ISLIP OB - GYN

Please Complete Your Patient Information

Date/Fecha:_____

Name/Nombre: _____ SS#_____

Home Phone/ Telefono De Casa _____ Cell Phone/ telefono célular _____

Email _____ Work Phone/ telefono del trabajo _____

Address/ Dirección _____

City/Ciudad_____ State/ Estado _____ Zip/Código Postal _____

Date of Birth/ Fecha de Nacimiento _____ Marital Status: Single Married Divorced
Soltera Casado Divorciado

Occupation/ Trabajo_____ Employer/ Empleador _____

Preferred Language/ Idioma preferido _____
Whom may we thank for referring you?_____
A quien podemos agradecer por la referencia? _____

Primary Insurance **Seguro Primario**

Insurance Name/ Nombre de Seguro_____ ID#_____
Group#/ Grupo#_____

If the insured is different than the patient, please complete below:

Si el asegurado es diferente que el paciente, por favor complete la siguiente:

Person Responsible/ Persona _____ ID/SS#_____

Address/ Dirección _____ City/ Ciudad_____

State Estado_____ Zip/ Código Postal _____

Relationship/ Relación_____Date of Birth/ Fecha de Nacimiento_____

Employer/ Empleador_____ Occupation/Ocupación _____

Additional Insurance **Seguro adicional**

Insurance Name/ Nombre de Seguro_____ ID#_____
Group#/ Grupo#_____

Person Responsible/ Persona _____ ID/SS#_____

Date of Birth/ Fecha de Nacimiento _____SS# _____

Emergency Contact **Contacto de emergencia**

Name/Nombre: _____ Relationship/ Relación _____

Best Phone #/ Mejor Teléfono _____

What pharmacy do you use?
Name

_____
Address if known

_____
City and State

_____
Telephone

_____

Additional Information, HIPAA and Financial Policies

These are our financial policies. Please read, then write your initials next to each policy. At the end please sign your name.

Financial Policy
Thank you for being a valued patient of Islip OB-Gyn. Please take a moment to read and sign our policies.

In order to reduce confusion and misunderstanding between our patients and our practice, we have adopted a set of financial policies. If you have any questions about the policies, please ask to discuss them with our practice administrator or with our billing office. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an element of your care and treatment. ***You are responsible to know your own policy and its limitations.***

Insurance/ Financial Policies
*We are contracted with most insurance plans. These plans may have a co-payment (A fixed amount ($20, for example) you pay for a covered health care service), coinsurance (The percentage of costs of a covered health care service you pay (20%, for example)) or deductible (a specified amount of money that the insured must pay before an insurance company will pay a claim.). We expect co-payment at the time of service, but deductibles and coinsurance are billed after receipt of your insurance statement. Some services are not covered. You will know in advance if a service is not covered. An example of a non-covered service is contraception, when under a catholic health service plan or organization. Payment plans for non-covered services can be arranged through our billing office.

*Each insurance plan is different and has its own policies on what is and is not a covered benefit. It is your responsibility to know what is covered and which benefits fall under your plan. We will explain these to you prior to any services as best we can.

Initial

_____

Delinquent Accounts (For amounts that patients are responsible for)

*Account balances should be paid within 30 days of the account statement.

*Outstanding balances after 90 days will be transferred to a collection agency unless prior arrangements have been made with our billing office.

Initial

_____

Cancellation of Appointments/ No Show

We do our best not to overbook, with the exception of same day emergencies. When appointments are not kept, it creates an unused appointment slot that could have been used for another patient. It is very important that you call to cancel your appointment.

*If for any reason you need to cancel or reschedule an appointment, please notify our office within 24 hours to avoid a fee.

*A no show occurrence maybe subject to a $25 charge for an office and/or ultrasound visit. There may also be a $50 charge for a no show to a procedure or surgery.

*If you are going to be late please contact our office. If you are more than 15 minutes late without notice you will be worked into the schedule if time allows or you can be rescheduled for another day.

