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: _____ Miscarriages: _____
Prolonged or abnormal bleeding: ☐ No ☐ Yes (describe): _____
Leakage of urine: ☐ No ☐ Yes (describe): _____
Pelvic pain: ☐ No ☐ Yes (describe): _____
Abnormal discharge: ☐ No ☐ Yes (describe): _____
History of abnormal pap smear: ☐ No ☐ 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? _____ Colonoscopy? _____

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: ☐ No ☐ Yes (describe type)				
High blood pressure:	☐ No	☐ Yes		
Heart disease:	☐ No	☐ Yes		
Diabetes:	☐ No	☐ Yes		
Stroke:	☐ No	☐ Yes		
Bleeding diseases:	☐ No	☐ Yes		
Other:				

MEDICATIONS

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

Drug Name	Dose	Drug Name	Dose

PREVENTION

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

PATIENT SIGNATURE: _____ Date: ____/____/____

hcas11092005

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 my 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 overage 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.

OB QUESTIONNAIRE

Patient Name_____ Patient #_____ Date_____

1. Will you be 35 years or older when the baby is due? Yes____ No____

2. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders?
   - Down syndrome (mongolism) Yes____ No____
   - Other chromosomal abnormality Yes____ No____
   - Neural tube defect, i.e., spina bifida (meningomyelocele or open spinel, anencephaly) Yes____ No____
   - Hemophilia Yes____ No____
   - Muscular dystrophy Yes____ No____
   - Cystic fibrosis Yes____ No____

   If yes, indicate the relationship of the affected person to you or to the baby's father_____

3. Do you or the baby's father have a birth defect? Yes____ No____
   If yes, who has the defect, and what is it? _____

4. In any previous marriages, have you or the baby's father had a child, born dead or alive, with a birth defect not listed in question #2 above? Yes____ No____
   If yes, who had the defect, and what was it? _____

5. Do you or the baby's father have any close relatives with mental retardation? Yes____ No____
   If yes, indicate the relationship of the affected person to your or the baby's father_____
   Indicate the cause, if known_____

6. Do you, or the baby's father or a close relative in either of your families have a birth defect, any familiar disorder, or a chromosomal abnormality not listed above? Yes____ No____
   If yes, indicate the condition and the relationship of the affected person to you or the baby's father_____

   _____

7. In any previous marriages, have you or the baby's father had a stillborn child, or three or more first trimester spontaneous pregnancy losses? Yes____ No____
   Have either of you had a chromosomal study? Yes____ No____
   If yes, indicate who and the results_____

8. If you or the baby's father are of Jewish ancestry, have either of you been screened for a Jewish Panel? Yes____ No____
   If yes, indicate who and the results_____

9. If you or the baby's father are black, have either of you been screened for the sickle cell trait? Yes____ No____
   If yes, indicate who and the results_____

10. If you or the baby's father are of Italian, Greek, Mediterranean, Philippine or Southeast Asian background/ancestry, have either of you been tested for thalassemia? Yes____ No____
    If yes, indicate who and the results_____

11. Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual Period? (include non-prescription drugs) Yes____ No____
    If yes, give name of medication and time taken during pregnancy_____

    _____

12. Do you have any animals (cats, dogs etc.) in your household? Yes____ No____

13. Do you receive routine dental care? Yes____ No____

14. Do you ever feel afraid of your partner? Yes____ No____

15. Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? Yes____ No____

16. Do you feel safe at home? Yes____ No____

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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:_____