Eastside OB/GYN

Registration form

PRINT RESET

Patient Information – Please Print

Name: _____ Prefer to be called: _____
Last First MI Age: _____Birth Date: ___ / ___ / ____
MM DD YYYY
Former name: _____
Marital Status: Single Married Divorced Home Phone: (_____) _____
Circle One Widowed Separated Work Phone: (_____) _____
Cell: (_____) _____
Email Address: _____
Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ African American ☐ Pacific Islander ☐ Caucasian
Circle One Other: _____ Decline
Ethnicity: _____ Decline

Street Address: _____ Apartment or PO Box Number: _____
City: _____ State: _____ Zip Code: _____

Employer:_____
Name Location Occupation
OB/GYN Physician: ☐ Dydell ☐ Price ☐ Tsuang ☐ Tun ☐ Family/Primary Care Physician: _____
Circle One
Preferred Pharmacy: _____ (_____) _____
Name Location Phone Number

Have you had services at EvergreenHealth before? ☐ Yes ☐ No
(including lab, x-ray or ER)

Family Information

Partner or Parent Name: _____ Relationship to Patient: _____
Birth Date: ___ / ___ / ____ Employer:_____ Occupation: _____
Work Phone: (_____) _____ Cell: (_____) _____ Home: (_____) _____
If patient is a minor, with whom does the child live with? _____

Persons to Call in case of Emergency

Next of Kin: _____ Home Phone: (_____) _____
(or legal guardian, if same as family information, note same)
Relationship to Patient: _____ Work Phone: (_____) _____

Emergency Contact: _____ Home Phone: (_____) _____
(other than a relative or person living with you)
Relationship to Patient: _____ Work Phone: (_____) _____

Insurance Information – Please present Insurance Card(s) to Receptionist

Advance Directives: Do you have a living will? ☐ Yes ☐ No Do you have a Healthcare Power-of-Attorney? ☐ Yes ☐ No
Religion: If you would like it included in your record, what is your religious preference? _____

Release of Benefits & Information: I authorize my insurance benefits be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for processing insurance claims. I understand this may include information regarding HIV, sexually transmitted diseases, mental health, drug and/or alcohol use.

SIGNED: Print your name in full _____ DATE: _____

Eastside OB/GYN

12303 N.E. 130th Lane Suite #230, Kirkland, WA 98034
425-899-5000 (phone) 425-899-5006 (fax)

Consent to use of Electronic Mail

Eastside OBGYN would like to give you the chance to communicate with your doctors, other healthcare providers (such as nurses), and administrative services by electronic mail (email).

Sending private patient information by email, however, has a number of risks that you should think about.

Risks of Email

- Email may be instantly sent worldwide and be received by many intended and unintended recipients.
- Those who get email can pass on messages to anyone without the original sender's permission or knowledge.
- Users can easily misaddress an email.
- Backup copies of email may exist even after the sender or the recipient has erased their copy. All emails will be kept in your medical record. This means that all people who have access to the medical record will be able to see the emails.
- You should not use your employer's email system to send or receive private medical information. If you choose to send or receive an email from your workplace, there is a change your employer could read the message.
- Email messages may not be answered on the same business day. We will make an effort to read and respond to email as soon as possible, but we cannot guarantee that any email message will be answered within any set period of time.

Never use email in an urgent situation or in an emergency, or medical questions. Please call our office for ALL medical questions/concern at (425) 899-5000

Conditions for the Use of Email

If you agree to the use of email, you agree to the following rules:

- Your message should be short. If you feel your message is too long for an email, you may wish to call our office or schedule an appointment.
- Please write the topics of your email in the subject line.
- Please write your name and patient identification number, if known, in the message. It is the policy of EASTSIDE OBGYN to make all email messages sent or received that are about medical treatment a part of your medical record. We will treat such email messages with the same amount of confidentially as other portions of the medical record.

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- We will make every effort to protect the privacy of email information. All of our employees must use password-protected screen savers whether they are working in the office, hospital, or their home office. However, due to the possibility of technical problems, we cannot guarantee the security of all emails. Your use of email is an acknowledgement of this insecurity and your acceptance of the risk.
- EASTSIDE OBGYN may forward email messages as needed for diagnosis, treatment, and reimbursement. EASTSIDE OBGYN will not pass on the email to others without your prior consent.
- Because some medical information is sensitive and the privacy of email is not guaranteed, you should not use email for communications about sensitive information. Some examples are protected diagnoses (such as mental health conditions or substance abuse problems), information about HIV/AIDS, and workers' compensation injuries.
- To prevent identity theft, we require that you come into the office to change your address or other contact information maintained in our records. You cannot do this by email.
- Do NOT send financial information, credit card numbers, checking account numbers, or any similar information to EASTSIDE OBGYN by email. We will not ask you for this information by email. Any email supposedly from EASTSIDE OBGYN asking for credit card or checking account information is fraudulent. Please let us know if you receive such an email.