Initial

_____

Returned Check and other fees

*There will be a $25 service fee for any check returned for insufficient funds.

*After 2 returned checks we will no longer accept checks as your form of payment.

***There will a fee of $25 for any paperwork that needs to be filled out by our administrator including disability papers.**

Initial

_____

Please be mindful of cellphone use. They should not be being used while the doctor is in the room or during triage.

I have read and understand the above policies.

Please sign your name below

_____

Privacy Policies

These are our privacy and policies regarding protected health information. Please read and sign your name.

Assignment and Release

Please carefully read and sign both statements below:

It is understood that I, or we, will be responsible for all charges incurred on this account, to include all present and future services. I understand that regardless of the insurance coverage that I may have, I am responsible for payment of all charges. In the event of non-payment of charges for the services rendered, I agree to pay all costs of collection, including reasonable attorney's fees. I have read this agreement and do understand its provisions.

Please sign your name

_____

Optional

I hereby authorize Islip Ob-Gyn to send me newsletters, bulletins and other documents via email. Sensitive medical information will never be sent via email, since security and privacy cannot be assured. I understand that Islip Ob-Gyn will not share my email address with any other person or agencies without my express, written consent. This authorization will remain in effect until I revoke this authorization.

Please sign your name

_____

Identifying information

If your visit will be covered by an **insurance plan**, we require a current insurance card and an **acceptable form of identification that matches your insurance card**.

If your visit will be self-pay, and you will be paying by **credit card or check**, you will need an **acceptable form of identification that matches your credit card or check**.

HIPAA

Notice of Privacy Practices

This notice describes how health information about you (As a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable or Personal Health Information (PHI). This information is required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Please review this notice carefully

Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your individually identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and privacy practices that we maintain in our practice concerning you PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.
Our practice must provide you with the following important information:
*How we may use and disclose your PHI
*Your privacy rights in your PHI
*Our obligations concerning the use and disclosure of your PHI

We may use and disclose your PHI in the following ways:
*Treatment: Our practice may use your PHI to treat you by providing, coordination, or managing health care and related services by on or more health care providers. For example, we may request laboratory tests and use the results to reach a diagnosis. We might use your PHI to write a prescription and might disclose your PHI to a pharmacy and access your PHI from other pharmacies.
*Payment: Our practice may disclose your PHI to obtain reimbursement for services, confirming coverage, billing or collection activities and utilization review. For example, we may contact your health insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your treatment to determine if your insurer will cover your treatment.
*Health Care Operations: Our practice may use your PHI to operate our business, such as conducting quality assessment and improvement activities auditing functions, cost management analysis and customer service.
*Appointment Reminders: Our practice may use and disclose your PHI to contact you and remind you of an appointment.
*Electronic Transmission: Our practice may display the office name, address and patient identifiable information on electronic transmission of insurance claims and statements.
*Release of Information to Family/Friends: Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. **You have to give consent or we cannot release any information.**

Use and disclosure of your PHI in certain special circumstances:
*For public health activities including reporting of certain communicable diseases.
*To authorities when we suspect abuse, neglect, or domestic violence.
*To health oversight agencies.
*For judicial and administrative processing pursuant to an administrative order.
*For law enforcement purposes.
*To advert a serious threat to your health and safety or that of others.
*For governmental purposes such as military service or for national security.
*In the even of an emergency or disaster relief.
*For Worker's Compensation or similar programs as required by law.
*Inclusive of any other instance required by law.

