Eastside OB/GYN

Registration form

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: _____ 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)

_____ _____

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 OB 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 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 $350. Please check with your insurance company regarding coverage for your newborn.

7. We do require 24 hours' notice for cancelling 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: _____ 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: _____

Date of Signature: _____

Eastside OB/GYN

PLEASE FILL OUT COMPLETELY AND RETURN NO LESS THAN 3 DAYS PRIOR TO APPOINTMENT

Email: admin@eastsideob.com *** Fax 425-899-5006 ***

Mail: 12303 NE 130th Ln, Suite #230, Kirkland, WA 98034

OB 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**

Did you take a home pregnancy test that was positive? **YES NO**

Have you ever been treated for infertility? **Yes or No**

If yes when and how long and what treatments? _____

Pregnancy History

What was your pre-pregnancy weight? _____ How tall are you? _____

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
		M or F		Yes or No			
		M or F		Yes or No			
		M or F		Yes or No			
		M or F		Yes or No			

***If you have had a c-section would you like a: **Repeat C-Section or TOLAC/VBAC**

What pregnancy symptoms have you had since your last menstrual period?

Symptom	Yes	No	**Symptom**	Yes	No
Breast Tenderness			Vomiting		
Nausea			Headache		
Vaginal Spotting					
Vaginal Bleeding YES or NO If yes, how many times and when did it start					
Any other symptoms not listed…					

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Social History

Do you drink alcohol currently? **Yes or No** Did you drink alcohol prior to pregnancy? **YES or 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 or No**
Has your partner or parents ever had any alcohol or drug abuse (current or past)? **Yes or No** If yes please elaborate:_____
Do you or have you ever smoked cigarettes? **YES or No** If yes how much how often?_____
Did you quit? **Yes or No** When? _____
Are you a vegetarian? **YES or No** Do you eat eggs? **Yes or No** Do you eat dairy products? **Yes or NO**
Are you married? **YES or NO** **What is your partner's 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					

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)							

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Family Medical History

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

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? _____

_____

Family History and Genetic Screening

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)
What is your ethnicity? _____
What is the ethnicity of the baby's father? _____

Have you or the baby's father ever been born with a birth defect? **Yes or No**

Have you of the baby's father ever had any CHILDREN born with a defect? **Yes or No**

If yes, what condition and who? _____

_____

Have you or the baby's father ever had any genetic screening done? **Yes,or No**

If yes, what testing and results? _____

_____

Are you interested in genetic screening and down syndrome risk assessment that also includes screening for other chromosomal disorders? **Yes or No**

Is there a history of twins in either family? **Yes or No**

If yes who? _____

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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

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 No**

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Obstetrical Fees

OB Fees:

Global Vaginal Fee: $4,000.00

Global C-section Fee: $4,200.00

These global fees include all of your prenatal check up visits, the delivery fee and your postpartum visit. The first visit with your Doctor is a history and physical and is NOT included in the global fee. If your postpartum visit is later than 6 weeks after your delivery, it is not part of the global fee and you may be billed separately.

Please be aware that the hospital has separate fees from us. Please contact them directly for information regarding their charges at 425-899-1000.

Additional Fees:

Ultrasounds, NSTs (Non-stress tests) and lab work are NOT included in your global OB care. They are billed out immediately after your visit.

After your insurance processes your claim you may be left with a balance. If you have a balance owing, we will send a statement to you in the mail.

If you had lab work done, you may also receive a statement from the lab. You will want to contact them directly with any billing questions.

We like you to have a screening ultrasound done when you are 20 weeks pregnant. Any additional ultrasounds require a medically necessary reason.

We will contact your insurance company regarding your benefits and will notify you in writing what your benefits are. We encourage you to also verify your OB benefits.

Thank you for choosing our office for your care.

Tricefy™

☐ I authorize the sending of images during my pregnancy.

☐ I have read, understand, and agree to this disclaimer.

☐ I will have access to my images for 30 days from exam date.

<u>Please choose one of the following:</u>

☐ I want my ultrasound images delivered digitally as an email.
Email Address: _____

☐ I want my ultrasound images delivered to me via text message.
Mobile Phone Number: _____

Please download and store your images on your computer or other device since they will be removed from the server at the end of 30 days.

Name: _____

Signature: _____ Date: _____

Patient Sticker

Service provided by
Trice

08/2021

Patient Disclaimer and Authorization

Tricefy™ is a communication service licensed to Your Provider. This Disclaimer and Authorization Agreement sets forth the terms and conditions under which you, the undersigned patient authorize Your Provider to transmit your ultrasound examination through Trice Imaging, Inc. to a mobile phone number or email address of your choice. **This Agreement will become effective on the date of your signature and will terminate after all images throughout your current pregnancy are sent to you.**

After you complete and sign this Agreement, a mobile telephone number or email address you designate will be entered into our ultrasound system and re-verified with you. When your ultrasound screening is complete, in accordance with Your Provider policies and procedures, the sonographer will trigger the ultrasound machine to send an encrypted copy of your examination to the Tricefy™ server. The server will reformat and encrypt the file and provide access to the examination through your mobile phone number and a text or email. The Physician will have the discretion to determine whether your ultrasound screening is complete and whether to transmit your images to Tricefy™. The Physician has the right to refuse to transmit or to delay the transmission of your images. Both the text and email message will contain secure links and instructions on how to access the images. Images and videos can be accessed and downloaded to you mobile phone and computer.

Messages and data rates may apply as determined by your mobile service provider. Transmission of the images through Trice Imaging, Inc. is not a medical service. The transmitted images are not considered diagnostic medical images and are not a part of your medical record; they are not to be used for your health care, diagnosis or treatment. If you want to see your medical records, you need to contact Your Provider, who is responsible for maintaining your medical records. Neither Your Provider nor Trice Imaging, Inc. is responsible for the security of the transmitted images once the text and email recipients you have designated download the images. By directing Your Provider to transmit the images to an email address or telephone number that you specify, you authorize Your Provider and Trice Imaging, Inc. to provide the images to the person who owns or uses the email address or telephone number and any persons who may have access to the telephone number or email address. **We would recommend immediate download of any images, as the link to the images will only be active for a maximum of 30 days.** Trice Imaging, Inc. will not store the images on its server for you.

As a licensee of Tricefy™ through Trice Imaging, Inc., Your Provider is permitted to offer the services under the terms and conditions of the license. This is the sole agreement between Trice Imaging, Inc. and Your Provider.

Service provided by

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Circumcision fee

If you desire a circumcision for your baby boy, you may schedule an appointment with Dr. Tsuang or Dr. Price, here in our office. The procedure needs to be done within 14 days of your delivery.

Not all insurance companies cover circumcisions. They may be considered cosmetic and not medically necessary. If you desire this for your baby, it is your responsibility to verify coverage with your insurance company. If this is not something that your insurance plan covers, the physician fee is $350.00. Payment needs to be paid in cash or credit card before the procedure will be done.

If you have any questions, please give our office a call at 425-899-5000.