It is your duty to protect your password or other means of access to email sent or received from EASTSIDE OBGYN. EASTSIDE OBGYN is not responsible for breaches of confidentiality caused by the patient.

You may withdraw consent to the use of email at any time by email or written.

Your signature below allows EASTSIDE OBGYN to send an email to this address:

_____ _____

Email Address (please print) Full Name (please print)

Print your name in full _____ _____

Signature of Patient or Responsible Party Date and Time

_____

Date of Birth

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

We keep a record of the health care services we provide to you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting your doctor.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____
Patient or legally authorized signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship
(parent, legal guardian, personal representative)

(Notation, if any, by staff)

This form will be retained in your medical record.

Last updated: _____

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Financial Policy

1. We bill most insurance companies on your behalf, but ultimately you as the patient are responsible for the charges you incur. Your insurance is a contract between you and that company.

2. Please provide us with current insurance information. Failure to provide us with complete and accurate information could result in non-payment of claims and a large bill for you. If your insurance changes, please inform us as soon as possible and provide us with a copy of your new insurance card. This is especially true for our maternity patients whose coverage might change in the middle of their prenatal care.

3. Patients with coverage through multiple insurance companies need to be aware that primary insurance is always their own insurance, usually provided through an employer. Coverage provided through a spouse or parent will always be secondary to a patient's own insurance. For patients with DSHS coverage, please be aware that the State always pays last; after all other coverage has paid. Unfortunately, you cannot choose which insurance company is primary or which insurance to bill. There are strict guidelines between insurance companies regarding responsibility for payment of claims.

4. Co-pays are due at the time of service.

5. Patients seeking surgery or OB/prenatal care will find that we request payment of the patient portion before surgery or delivery takes place. Any payment plan agreements must have patient portions paid before the services is completed. OB patients without insurance need to come to their first visit prepared to pay half of the OB fee of $1400 as a deposit. The remaining balance can be paid in monthly payments, due in full by the 32nd week of pregnancy.

6. Circumcisions are not covered by all insurances or may be applied to the baby's deductible. Our fee is $275. Please check with your insurance company regarding coverage for your newborn.

7. We do require 24 hours' notice for cancellation of an appointment. Failure to cancel 24 hours prior or missing an appointment may result in a $50 fee.

I _____, have read the Financial Policy for Eastside OB/GYN and understand that I will be charged a fee of $50 for a missed appointment, unless I notify the office 24 hours prior to my scheduled appointment.

Signature: Print your name in full _____ Date: _____

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Authorization to Release Health Care Information

I would like to allow access to my personal health care information as defined in the Notice of Privacy Practices to the following people. Without my permission, no one will be given verbal or written information regarding my (protected) health care information.

_✔_ Spouse Spouse's Name: _____

_____ Other Relationship to Patient: _____

Name: _____

_____ Parent Parent's Name: _____

****

Patient's Name: _____

Date of Birth: _____

Patient's Signature: Print your name in full _____

Date of Signature: _____

PLEASE FILL OUT COMPLETELY AND RETURN NO LESS THAN 5 DAYS PRIOR TO APPOINTMENT

Email: admin@eastsideob.com *** Fax 425-899-5006**
Mail: 12303 NE 130th Ln, Suite #230 Kirkland, WA 98034

GYN History

Name: _____ Pt Account #: _____

DOB: _____ MD: ☐ **DYDELL** ☐ **PRICE** ☐ **TSUANG** ☐ **TUN**

Date: _____

Reproductive History

- When was your last menstrual period? _____
- At what age did you begin having your period?_____
- Usually how many days between your cycles from the start of your first day to the start of your next period? _____ **days** How many days do your periods last?_____
- How would you describe your flow? ☐ **Light** ☐ **Normal** ☐ **Heavy**
- How certain are you of your last menstrual period? ☐ **UNSURE** ☐ **CERTAIN**
- Have you ever been treated for infertility? ☐ **Yes** ☐ **No**
  If yes when and how long and what treatments? _____
- Do you think you could be pregnant today? ☐ **Yes** ☐ **No**
- What is your current birth control? _____ Are you happy with it? ☐ **Yes** ☐ **No**

Pregnancy History

- Do you have other children? Yes or No If yes please fill out the table below.
- Have you ever had any prior pregnancies that did not result in a live birth? **Yes or No**
  If yes year and outcome: _____
- Any pregnancy complications such as Gestational Diabetes, High Blood Pressure, Low or High Fluid, Pre-eclampsia, Eclampsia, Pre-term labor, Short Cervix, Premature rupture of Membranes? **Please state any pregnancy complications**
  _____
  _____

