

# Shrewsbury Obstetrics and Gynecology, PC

## REGISTRATION FORM

Date: \_\_\_\_\_ \_\_\_\_ David A. Klein, MD  
\_\_\_\_ Nicole K. Manning, NP

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Insurance Subscriber: \_\_\_\_\_ Their Date of Birth: \_\_\_\_\_

Email address: \_\_\_\_\_

Who may we thank for referring you?: \_\_\_\_\_

### Authorization for treatment and promise of payment

I hereby consent for medical treatment by B. Dale Magee, MD or David Klein, MD.  
I hereby understand I am responsible for fees not covered by my insurance

Signature of Patient or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

### Release of information and direct Payment to Physician

I hereby authorize B, Dale Magee, MD or David Klein, MD to release medical information necessary to process my claim to my insurance company for services rendered. I also authorize my insurance company to pay benefits directly to Shrewsbury Obstetrics and Gynecology.

Signature of Patient or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

### Notification of Privacy Practices

I have received a copy of the Notice of Privacy Practices prior to signing this consent. By signing this form, I am consenting to Shrewsbury Ob-Gyn's use and disclosure of my Private Health Information (PHI) to carry out Treatment, Payment & Healthcare Operations (TPO). With my consent, Shrewsbury Ob-Gyn **may call my home or other designated location, mail to my home or other designated location, and call my home or other designated location and leave a message on voice mail or with a person for me to return a call to this office** in reference to any appointment reminders, insurance items and any call pertaining to my clinical care. If I do not sign this consent, Shrewsbury Ob-Gyn may decline to provide treatment to me.

I have the right to request that Shrewsbury Ob-Gyn restrict how it uses or discloses my PHI to carry out TPO, however, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. Shrewsbury Ob-Gyn reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Shrewsbury Ob-Gyn Privacy Officer at 555 Main Street, Shrewsbury, MA 01545.

Signature of Patient or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Patient ID: \_\_\_\_\_

SHREWSBURY OBSTETRICS & GYNECOLOGY, P.C

David A. Klein, MD  
Nicole K. Manning, NP

***Patient Financial Responsibility Disclosure Statement***

Your signature below forms a binding agreement between Shrewsbury OB/Gyn, P.C. and the Patient who is receiving medical services, or the Responsible Party for minor patients. Responsible Party is the individual who is financially responsible for the payment of medical bills.

All charges for services rendered are due and payable at the time of service.

**MEDICAL INSURANCE:** We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for **any reason**.

The person signing on behalf of themselves or the Patient as the Responsible Party must:

- Inform our office with changes to contact information
- Present all **current** insurance cards prior to each visit
- Pay any required co-pay at the time of the visit
- Call your insurance company to find out whether the MD you are seeing is a contracted provider with your health plan and if you have any additional costs such as co-pays, co-insurance and/or deductibles
- Pay any additional amount billed after the services were rendered with in 30 days unless a payment agreement is set up between the Practice & the Responsible Party
- Contact Quest Diagnostics with any lab service fee questions

**SELF PAY PATIENTS:** We offer discounted prices to Patients with out active insurance coverage that pay in full on the date of service. Any lab fees will be applied separately from Quest Diagnostics.

**Non-Payment on the Account will result in collection proceedings.**

By signing below, you agree to accept full financial responsibility as a Patient who is receiving medical services or as the Responsible Party for a minor patient. Your signature verifies that you have read the above disclosure statement, understand your responsibility and agree to the terms.

*Signature of Patient or Responsible Party:* \_\_\_\_\_

*Date:* \_\_\_\_\_

# Shrewsbury Obstetrics and Gynecology, PC

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_ Highest Level of Education: \_\_\_\_\_

Race:  White  Black  Asian  Indian/Alaskan  Pacific Islander  Hispanic-Black  Hispanic-White  Other/Mutiracial

Do you prefer a chaperone for your exams? YES NO Preferred Language: \_\_\_\_\_ Ethnicity: Hispanic OR Non-Hispanic

## MENSTRUAL & PREGNANCY HISTORY

Date of last menstrual period: \_\_\_\_\_ Menses occur every: \_\_\_\_\_ days Menses length: \_\_\_\_\_ days Any bleeding between periods? \_\_\_\_\_ Age of onset of periods: \_\_\_\_\_

### Deliveries

| Year | Hospital | Duration of Preg. | Length of Labor | Type of Delivery | Type of Anesthesia | Weight of Infant | Gender | Problems |
|------|----------|-------------------|-----------------|------------------|--------------------|------------------|--------|----------|
|      |          |                   |                 |                  |                    |                  |        |          |
|      |          |                   |                 |                  |                    |                  |        |          |
|      |          |                   |                 |                  |                    |                  |        |          |

### Miscarriages

| Year | Weeks Pregnant | D&C? |
|------|----------------|------|
|      |                |      |
|      |                |      |

### Abortions

| Year | Weeks Pregnant | Facility |
|------|----------------|----------|
|      |                |          |
|      |                |          |