Your rights regarding your PHI:

*Confidential Communications: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location.
*Requesting Restrictions: You have the right to request a restriction in our use of disclosure of your PHI treatment, payment or healthcare operations.
*Inspection of Copies: You have the right to inspect and obtain copy of the PHI that may be used to make decisions about you, including patient medical record and bill records.
*Amendment: You may ask us to amend your health information if you believe it is incorrect or incomplete and you may request an amendment for as long as the information is kept by or for our practice. To request and amendment, your request must be made in writing providing a reason that supports your request.
*Accounting of Disclosures: All patients have the right to request an "accounting of disclosures" consisting of al list of certain non-routine disclosures our Practice has made of our PHI for purposes not related to treatment, payment or operations. For example, the provider sharing information with the medical assistant or the billing department using information to file your insurance claim.
*Right to a Paper Copy of this Notice: You are entitled to receive a paper copy of our notice of privacy practices.
*Right to File a Complaint: If you believe your privacy rights have been violated, you may file a written complaint with our office, or with the Department of Health and Human Services, or the Office of Civil Rights.
*Right to Provide and Authorization for Other Uses and Disclosures: Our practice will obtain written authorization for uses and disclosures that are identified by this notice or permitted by applicable law. Our practice is required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change terms of our Notice of Privacy practices and to make the new provisions effective of all protected health information we maintain.

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I have reviewed a copy of Islip OB-GYN's Privacy Practices

Please sign your name

_____

Please use this section to show us who can receive your medical information

I give my authorization to use and disclose my protected health information to every doctor and employee at Islip Ob-Gyn.
(required) Initial _____

I give my authorization to Islip Ob-Gyn to release any medical record that will help any specialist or primary care doctor with any medical care.
(required) Initial _____

I give my authorization to Islip Ob-Gyn to send my test results by email or mail if I request them.
(optional) Initial _____

Family and Friends (optional)

Please name the people (friends or family members) who are authorized to receive any medical information from your chart.

Name _____Relationship_____

Name _____Relationship_____

Additional Patient Responsibilities

*I understand and agree that I am financially responsible for all charges for any services rendered. This includes any medical service, visit or routine examination.
*I understand that while my insurance may confirm my benefits, that confirmation of benefits does not guarantee payment and that I am responsible for any unpaid balances.
*I understand and agree that it is my responsibility to know if my insurance carries a deductible, co-payment, co-insurance, or out of network benefit limitations for the services I receive, and I agree to make payment in full.
*I agree to inform the office of any changes to my insurance coverage.

***If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full**

***I UNDERSTAND THAT THIS OFFICE DOES NOT PARTICIPATE WITH MEDICAID. This means if for any reason my coverage lapses, and I am only covered by Medicaid that any services provided will not be paid for and I will be held responsible.**

*I understand that if any reason my coverage lapses, and I am only covered by Medicaid, that I will be required to make a payment arrangement prior to any services being provided.

*If I am a Medicare patient, and I have Medicaid as a secondary I understand that **this office DOES NOT participate with Medicaid and that I will still be responsible for my 20% co-insurance**.

Please sign your name

_____

Clinical Information **Name**_____**Date of Birth**_____

Personal Medical History and Information / Historia anual del paciente

Complete as much as possible. We can also complete this information in the examination room
Completa lo más possible. Podemos completer todo en la sala de examen

What is the reason for your visit today? ¿Cuál es el motivo de su visita hoy?

Annual Visit Yes No **Problem Visit** Yes No **Pregnancy** Yes No
¿Visita annual? Sí No ¿visita problemática? Sí No ¿Embarazada? Sí No

Explanation/Explicación_____

Do you have any chronic illnesses? No Yes ¿Tienes alguna enfermedad cronica? Sí No
If yes, which illnesses? ¿En caso affirmativo, cuál?
_____

Have you had any surgeries? No Yes ¿Has tenido alguna cirugía? Sí No

Surgical and Hospitalization History not related to childbirth: **Antecedentes quirúrgicos y de hospitalización no relacionados con el parto**:

Hospital_____Month/Year_____Illness/Operation_____
Hospital_____Mes año_____Enfermedad / Operación_____

Hospital_____Month/Year_____Illness/Operation_____

Hospital_____Month/Year_____Illness/Operation_____

More than 3 surgeries or hospitalizations? Please discuss the additional surgeries during your visit.
Yes No
¿Más de 3 cirugías u hospitalizaciones? Por favor discuta durante su visita(Otras)
Sí No