Date of Birth	Weeks Delivered	Male or Female	Vaginal or C-Section	Epidural	Hospital Delivered	Birth Weight	Complications
		--		--			
		--		--			
		--		--			
		--		--			
		--		--			
		--		--			

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Social History

- Do you drink alcohol/or use recreational drugs currently? ☐ **Yes** ☐ **No**
- How often? _____ How many drinks per setting? ☐ **1-2 drinks** ☐ **3-4 drinks** ☐ **5 or more**
- Have you ever had difficulties in your life because of alcohol, prescription drugs, and or recreational drugs? ☐ **Yes** ☐ **No**
- Has your partner or parents ever had any alcohol or drug abuse (current or past)? ☐ **Yes** ☐ **No** If yes please elaborate:_____
- Do you currently use any recreational drugs? ☐ **Yes** ☐ **No**
  - If yes, what and how often? _____
- Do you or have you ever smoked cigarettes? ☐ **YES** ☐ **No**
  - If yes how much how often?_____
  - Did you quit? ☐ **Yes** ☐ **No** When? _____

Are you a vegetarian? ☐ **YES** ☐ **No** Do you eat eggs? ☐ **Yes** ☐ **No**
Do you eat dairy products? ☐ **Yes** ☐ **NO** Are you married? ☐ **YES** ☐ **NO** **What is your partners name?** _____ What do you do for work?_____

Past Medical History

Do you have any past medical history that is relevant? (Including pregnancy)

	Yes	No		Yes	No		Yes	No
Allergies			Genital Warts			Malformation		
Abnormal Pap			Hearing Loss			Anxiety/Depression		
AIDs/HIV			Diabetes			Mental Illness		
Anemia			Migraine/Headaches			Neurological disorders		
Angina			Emphysema			Kidney Problems		
Asthma			Epilepsy/Seizures			Liver Problems		
Back pain			Gallbladder problems			Pneumonia		
Bleeding/Coagulation			Glaucoma			Rheumatic fever		
Blindness			Gout			Sinus Problems		
Blood Clots			Heart Problems			Stomach ulcers		
Blood Transfusions			Heart Murmurs			Stroke		
Cancer			Hepatitis			Thyroid problems		
Cataracts			HIV positive			Tuberculosis		
Cholesterol Problems			High Blood Pressure			STD		
Colitis			Urinary Infections			Alcohol/Drug		

Surgical History

Have you ever had any of the following operations?

Surgery	Yes	No	Year	Surgery	Yes	No	Year
Appendix				Removal of Ovaries/Ovary			
Back				Stomach			
Breast				Thyroid			
Cataract				Tonsils and Adenoids			
Heart Bypass				Tubal Ligation/sterilization			

Gallbladder				Hernia			
Hysterectomy				C-Section			
Hemorrhoid				Wisdom Teeth Extraction			
Other surgery: (Please include type and year)							

Family Medical History

Family Member	Health Problem	If deceased, cause and age
Mother		
Father		
Sibling		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Other: _____		

Family Medical History (continued)

- It is important in terms of genetics to know your ethnicity as some genetic conditions run a higher probability with certain ethnicities. (Asian, Jewish, Black, French Canadian/Cajun, Mediterranean. Etc.)
  What is your ethnicity? _____
- Has anyone in your family **(other than listed above)** ever been diagnosed with Diabetes, High Blood Pressure, Cancer (What type?), Asthma, or any other diseases or disorders? **Yes, or No If yes who and what disease?** _____
  _____
- Has anyone in your family, including yourself or partner ever been born with any congenital abnormalities or defects including heart defects, cleft palate, etc.?
  If yes who and what disease? _____
  _____

Allergies

Are you allergic to **medications? YES or NO (**Please list medication and reaction below)

Medication	Reaction

Do you have anything else you are allergic to? (**Food or otherwise**)

Allergen	Reaction

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Medications (Please list all your medication including vitamins)

Medication	Dosage (mg, mcg, etc)	Frequency (how often)	Condition treated

Gynecologic History

- When was your last pap? _____
- Was it normal? **Yes or No** --
  If no what was the result? _____
- Have you ever had an abnormal PAP? **Yes or No** --
  What were the results? _____

Infection and Vaccination History

- Have you ever had the chicken pox? **Yes or No** --
- Did you get the flu shot this year**? Yes or No** --
  If yes what month? _____
- Have you ever been diagnosed with HPV? **Yes or No** --
  Have you ever had the HPV vaccine? **Yes or No** --
- Have you ever been diagnosed with an STD? (Herpes, Gonorrhea, Chlamydia, Pelvic Inflammatory Disease) **Yes or No** -- If yes, please when and how were you treated?
  _____
- Do you have any cats at home? **Yes or No** --
- If yes are they indoor only? **Yes or N** --