

RAMAPO VALLEY OB/GYN - PC

NEW PATIENT MEDICAL HISTORY

Date: ____ / ____ / ____

Patient Name: _____	Age: _____	DOB: _____
Address: _____	Primary MD: _____	
	Referred By: _____	
Occupation: _____	Home Phone: _____	
Marital Status: _____	Work Phone: _____	
Spouse's Name: _____	Emergency Contact: _____	
Children's Name(s) & Age(s): _____	Phone: _____	

REASON FOR TODAY'S VISIT _____

ALLERGIES TO MEDICATIONS, DYES OR OTHER SUBSTANCES ____ NO ____ YES
 (If YES, please list name of medication and type of reaction)

OBSTETRIC & GYNECOLOGIC HISTORY

Age at onset of periods: _____	Frequency: _____	Length of Period: _____
Number of pregnancies: _____	Births: _____	Abortions: _____
Prolonged or abnormal bleeding: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (describe): _____	Miscarriages: _____
Leakage of urine: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (describe): _____	
Pelvic pain: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (describe): _____	
Abnormal discharge: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (describe): _____	
History of abnormal pap smear: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (describe): _____	
Current method of birth control: _____		
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

(Please circle if YOU have had problems with or are presently complaining of any of the following)

1. high blood pressure	10. constipation	19. hepatitis/jaundice	28. anemia
2. diabetes	11. diarrhea	20. thyroid disease	29. alcohol abuse
3. cancer	12. blood in stool	21. headache	30. drug abuse
4. heart disease	13. ulcers	22. kidney disease	31. eating disorder
5. chest pain/tightness	14. abdominal discomfort	23. difficulty urinating	32. eyes
6. frequent urination	15. change in weight	24. blood disorders	33. ears, nose, mouth, throat
7. rheumatic fever	16. hemorrhoids	25. venereal diseases	34. musculoskeletal
8. asthma	17. gall bladder disease	26. anxiety	35. skin
9. change in bowel habits	18. colitis	27. depression	36. other

(PLEASE CONTINUE ON OTHER SIDE OF PAGE)

PATIENT NAME: _____

Date: ____ / ____ / ____

PLEASE LIST & SUPPLY DATES OF:

Operations:	_____		
Other Hospitalizations:	_____		
When was your last:	_____		
Pap Smear?	Breast Exam?	Colonscopy?	
Mammogram?	Cholesterol Check?	Bone Density Test?	

FAMILY HISTORY

(Has any member of your family ever had the following?)

Illness	Which family members?	Age when diagnosed
Cancer: <input type="checkbox"/> No <input type="checkbox"/> Yes (describe type) _____	_____	_____
High blood pressure: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
Heart disease: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
Diabetes: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
Stroke: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
Bleeding diseases: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
Other: _____	_____	_____

MEDICATIONS

(Please list any prescription medicines you take on a regular basis)

<u>Drug Name</u>	<u>Dose</u>	<u>Drug Name</u>	<u>Dose</u>
_____	_____	_____	_____
_____	_____	_____	_____

PREVENTION

Do you smoke cigarettes?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, packs per day: _____
Do you drink alcoholic beverages?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, drinks per week: _____
Do you drink coffee or tea?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, cups per day: _____
Do you use recreational drugs (marijuana, cocaine, crack, etc.)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, list type and frequency: _____
Have you ever engaged in any activity which has put you at risk of getting AIDS?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, explain: _____
Do you wish to be tested for AIDS?	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner?	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Do you ever feel afraid of your partner?	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____

PATIENT SIGNATURE: _____

Date: ____ / ____ / ____

RAMAPO VALLEY OB/GYN PC

PATIENT INFORMATION

Patient #:	Social Security #:
Name:	Date of Birth: Age:
Address:	Marital Status:
City:	Sex: Race:
State: Zip:	Ethnicity:
Home Phone#:	Language:
Cell Phone#:	
Work Phone#:	Emergency Contact:
Employer:	Emergency Phone#:
E-Mail:	Emergency Relationship:

GUARANTOR INFORMATION

Name:	Date of Birth:
Address One:	Social Security#:
Address Two:	
City:	Employer:
State: Zip:	Work Phone#:
Home Phone#:	
Cell Phone#:	

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
ID#:	Certificate#:
Group Number:	Group Number:
Group Name:	Group Name:
Copay:	Copay:
Subscriber Name:	Subscriber Name:
Date of Birth:	Date of Birth:

If Patient is a Medicare Recipient: I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services (CMS) or their intermediaries or carriers, or to the billing agent of this Physician, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I authorize this office to furnish my insurance carriers with any information relevant to my claim, and to make direct payment when accepted.

If Patient is Covered by Health Insurance: I request all payments be made to this Doctor directly for covered services. I agree to pay any amount the Insurance Company did not or will not pay.

Medigap Waiver: I request that payment of authorized Medigap Benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by the provider of service and (or) supplier. I authorize any holder of Medicare information about me to release to my Medigap Insurance _____, any information needed to determine these benefits payable for related services. HIC# _____.

Signed (Patient or Parent if Minor)

Date

Ramapo Valley OB / GYN, P.C.

DIPLOMATES OF THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

Amnon Fein, M.D., F.A.C.O.G.
Michele D'AngeloBatista, M.D., F.A.C.O.G.
Carrie Panoff, D.O., F.A.C.O.G.
Etana Berkowitz, C.N.M., W.H.N.P.-B.C.
Brynne Love, C.N.M.