At what age did you have your <u>first</u> menstrual period? _____
¿A qué edad tuvo su **<u>primer</u>** período menstrual? _____

Obstetrical History
How many times have you been pregnant? _____How many living children do you have?_____
How many miscarriages have you had? _____How many abortions have you had?_____

Other Details:_____
Historia obstétrica:
¿Cuantas veces has estado embarazada?_____¿Cuántos hijos vivos tienes?_____
¿Cuántos abortos espontáneos has tenido?_____¿ Número de abortos?_____

Detalles:_____

When was your last menstrual period? _____¿Cuando fue su **ultimo** período menstrual?_____

Is your period regular or irregular? Reg Irreg

Comments/Details_____

¿Tu período es: regular irregular?
Detalles:_____

Pap smears
When was your last Pap Smear? _____ Normal Abnormal

Papanicolau
¿Cuándo fue tu última Papanicolaou?_____
Normal Anormal

Are you using birth control? Yes No

What method? _____

What other methods have you used in the past? None
_____

¿Estás usando anticonceptivos? Sí No
¿Que metodo?_____
¿Qué otros métodos has usado en el pasado? Ninguna
_____

Mammograms
Have you ever had a mammogram? Yes No

When was your last mammogram? _____ Normal Abnormal
Mamografías
En el pasado, ¿alguna vez te has hecho una mamografía? Sí No
¿Cuándo fue tu última mamografía? _____
Los Resultos: Normal Anormal NA

Prior Infections	**Infecciones previas**
Have you ever had Bacterial Vaginosis? Yes No	¿Alguna vez ha tenido vaginosis bacteriana? Sí No
Do you suffer from Yeast Infections? Yes No	¿Sufres de infecciones por hongos? Sí No
History of HPV (Human Papillomavirus) ? Yes No	¿Alguna vez ha tenido el HPV (virus del papiloma humano)? Sí No
Have you ever had Chlamydia? Yes No	¿Alguna vez has tenida clamidia? Sí No
Have you ever had Gonorrhea? Yes No	¿Alguna vez ha tenida gonorrea? Sí No
Do you have Herpes? Yes No	¿ Tienes herpes? Sí No
Do you have HIV? Yes No	¿Tienes El Sida o VIH? Sí

Menopause **Menopausia**

Do you have Hot Flashes? Yes No ¿Tienes sofocos o calores? Sí No

Do you have Vaginal Dryness? Yes No ¿Tienes sequedad vaginal? Sí No

Do you have Night Sweats? Yes No ¿Tienes sudores nocturnos? Sí No

Do you have problems with Memory or Concentration? Yes No

¿Tienes problemas con la memoria o la concentración? Sí No

Have been getting treatment for any of the above? Yes No

Details:_____

¿Has estado recibiendo tratamiento para la menopausia? Sí No

Detalles:_____

Sexual Problems **Problemas sexuales**

Do you have decreased desire? Yes No ¿Tienes disminución del deseo sexual? Sí No

Do you have difficulty achieving orgasms? Yes No ¿Tienes dificultades para alcanzar los orgasmos? Sí No

Do you have pain when you have sex? Yes No ¿Tienes dolor cuando tienes relaciones sexuales? Sí No

Urinary Problems **Problemas urinarios**

Do you get frequent urinary infections? Yes No ¿Tienes infecciones urinarias frecuentes? Sí No

Do you use the bathroom frequently? Yes No ¿Usas el baño con frecuencia? Sí No

Do you leak urine when you cough, sneeze or laugh? Yes No **¿Gotea orina cuando tose, estornuda o ríe?** Sí No

Do you have sudden urges to use the bathroom? Yes No ¿Tienes deseos repentinos de usar el baño? Sí No

How many times per day? Cuantas veces por dia?

