Comprehensive Women's Care

Obstetrics & Gynecology - Dr. Keith J. Reisler

Diplomate of the American Board of Obstetrics and Gynecology

REGISTRATION FORM

Legal Name: ________________ Preferred Name: ________________

DOB: ________________ Marital Status: ❒ Single ❒ Married ❒ Separated ❒ Divorced

SS#: ________________ DL#: ________________ Email: ________________

Address: ________________ Home Phone: ________________

City: ________________ State: ________________ ZIP: ________ Mobile Phone: ________________

Employer: ________________ Occupation: ________________

Employer Address: ________________

City: ________________ State: ________________ ZIP: ________ Work Phone: ________________

Referred By: ________________ Primary Care Physician: ________________

Spouse's/Parent Name: ________________

DOB: ________________ SS#: ________________ DL#: ________________

City: ________________ State: ________________ ZIP: ________ Mobile Phone: ________________

Employer: ________________ Occupation: ________________

Employer Address: ________________

City: ________________ State: ________________ ZIP: ________ Work Phone: ________________

Primary Insurance: ________________ Name of Insured: ________________

Address: ________________ DOB: ________________

City: ________________ State: ________________ ZIP: ________ Phone: ________________

ID#/SS#: ________________ Group #: ________________

Secondary Insurance: ________________ Name of Insured: ________________

Address: ________________

City: ________________ State: ________________ ZIP: ________ Phone: ________________

ID#/SS#: ________________ Group #: ________________

In Case of Emergency, Contact: ________________ Relation To You: ________________

City: ________________ State: ________________ ZIP: ________ Phone: ________________

Pharmacy: ________________ Location: ________________ Phone: ________________

I assign all medical/surgical benefits to which I am entitled to attending physician. I authorize the release of medical information necessary to request reimbursement from insurance companies. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. Consent to receive treatment: I hereby authorize the physician to treat myself or if a minor, my daughter, as deemed medically necessary.

Signature: ________________ Date: ________________

PATIENT CONSENT FORM

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I authorize Keith J. Reisler, MD to release and furnish on a confidential and a strict need to know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate payment by third parties for services rendered by Physicians, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's, PPO's, Managed Care Organizations, Indemnity Plans, Medicare/Medicaid or other governmental or third party payers, or any organizations contracting with any of the above entities to perform such functions.

I also give my authorization to have a copy of my medical records delivered to a primary care physician or any other physician that is directly or indirectly responsible for my medical care or the payment thereof.

I also give my authorization for _______________ to talk to the office staff about my financial data and all medical information.

Patient's and/or Guardian Signature: ____

Date: _____/______/_____

* This authorization will remain in effect permanently.*

PATIENT'S RESPONSIBILITY

Signing of this form in no way implies that your insurance company will cover your visits with this office. Keith J. Reisler, MD and his employees cannot guarantee any information given to us by your insurance carrier regarding your benefits.

1. If you are not part of an HMO, PPO, Medicare/Medicaid, or Managed Choice Plan that your physician participates in, you will responsible for your bill at the time of service.

2. If you are part of a PPO plan and you have a deductible for services other than your regular office copay, you will be responsible for payment of said deductible.

3. If you are part of a Managed Choice or HMO plan, failure to obtain a valid referral from your Primary Care Physician (PCP) may result in no benefits being paid. You will be responsible for any non-payment from your insurance carrier.

Patient's and/or Guardian Signature: ____

Date: _____/______/_____

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PATIENT MEDICAL HISTORY AND CONSENT FORM

Patient Name ____ Date of Visit ____/_____/_____

Age ______ Weight __________ lbs ________ kg Height ________ ft/in

Reason(s) for today's visit:

____

____

____

GYNECOLOGICAL HISTORY

Age of first period ______ Periods are ❒ regular ❒ irregular ❒ painful ❒ not bothersome

Age of last period ______ Menstrual flow is ❒ light ❒ moderate ❒ heavy ❒ very heavy

❒ Change tampon or pad every ______ hours

Usual cycle length ______ days, lasting ______ days

First day of last menstrual period ____/____/_____

Date of last pap smear ______/_____/______ ❒ normal ❒ abnormal findings ______________

Are you sexually active? ❒ yes ❒ no ❒ virginal

Method of Birth Control: ❒ condoms ❒ birth control pill ❒ patch ❒ vaginal ring

❒ tubal ligation / Essure® birth control ❒ IUD- intrauterine device

❒ natural family planning ❒ partner with vasectomy ❒ other

❒ I am considering pregnancy in the future. Please complete a **Prenatal Questionnaire**.

