Mount Sinai Faculty Practice Associates
Department of Obstetrics, Gynecology and Reproductive Sciences
New Patient History

Last Name	First Name	Birth Date	Age
Reason for Visit:			

Gynecological/Obstetrical History

Last Menstrual Period	Last Pap	Have you ever had an abnormal Pap? (please explain)
Present Method of Birth Control:		
Have you ever had a sexually transmitted disease?		

	Number		Number		Number
Pregnancies		Terminations		Miscarriages	
Any obstetrical complications?					

Do you have history of genetic illness?
Please list any allergies to medications/substances:

Please list any current medications:
Do you have a family history of the following : Breast Cancer_____ Ovarian Cancer _____ Uterine Cancer _____ Colon Cancer _____
If applicable, when was the last of these test performed :
Mammography: Year _____ Colonoscopy: Year _____ Dexa Scan: Year _____

Social History

	Yes	No	
Alcohol Use			Number of drinks per week:
Cigarettes			Packs per day:
Drugs			

Patient Signature	Date
Physician Signature	Date

Patient Financial Information and Acknowledgement

Last Name: _____ First Name _____ DOB_____

Subscriber Information (If other than patient)

Subscriber Name: _____ ID#_____ DOB_____

As a member covered under_____ Insurance Company, I understand and agree to the following terms and conditions:

- For diagnostic, consultation, office visits and/ or procedures, a referral and/ or authorizations from my insurance company may be required. I acknowledge it is my responsibility to get any referral/ authorization needed for services from my insurance company.
- For any services that are considered non-covered by my insurance company, I agree to be financially responsible for any charges incurred for these services
- I understand that I will be responsible for all fees for this visit or any other services that predate my insurance coverage
- I understand that I am responsible to pay my co-payment, in-network deductible and coinsurance for any in-network visits.
- If the provider I am seeing is out of network, I understand that I am ultimately responsible for any deductibles, co-insurance and/ or payment due balances. It is my responsibility to resolve any billing issues that may arise if my insurance company is billed for services.

_____ _____

Patient/ Subscriber Signature Date

_____ _____

Employee Name (Witness) Date

For Self Pay Patients: The policy of the Department of Obstetrics, Gynecology and Reproductive Science requires a deposit prior to the physician rending services.

Please give us permission to charge your credit card

Type of card: ____ Visa, _____ MasterCard _____Amex ____ Discover

Card Number_____Expiration Date_____

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NOPP)

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospitals and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information

_____
Patient Name

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative Authority

I was not able to obtain the patient's acknowledgement of receipt of the NOPP upon registration because:

- ☐ The patient refused to sign despite good faith efforts
- ☐ The patient was unaccompanied and not alert and oriented
- ☐ The patient was unaccompanied and needed emergency care
- ☐ Other, (explain): _____

Employee Signature: _____ Employee Title: _____

Print Name: _____ _____ Date: _____

☐ Acknowledgement subsequently obtained, (see above).

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CONSENT FOR COMMUNICATION VIA E-MAIL... (Provider-Patient)

I, _____, herby consent to have my physician, _____, communicate with me or members of his staff, where appropriate or other physicians, nurse practitioners and pharmacists via e-mail regarding the following aspects of my medical care and treatment: [test results, prescriptions, appointments, billing, etc.]. I understand that e-mail is not a confidential method of communication. I further understand that there are risks that e-mail communications between my physician and me or members of my physician's office staff or between my physician and other physicians, nurse practitioners and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between my physician and me or members of his office staff or between my physician and other physicians, nurse practitioners or pharmacists regarding my medical care and treatment will be printed out and made a part of my medical record. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail.

Signature: _____ Date: _____

Email Address: _____