_____ _____

Do you wake up at night to use the bathroom? Yes No ¿Te levantas por la noche para ir al baño? Sí No

If yes, how many times per night? ¿ Cuantas veces por noche?

_____ _____

Obstetrical History

Information about your Deliveries Información sobre sus partos obstétricos

Month/Year	Number of weeks	Vaginal	C Section	Weight	Male/ Female	Hospital
Mes / año	Numero de semanas	Vaginal/ Cesárea		Peso	Niña/ Niño	Hospital

_____

_____

_____

_____

If there are more than four (4) we will discuss in the office. Please write the total number here:

Si hay más de seis, escriba el número total aquí:

_____

General Medical **Medicina general**

Have you had a recent tetanus shot? Yes No ¿Has recibido una vacuna contra el tétanos recientemente? Sí No
Have you had a Flu shot this year? Yes No ¿Te has vacunado contra la gripe este año? Sí No
Have you had an HPV Immunization? Yes No ¿Te has vacunado contra la HPV en el pasado? Sí No
Are you up to date on all of your immunizations? Yes No ¿Está al día con todas sus vacunas? Sí No
Have you traveled out of the country recently? Yes No ¿Has viajado fuera del país recientemente? Sí No
Where?_____ ¿Dónde?_____
What medications are you currently taking? None ¿Qué medicamentos estás tomando ahora? Ninguna
Name: _____ Nombre:_____
What supplements do you take? None ¿Qué suplementos estás tomando ahora? Ninguna
Which:_____ Nombre: _____
Do you have any allergies? Yes No ¿Tienes alguna alergia? Sí No
List your allergies: Enumere sus alergias:
_____

Family and Personal History **Historia familiar y personal**

Alzheimer's	Alzheimer
Arthritis	Artritis
Asthma	Asma
Cancer	Cáncer
Depression	Depresión
Alcoholism	Alcoholismo
Diabetes	Diabetes
Hypertension	Hipertensión,
Migraines	Migrañas
Obesity	Obesidad
Osteoporosis	Osteoporosis
Kidney Disease	Enfermedad renal
Stroke	Accidente cerebrovascular
Thyroid Disease	Enfermedad de la tiroides

Mother: Alive Deceased **Madre**:
If Deceased, the cause?_____ Viva Muerta
Si estaba muerta, ¿cuál era la causa?_____
Father: Alive Deceased **Padre**:
If Deceased, the cause?_____ ? Viva Muerta

Si estaba muerta, ¿cuál era la causa?_____

Siblings: **¿Tienes Hermanos & Hermanas?** Sí No
How many brothers? _____ ¿Cuantos Hermanos?_____
How many sisters? _____ ¿Cuantos Hermanas?_____
Are all of them Alive? ¿Están todos viviendo?
Yes No Sí No
If any are deceased what was the cause? ¿Si ellas no están viviendo cuál fue la causa de la muerta?
_____

Recent or prior personal and family medical problems

Weight loss/gain	No Self	Family Member	Pérdida o aumento de peso	No Yo	Miembro de la familia
Headaches/Migraine	No Self	Family Member	Dolores de cabeza / migraña	No Yo	Miembro de la familia
Heart Disease	No Self	Family Member	enfermedades cardíacas	No Yo	Miembro de la familia
Hypertension	No Self	Family Member	Hipertensión	No Yo	Miembro de la familia
Respiratory Disease	No Self	Family Member	Enfermedad respiratoria	No Yo	Miembro de la familia
Breast disease	No Self	Family Member	enfermedades de los senos	No Yo	Miembro de la familia
Jaundice/Hepatitis	No Self	Family Member	Ictericia / Hepatitis	No Yo	Miembro de la familia
Gallbladder disease	No Self	Family Member	Enfermedad de la vesícula	No Yo	Miembro de la familia
Hernia/Ulcers	No Self	Family Member	Hernia / úlceras	No Yo	Miembro de la familia
Bowel disorders	No Self	Family Member	Trastornos intestinalis	No Yo	Miembro de la familia
Kidney Disease	No Self	Family Member	Enfermedades renales	No Yo	Miembro de la familia
Incontinence	No Self	Family Member	*Incontinencia*	*No Yo*	*Miembro de la familia*
Anemia/Blood diseases	No Self	Family Member	Anemia	No Yo	Miembro de la familia
Blood transfusion	No Self	Family Member	Transfusión de sangre	No Yo	Miembro de la familia
Varicose veins	No Self	Family Member	Venas varicosas	No Yo	Miembro de la familia
Thyroid Disease	No Self	Family Member	Enfermedad de tiroides	No Yo	Miembro de la familia
Diabetes	No Self	Family Member	Diabetes	No Yo	Miembro de la familia