PREGNANCY HISTORY

Total # Pregnancies ______ = Full Term _____ + Premature _____ + Miscarriages _____ + Abortions _____

Child	Date	Type of Delivery Cesarean Vaginal	Name of Child	Boy or Girl	Birth Weight	Length of Pregnancy (weeks gestation)	Complications Premature, Miscarriage, Abortion, Gestational Diabetes, Pre-eclampsia-High Blood Pressure
1st							
2nd							
3rd							
4th							
5th							

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PAST MEDICAL HISTORY (Please check the relevant conditions below and explain here if necessary)

____

____

____

____

____

Smoking History: ___ PPD x ____ years ❒ Quit ___/___/______ Alcohol Consumption: ____________________________

Medical Problem	Current	Past	Medical Problem	Current	Past
Severe Headaches			Ovarian Disease		
Migraine Headaches			Endometriosis		
Seizures			Pelvic inflammatory Disease		
Vision			Infertility		
Ear Nose Throat			Venereal Disease		
Thyroid			Genital Herpes		
Asthma			Chlamydia		
Shortness of Breath			Gonorrhea		
Coughing Blood			HPV or condyloma		
Chest Pain			Pelvic pain		
Abnormal Heartbeat			Abnormal periods		
Heart Murmur			Loss of Urine		
Mitral Valve Prolapse			Urinary Tract Infection		
Rheumatic Fever			Pain With Intercourse		
Other Heart Disease			Bleeding Disorder		
Breast Disease			Unusual Bruising		
Intestinal Tract Disease			Birth Defect		
Hepatitis			Genetic Disease		
Mononucleosis			Cancer		
Blood in Stool			Excessive Weight Loss/Gain		
Vulvar Disease			Hypertension		
DES Exposure			Diabetes		
Abnormal Pap Smear			Anemia		
Uterine Disease			Psychiatric		
Fallopian Tube Disease			Alcohol or Drug Abuse		
Other			Blood Transfusion		

PAST SURGICAL HISTORY AND HOSPITALIZATIONS

Year	Hospital	Diagnosis	Treatment or Surgery

MEDICATIONS	Dosage

DRUG ALLERGIES OR REACTIONS (Please list sign/symptoms) ❐ None

FAMILY MEDICAL HISTORY Please list details of family members with:

Disease	Family Member	Disease	Family Member
Breast cancer		Hypertension	
Ovarian cancer		Diabetes	
Uterine cancer		Heart Attack/MI	
Colon cancer		Bypass Surgery	
Leukemia		Stroke	
≥ 3 Miscarriages		Kidney Disease	
Bleeding disorders		Genetic Disease	
Anemia other than iron deficiency		Birth Defect	

Other family diseases: ____________________

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Prenatal Questionnaire

(To be completed if pregnant or planning pregnancy in the future)

1. Have you ever had a miscarriage? ❒ **Yes** ❒ **No**

2. Have you had a stillbirth? ❒ **Yes** ❒ **No**

3. Have any of your children died? ❒ **Yes** ❒ **No**

4. If your baby's father has had children by another woman/other women, did she/they have miscarriages, stillbirths, children who died, children with birth defects or children who are mentally retarded? ❒ **Yes** ❒ **No**

5. Will you be 35 or older when your baby is due? ❒ **Yes** ❒ **No**

6. Are you and the baby's father **related** to each other? (e.g. first cousins, second cousins) ❒ **Yes** ❒ **No**

7. Do you, the baby's father, or any close relatives on either side have a **genetic disease**? Please circle: Down syndrome, spina bifida (open spine), hemophilia, muscular dystrophy, cystic fibrosis, or mental retardation, Tay Sachs disease, Canavan's Disease (aspartoacylase deficiency or aminoacylase 2 deficiency), or other ______________________?
   ❒ **Yes** ❒ **No**

8. Have you or the baby's father, or any close relatives, had a **child born** dead or alive with a birth defect or genetic condition or inherited disorder not listed in question 7 above?
   ❒ **Yes** ❒ **No**

9. Is there any condition, disease, disorder, or birth defect that is "genetic", "inherited", or "runs" in your family or in the family of the baby's father? ❒ **Yes** ❒ **No**

10. People of certain backgrounds are at increased risk for certain medical conditions. Are you or the baby's father from any of the following backgrounds: Jewish, Cajun or French Canadian, Irish, African American, Asian, Mediterranean (Greek, Italian, Turkish)? ❒ **Yes** ❒ **No**

