a minimal charge per form.
- Please allow 24 hours for medication refills to be called in. Medication refill requests must be made during business hours only.
- You may be discharged from the practice after 3 missed appointments. New patients will be discharged after 2 missed appointments.

Assignment and Release

I certify that I, and/or my dependant(s) have insurance coverage with the above named insurance companies and assign directly to OB GYN Associates all insurance if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance admissions. The above named office may use my health care information and may disclose such information to the above named Insurance Company (ies) and agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I acknowledge that I have received a current copy of the Privacy Notice. I also authorize the above practice or any outside agency to contact me regarding my patient balance. I understand and agree to receive artificial or pre-recorded voice or auto-dialed calls to designated cellular or residential telephone numbers for the purposes of debt collection or other purposes. I also acknowledge that I have read and understand all other policies and agree to the terms set above.

X_____ _____
Signature of patient/guardian/personal representative Date

6301 University Commons, Ste 310
South Bend, IN 46635

Please complete both sides of form.

OB-GYN ASSOCIATES OF NORTHERN INDIANA, P.C.

NAME: _____ AGE: _____ DATE: _____

INITIAL PATIENT SELF-HISTORY FORM

Provide all information requested to the best of your ability.
ALLERGIES (Include medications, Latex, Iodine)

_____

GYNECOLOGIC HISTORY

Age at first menses (period) _____ Age at menopause (if applicable) _____

(The following questions refer to your "natural" periods when not on birth control pills or hormones)

Usual # of days of period _____ Period interval (1st day to 1st day) _____ days

How many days are: Heavy _____ Medium _____ Light _____

Have you ever had an abnormal pap smear? _____

If yes, how was it treated? _____When? _____

Date of last pap smear _____ Have you had a mammogram? _____ When? _____ Result _____

Types of birth control used, including vasectomy _____

Have you had any gynecologic surgery? (Including Tubal Ligations, D&C's, Cryo, Leep, Ovarian surgery)

If yes, what kind? _____ When? _____

_____ _____

_____ _____

Do you have any knowledge of your mother using hormones (DES, Diethylstilbestrol) during her pregnancy with you? _____

PREGNANCY HISTORY

# of full-term deliveries _____ # of premature deliveries _____ # of miscarriages _____ Was surgery needed? _____

# of abortions _____ Any complications? _____ Any "tubal" pregnancies? ____ When? _____

# of vaginal deliveries _____ # of Cesarean sections _____ Years of deliveries _____

Any serious complications during your pregnancies or deliveries? _____

_____

RISK FACTORS

Your answers to these questions help us to determine if you have risk factors for cancer, infections or AIDS:

Have you ever received a blood transfusion? _____ Do you smoke? _____ How much? _____ How many years? _____

Do you consume alcohol? _____ How often? _____

Have you ever used marijuana, cocaine, heroin, barbituates, or speed? _____ If yes, last used? _____ Any needles? _____

Age at first intercourse _____ Total # of sexual partners _____ Total # of sexual partners in last year _____

Have you had any sexually transmitted infections? _____ If yes, what? _____ When? _____

Do you believe yourself to be at risk of exposure to the AIDS virus? _____

Please complete both sides of form.

SURGERY (Other than gynecologic)

TYPE	WHEN	DOCTOR	COMPLICATIONS

HOSPITALIZATIONS (Non-surgical, other than pregnancy)

CONDITION	WHEN	DOCTOR	TREATMENT

PAST AND PRESENT MEDICAL PROBLEMS

- ☐ **Abnormal PAP, h/o**
- ☐ Anemia
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Bartholin's gland cyst
- ☐ Blood transfusion, h/o
- ☐ Breast cancer
- ☐ Breast mass
- ☐ Bruising / bleeding disorder
- ☐ Cerebrovascular accident
- ☐ Cervical cancer
- ☐ Clotting disorder
- ☐ Coronary heart disease
- ☐ Cystocele
- ☐ Depression
- ☐ DES Exposure
- ☐ Diabetes mellitus
- ☐ Drug/alcohol use
- ☐ Endometriosis
- ☐ Family hx of genetic disorder
- ☐ Fetal death, prior
- ☐ Fibroid uterus
- ☐ Gallbladder disease
- ☐ Genital herpes, exposure
- ☐ Genital herpes, h/o
- ☐ Heart murmur
- ☐ Hemoglobinopathy
- ☐ Hepatitis/Liver disease
- ☐ Hypercoagulable disorder
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Incompetent cervix
- ☐ Infertility
- ☐ Neonatal death, prior
- ☐ Phlebitis
- ☐ Obesity
- ☐ Ovarian cancer
- ☐ Ovarian cyst
- ☐ PID
- ☐ Polycystic ovary syndrome
- ☐ Prolapsed uterus
- ☐ Premature rupture of membranes
- ☐ Preterm delivery, prior
- ☐ Psychiatric disease
- ☐ Pulmonary embolism
- ☐ Recurrent miscarriages
- ☐ Seizure disorder
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Uterine cancer
- ☐ UTI, h/o recurrent
- ☐ Vaginal infections, recurrent
- ☐ STD

Other Medical/Surgery History not listed_____

_____

FAMILY HISTORY *Include Mother (M), Father (F), Sister (S), Brother (B), Grandmother (GM), Grandfather (GF), and Children (C) only.*

Diagnosis	◀ Family member Indicated by M-Mother, F-Father, B-Brother, C-Child, etc.		Diagnosis		
Alive and Well ☐			Diabetes	○ Yes ○ No	
Alcoholism	○ Yes ○ No		Downs syndrome	○ Yes ○ No	
Asthma	○ Yes ○ No		Hemophilia-A	○ Yes ○ No	
Autoimmune disorder	○ Yes ○ No		Hyperlipidemia	○ Yes ○ No	
Breast cancer	○ Yes ○ No		Hypertension	○ Yes ○ No	
Cervical cancer	○ Yes ○ No		Mental illness	○ Yes ○ No	
Coagulopathy	○ Yes ○ No		Mental retardation	○ Yes ○ No	
Colon cancer	○ Yes ○ No		Muscular dystrophy	○ Yes ○ No	
Coronary artery disease	○ Yes ○ No		Ovarian cancer	○ Yes ○ No	
Cerebrovascular accident	○ Yes ○ No		Seizure disorder	○ Yes ○ No	
Cystic fibrosis	○ Yes ○ No		Sickle cell disease	○ Yes ○ No	
Depression	○ Yes ○ No		Spina bifida	○ Yes ○ No	
Developmental delay	○ Yes ○ No		Thyroid disease	○ Yes ○ No	
			Other	○ Yes ○ No	

Other Family History not listed_____

_____

Check if adopted/family history not known ☐