POMONA PROFESSIONAL PLAZA
974 ROUTE 45
Suite 1000
POMONA, N.Y. 10970
TEL. (845) 354-1113
FAX. (845) 354-1813

SHOP-RITE PLAZA
785 ROUTE 17M
Suite 17
MONROE, N.Y. 10950
TEL. (845) 782-9449
FAX. (845) 783-9553

Date: _____

Patients Name: _____

I consent to examination and treatment by the physician and nursing staff of Ramapo Valley OB/GYN – PC.

I authorize Ramapo Valley OB/GYN – PC to release any and all of my medical Records including but not limited to:

- Records of Office Visits
- Records of Treatments
- X-Ray Reports
- Video Tapes and Photographs

Such records may be released to my attorney, another physician, or any other Health care professional or facility for the purpose of discussing my condition, consulting on my case, or reviewing my medical records.

These records in their entirety regardless of dates of coverage may also be released to any governmental agency, insurance company and employees of insurance companies for the sole purpose of pursuing payment, insurance reimbursement, submission of health insurance claims for services rendered, or performing quality assurance reviews as required by law.

PATIENT'S SIGNATURE

DATE

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PATIENT CONSENTS

PATIENT WAIVER- FINANCIAL CONSENT

By my signature below, I acknowledge I have requested an exam/treatment from Ramapo Valley OB/GYN, P.C. If my insurance company does not provide coverage and reimbursement for such services, I agree to be personally responsible for payment of such services.

MISSED APPOINTMENT

By my signature below, I acknowledge that should I not keep a scheduled appointment and/or not cancel one business day prior to scheduled appointment, I will be charged \$50.00 for a missed Routine/Well-Woman Exam and \$100.00 for any other type of appointment.

I have read and understand the above information.

Signature of Patient

Date

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INSURANCE WAIVER

Dear Patient:

At the time of your visit you are responsible to notify us of your proper insurance information. If you are enrolled in a managed care plan(s) that the practice participates with, you must present your valid insurance card(s) and pay your copay at each visit.

Non-participating insurance plans, require that the patient pay when checking in at each visit.

If your insurance does not provide coverage for your services performed, which could include genetic testing, you will be responsible for the charges incurred.

Most managed care plans require use of in-network labs, radiologists and specialists. Please do not utilize an out of network facility.

Laboratory visits require a requisition form. These will be given to you by your physician after your office visit, or can be obtained from a medical assistant.

Not all insurances cover contraceptive care and well (preventative care) physicals. It is your responsibility to contact your insurance company to verify your particular coverage, and how often you are allowed these types of visits.

Some insurance plans require referrals or authorizations for medical procedures or other types of specialized office visits. If your doctor deems a service as medically necessary, a referral can be obtained from our office. Non-emergency referrals will be accommodated within a 72-hour period, from the date of the request. Failure to obtain a referral will result in the patient being responsible for the charges incurred.

I have read and understand the information that has been provided.

Signature of Patient

Date

RAMAPO VALLEY OB/GYN, P.C.
Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Request for Limitations and Restrictions of Protected Health Information

I, give my permission to speak to the following person(s) regarding my health information:

Name	Phone	Relationship
------	-------	--------------

Name	Phone	Relationship
------	-------	--------------

With my consent, **Ramapo Valley OB/GYN, P.C.** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operation (TPO).

I have the right to review the **Notice of Privacy Practices** prior to signing this consent. **Ramapo Valley OB/GYN, P.C.** reserves the right to revise its' **Notice of Privacy Practices** at any time.

With my consent, **Ramapo Valley OB/GYN, P.C.** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

By signing this form, I am consenting to **Ramapo Valley OB/GYN, P.C.'s** use and disclosure of my PHI to carry out TPO. I am acknowledging that I have received **Ramapo Valley OB/GYN, P.C.'s Notice of Privacy Practices**.

I may revoke my consent in writing except to the extent that the practice had already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Ramapo Valley OB/GYN, P.C.** may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date

Patient's Name (Please Print)

Date

Ramapo Valley OB/GYN, P.C.
974 Route 45, Suite 1000, Pomona, NY 10970
Phone: 845-354-1113/ Fax: 845-354-1813
Web Site www.ramapovalleyobgyn.com

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please allow 7-10 business days for copying. There is a fee of 75 cents per page for copies of medical records. The medical records cannot be released until this form is completed and signed by the patient or legal guardian. *You must complete this form thoroughly.*

PLEASE PRINT

Step I: Patient Name _____ Date of Birth _____

Address _____
Street City State Zip Code

Step II: I hereby authorize Ramapo Valley OB/GYN, P.C:

_____ To release my health information _____ To obtain my health information.

Name of Physician/Medical Facility _____

Address _____
Street City State Zip Code Phone # Fax #

Step III: Information to be released: _____
Date (s)/Condition (s)

_____ Transferring out of the practice Reason: _____
(This section must be completed before records will be released)

_____ 2nd Opinion/will be continuing care with the practice

CONDITIONS OF AUTHORIZATION

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it certified mail, return receipt requested, to the Privacy Officer at the healthcare provider listed above.

Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.

This authorization is valid for 90 days for the release of information as indicated above. Only records from this facility can legally be released. Any records from other physicians must be obtained from them.

Patient Signature & Date

Parent/Guardian Signature & Date

Witness Signature & Date

Physician Signature & Date

Date Copied _____ #Pages Copied _____ Copied By _____

Signature at Pick Up: _____ Mailed: _____ Faxed: _____