11. Have you or the baby's father been screened for any of the following disorders: Tay Sachs Disease Cystic Fibrosis Sickle Cell Thalassemia? ❒ **Yes** ❒ **No**

12. Do you drink alcohol? ❒ **Yes** ❒ **No**

13. Do you smoke? ❒ **Yes** ❒ **No**

14. Do you presently take any medications (prescription, non-prescription, vitamins, or herbal supplements? ❒ **Yes** ❒ **No** Please list:

____

____

____

Prenatal Questionnaire

(To be completed if pregnant or planning pregnancy in the future)

15. Are you taking or have you taken Accutane or Vitamin A in high doses? ❐ **Yes** ❐ **No**

16. Have you used or are you now using any street drugs (for example, cocaine, marijuana, crack, speed)? ❐ **Yes** ❐ **No** If so, please list these:

17. Are you on any special diets? ❐ **Yes** ❐ **No**

18. Have you been exposed to x-rays or chemicals (at work or at home)? ❐ **Yes** ❐ **No**

19. If you are pregnant now have you had a fever of 103°F or greater at any time during the first three months of your pregnancy? ❐ **Yes** ❐ **No**

20. Have you or the baby's father ever had Herpes? ❐ **Yes** ❐ **No**

21. Have you or the baby’s father ever had hepatitis? ❐ **Yes** ❐ **No**

22. Do you have pets at home? ❐ **Yes** ❐ **No** If so, please list:

23. Do you eat raw or uncooked meat? ❐ **Yes** ❐ **No**

24. Testing for the **AIDS virus** is recommended for women who:

    a. have used drugs intravenously (injected themselves with drugs).
    b. were born in Haiti or Central Africa.
    c. have received a blood transfusion.
    d. are or have been sexual partners of IV drug abusers, homosexuals, bisexuals, men with hemophilia, men born in Haiti or Central Africa, men with AIDS or AIDS-like symptoms.

    Do you belong to any of the above groups? ❐ **Yes** ❐ **No**

25. Is your baby's father healthy? ❐ **Yes** ❐ **No**

26. Does your baby's father take any medications/drugs regularly? ❐ **Yes** ❐ **No**

27. Has your baby's father been exposed to x-rays, chemicals? ❐ **Yes** ❐ **No**

28. How old is your baby's father? _________

Is there anything that we need to know about you that has not been covered on this questionnaire?

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PATIENT RECORD OF DISCLOSURES

In general, the **HIPAA privacy rule** gives individuals the right to request a restriction on uses and disclosures of their **protected health information** (**PHI**).The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

❒ Home Telephone: ______________________________
- ❒ O.K. to leave message with detailed information
- ❒ Leave message with call-back number only

❒ Work Telephone: ______________________________
- ❒ O.K. to leave message with detailed information
- ❒ Leave message with call-back number only

❒ Written Communication
- ❒ O.K. to mail to my home address
- ❒ O.K. to mail to my work/office address
- ❒ O.K. to fax to this number

❒ Other: ________________________________

Patient's and/or Guardian Signature: ________________________________ Date: _____/______/______

Print Name: ____ Birthdate: _____/______/______

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose.These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed property, will constitute an adequate record.

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax Number	1	Description of Disclosure/ Purpose of Disclosure	Disclosed by Whom	2	3

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records: P-Payment Information;O:Healthcare Operations
(3) Enter how disclosure was made:F=Fax; P=Phone; E-Email; M=Mail; O=Other

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payers, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof. We may use or disclose your protected health information in an emergency treatment situation.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization, unless permitted or required by law. You may revoke your authorization at any time. Our office is collectively the sole owner and user of the information collected from the patient's.

You may request restrictions on certain uses and disclosures in writing. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to a copy of your medical information to inspect and request in writing an amendment of your protected health information. You may also request an accounting of disclosures of your protected health information from this office. Requests to view medical and billing records must be in writing.

We are legally obligated to maintain the privacy of your protected health, information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information at any time. The new notice will be effective for all protected health information that we maintain at that time.

You may register a complaint with the office manager for your physician (see below) if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services. Their address and telephone number are posted by our check out receptionists.

You may speak with the Office Manager to obtain additional information regarding any questions you may have concerning this Notice or to receive a copy of the Notice. This Notice of Privacy Practices is effective as of April 14, 2003.

Patient's and/or Guardian Signature: ____

Date: _____/______/_____

This Notice of Privacy Practice will remain in effect forever.

Office Manager
Sandy 972-985-9684 ext 260