## PAST MEDICAL HISTORY

|   | N Neg<br>Y Pos | DETAIL POSITIVE REMARKS<br>INCLUDE DATE & TREATMENT |  | N Neg<br>Y Pos | DETAIL POSITIVE REMARKS<br>INCLUDE DATE & TREATMENT |
|---|----------------|---|--|----------------|---|
| Psychiatric Disease/<br>Anxiety/Depression    |                |   | History of Genital Herpes  |                |   |
| Neurologic Disease                            |                |   | Infertility  |                |   |
| Hypertension                                  |                |   | Abnormal Pap Smear   |                |   |
| Heart Disease                                 |                |   | Sexually Transmitted<br>Diseases: Gonorrhea,<br>Chlamydia, HIV or Syphilis                     |                |   |
| Lung Disease                                  |                |   | Uterine Abnormalities  |                |   |
| Breast Disease                                |                |   | Major Injuries   |                |   |
| Kidney Disease/ UTIs                          |                |   | Violence (Domestic)  |                |   |
| Liver Disease/Hepatitis                       |                |   | Complications due to<br>Anesthesia   |                |   |
| Thyroid Disease                               |                |   | History of Relative with<br>Cancer of the Breast,<br>Uterus, Ovary or Colon                    |                |   |
| Diabetes                                      |                |   | History of Female<br>Relative with Heart Attack<br>before age 65 or Male<br>Relative before 55 |                |   |
| Lupus, Rheumatoid<br>Arthritis or Scleroderma |                |   |  |                |   |
| Varicosities/ Phlebitis                       |                |   |  |                |   |
| Bleeding Disorder                             |                |   |  |                |   |
| History of Blood<br>Transfusion               |                |   |  |                |   |
| Exposure to Tuberculosis                      |                |   |  |                |   |

## PROCEDURES AND OPERATIONS

| Year | Procedure or Operation |
|------|------------------------|
|      |                        |
|      |                        |
|      |                        |
|      |                        |

# Shrewsbury Obstetrics and Gynecology, PC

Name: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Husband/Partner's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Husband/Partner's Occupation: \_\_\_\_\_

Husband/Partner's Race:  White  Black  Asian  Indian/Alaskan  Pacific Islander  Hispanic-Black  Hispanic-White  Other/Mutiracial

Ancestral Countries of origin: \_\_\_\_\_ Husband/Partners Ancestral Countries of origin: \_\_\_\_\_

## GENETICS SCREENING & TERATOLOGY COUNSELING

(Includes patient, baby's father or anyone in either family unless where indicated)

|  | N Neg<br>Y Pos | DETAIL POSITIVE REMARKS |  | N Neg<br>Y Pos | DETAIL POSITIVE REMARKS |
|--|----------------|-------------------------|--|----------------|-------------------------|
| Thalassemia (or Italian, Greek, Mediterranean or Asian Descent)      |                |                         | Intellectual Disability/<br>Autism   |                |                         |
| Neural Tube Defect   |                |                         | Any other inherited disorders  |                |                         |
| Congenital Heart Defect  |                |                         | Patient or baby's father with a child with any birth defects not already listed                  |                |                         |
| Down Syndrome  |                |                         | Patient with more than 2 prior miscarriages or a stillbirth                                      |                |                         |
| Tay-Sachs (or Jewish, French Canadian or Cajun Descent)              |                |                         | Family history of fraternal (non-identical) twins  |                |                         |
| Sickle Cell Anemia (or African, Haitian or Central American Descent) |                |                         | Has the patient had a rash or viral illness since her last period?                               |                |                         |
| Muscular Dystrophy   |                |                         | Has the patient had or been vaccinated for the chicken pox?                                      |                |                         |
| Hemophilia   |                |                         | Is the patient Rh sensitized?  |                |                         |
| Cystic Fibrosis  |                |                         | Has the patient had any alcohol since her last period? If so, what kind, how much and how often? |                |                         |
| Huntington's Disease   |                |                         | Does the patient smoke? If so, how much?   |                |                         |
| Phenylketonuria (PKU) or any other metabolic disorders               |                |                         | Does the patient do any street drugs? If so, what kind?  |                |                         |

### DIETARY HISTORY

|  |  |                                      |  |
|--|--|--------------------------------------|--|
| Are you a vegetarian?                              |  | Do you consume dairy products daily? |  |
| How many caffeinated beverages do you drink a day? |  | Do you regularly use laxatives?      |  |
| Are you on a special diet? If so, what kind?       |  |                                      |  |

### MEDICATIONS AND ALLERGIES

|  |  |
|--|--|
| Please list the name and dosage of any medications that you are currently taking     |  |
| Please list any vitamins, herbs or dietary supplements that you are currently taking |  |
| Do you have any known allergies? If so, please list.                                 |  |

### SOCIAL & ENVIRONMENTAL FACTORS

|  |  |  |  |
|--|--|--|--|
| Do you or other members of your household ever go to bed hungry? |  | Do you do more than 3 hours a day of repetitive bending/lifting at work? |  |
| Will you be moving during this pregnancy?                        |  | Do you work over 50 hours per week?                                      |  |
| Do you feel safe where you live?                                 |  | Do you feel that you are under a lot of stress?                          |  |

Signature

Date