Any Cancer?	No Self	Family Member			
Breast	No Self	Family Member	**Cáncer de Los senos**	No Yo	Miembro de la familia
Ovarian	No Self	Family Member	**Cancer Ovárica**	No Yo	Miembro de la familia
Cervical	No Self	Family Member	**Cancer Cervical**	No Yo	Miembro de la familia
Epilepsy/Seizures	No Self	Family Member	Epilepsia / convulsions	No Yo	Miembro de la familia
Arthritis/Osteoporosis	No Self	Family Member	Artritis / Osteoporosis	No Yo	Miembro de la familia
Skin Disease	No Self	Family Member	Enfermedad de la piel	No Yo	Miembro de la familia
Anxiety/Depression	No Self	Family Member	Ansiedad / Depresión	No Yo	Miembro de la familia
Sleep Difficulty	No Self	Family Member	Dificultad para dormir	No Yo	Miembro de la familia

Other problems:_____

Otras problemas:_____

Social History **Historia social**

Marital Status Single Married Divorced Widowed
Estado civil Soltera Casada Divorciada Viuda

Who do you live with? Family Your children Partner or Husband
Solo Friends Shelter

¿Con quien vives?
Familia Pareja o esposo Tu hijos/hijas
Solo Amigas Refugio

Do you have pets? Yes No ¿Tienes mascotas? Sí No
If yes, what kind? _____

Occupation _____ Ocupación _____

How long have you lived in NY? _____Years
OR _____ Months
¿Cuánto tiempo has vivido en Nueva York? _____años
O_____ meses
Prior to NY where did you live? _____¿Antes de Nueva York donde vivías? _____

How is your nutrition?
Poor Diet Average Diet Good Diet Excellent Diet Vegetarian
¿Cómo es tu nutrición? Dieta pobre Dieta promedio Dieta Buena Dieta excelente Vegetariana

How is your exercise? Poor Average Good
¿Cómo es tu ejercicio? Pobre Promedio Buena

Sexual Activity: One current partner Multiple current partners Not sexually active
Actividad sexual:
Una pareja actual Múltiples parejas actuals No sexualmente active

Contraception: None Method: _____ Anticoncepción: _____ Ninguna Método:_____

Condom use? Yes No Uso de condones? Sí No

Smoking: You Yes No **De fumar:**
Spouse Yes No Usted Esposo Otras en su casa
Others in your home Yes No

Alcohol Use: Social Very Active Abuser/Problem
¿Usas alcohol?: Social Muy activa Abusador / Problema

Illicit Drugs: No Yes Drogas ilícitas: No Sí

Which drugs? _____ Que Drogas_____

Seatbelt use? Yes No ¿Usas el cinturón de seguridad? Sí No

If you have a young child, do you have a car seat or a booster seat?
Si tiene un niño pequeño, ¿tiene un asiento de seguridad o un asiento elevado?
Yes No No young children Sí No No tengo

Do you have a child or children in daycare? ¿Tiene un niño o niños en la guardería?
Yes No Sí No

Do you feel safe at home from your spouse? **¿Te sientes seguro en casa con su esposo?**
Yes No Sí No