OB GYN Associates
2769 Heartland Drive, Suite 201
Coralville, IA 52241

Account #________________

Request for Confidential Communication of Protected Health Information

Patient Information:

Legal Name:________________________________ Preferred Name:____________________ DOB:______________

Mailing Address:____

City/State/Zip:____

Race	Ethnicity
☐ White ☐ Asian ☐ Other	☐ Hispanic/Latino
☐ Black/African American	☐ Not Hispanic/Latino
☐ American Indian/Alaskan Native	☐ Declined
☐ Native Hawaiian/Pacific Islander	
☐ Declined	

SSN:______________________________

		Primary Number
Cell Phone:	______________________	☐
Home Phone:	______________________	☐
Work Phone:	______________________	☐

Email: ____

Financially Responsible/Statement Recipient: (if minor, must list parent/guardian)

Name:____ Relationship to Patient:_________________________

Mailing Address: ____

City/State/Zip:____

If we are contacted by someone that you know personally (example: parent, spouse, friend), may we release information to them? (Please select only one option.) If minor, must include parent/guardian for Financial information

☐ No, I prefer no information is released.
☐ Yes, information can be given to the contact below:

Name: ____

Relationship: ______________________________________ Phone: __________________

Information to be released to alternate contact (please check any that apply):

☐ Medical information (including but not limited to information about STDS, pregnancy, and birth control)
☐ Appointment dates/times
☐ Financial information about my account
☐ Other (please specify):____

Emergency Contact (Please select only one option):

☐ Please use the contact person I provided above as my emergency contact.
☐ The following person may be contacted in case of an emergency:

Name: ____

Relationship to Patient: ______________________________ Phone: __________________

I understand this authorization will remain in effect until I revoke or change it. I may do this at any time by contacting OB GYN Associates in writing.

Patient Signature: ____ Date: ____________________

Office use only:

_______Employee Initials

☐ PBM Consent ☐ Photo ☐ Changes updated in GW ☐ Portal Invite ☐ Copay Flag

Revised 7/2020

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Patient Acknowledgement and Consent

Welcome to OB GYN Associates of Iowa City and Coralville! We are committed to providing you with the best possible health care. The following information is provided to ensure you are aware and understand our policies.

Patient Liability We encourage you to become familiar with your health insurance plan. Each carrier has specific guidelines regarding coverage and benefits. It is **your** responsibility to understand the guidelines set by your insurance carrier. If you have benefit or coverage questions, please contact your insurance company directly. As a courtesy to our patients, we verify benefits for certain procedures. **A quote of benefits is not a guarantee of benefits or payment.** Your claim will process according to your plan. If a discrepancy exists between the benefits quoted and final payment of the claim, the terms of your insurance plan will override. We recommend you also contact your insurance carrier to check benefits.

Insurance Information We require complete and accurate insurance information in order to bill your insurance. If accurate information is not given to OB GYN Associates, the patient will be responsible for any balance. In accordance with your insurance contract, payment is required at time of service.

Appointment No-Show/Cancellation When cancelling an appointment, we require advance notice of 24-hours. If the appointment is not cancelled 24-hours in advance or you do not show up for a scheduled appointment, after **three late cancels or no-shows**, you will be charged a $25.00 no-show/late cancellation fee. This fee is not billable to your insurance and you will be responsible for the balance due. We reserve the right to discharge patients from OB GYN Associates for habitual abuse of this policy.

Returned Checks The charge for a returned check is $25.00. This charge is not billable to your insurance and you will be responsible for the balance due.

Minors A parent or legal guardian must sign the Patient Acknowledgement and Consent form. The parent or legal guardian that accompanies the minor patient to the clinic will be responsible for any payment as outlined above. It is the responsibility of the parent or legal guardian to forward any bills to other responsible parties.

Self-Pay Patients (No Insurance) Payment is due in full prior to services being rendered. If you are unable to pay at the time of your visit, your appointment will be cancelled and rescheduled at a time when payment can be made.

Collections If we have not received a payment on your account after sending 3 statements and no effort is made to make alternative payment arrangements with OB GYN Associates, your account may be turned over to an outside collection agency. This balance must be paid in full in order to continue your care with OB GYN Associates.

I hereby authorize OB GYN Associates to release necessary medical information to my insurance carrier to process all claims and hereby assign to OB GYN Associates all payments for medical services rendered. I understand I am responsible for all amounts not covered by insurance. I further understand that copays and coinsurance are due at the time of service.

I have been offered a copy of the Notice of the Privacy Practices of OB GYN Associates. OB GYN Associates reserves the right to modify the privacy practices outlined in the Notice of Privacy Practices.

I understand OB GYN Associates uses electronic prescribing. My prescriptions will be sent and my medication information may be obtained through OB GYN Associates electronic prescribing functionality.

I understand OB GYN Associates will report any vaccines administered throughout my care to IRIS (Immunization Registry Information System).

Patient Signature:____Date:_____________________
(Legal Guardian/Patient Representative - required if patient is minor or adult unable to sign)
Legal Guardian Address: ____

____

Relationship to Patient: ____

Revised 7/2020

OB GYN Associates

Patient Health History

Office Use Only:
Ht. ________ Wt. __________
BP ________ Pulse __________
Gardasil _Y or N_ Dexa__________
Pap _______ Labs __________
Mam ______ Colo __________

Today's Date ____________ Preferred Pharmacy ______________________________
Name ____
Date of Birth ____________ Age_________ Partner's Name _____________________
Reason for Visit ____
Employer __________________________________ Referred By ______________________________

CURRENT BIRTH CONTROL ☐ Pills ☐ Condoms ☐ IUD ☐ Tubal Ligation ☐ Vasectomy ☐ Nexplanon ☐ Depo ☐ Other ____________________

RELATIONSHIP STATUS:
☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Domestic - Partnership

MENSTRUAL HISTORY: 1st Day of Last Period __________________ ☐ Postmenopausal
# of days between periods _______________ Length of period_____________ ☐ Hysterectomy

PREGNANCY HISTORY

# of pregnancies	# of full term births	# of premature births	# of miscarriages	# of induced abortions	# of living children

BELOW DETAILS NOT NEEDED IF NO FUTURE PREGNANCIES ARE PLANNED

Born M/D/Y	# of wks pregnant	Hrs in labor	Birth weight	Baby's sex	Type of Delivery	Pain medication	Complications	Baby's Name

CURRENT MEDICATIONS (Prescription & over the counter, i.e. vitamins, etc.)
____
____

MEDICATION ALLERGIES or **NONE**
____
____
____

GYN HISTORY

Birth Control Method______________________________
Are you satisfied with your birth control? ☐ Yes ☐ No
Date of last pap smear_________________
Have you ever had an abnormal pap? ☐ Yes ☐ No
When? ____________________
Have you ever had a colposcopy or LEEP? ☐ Yes ☐ No
Have you ever had an STD or PID? ☐ Yes ☐ No
Which STD?__________________When? ____________
Are you sexually active? ☐ Yes ☐ No
If YES, with Men ☐ Women ☐ Both Men & Women ☐
Do you have pain with intercourse? ☐ Yes ☐ No
Do you have any urinary problems? ☐ Yes ☐ No
Do you have any breast problems? ☐ Yes ☐ No
Do you have problems with vaginal discharge? ☐ Yes ☐ No
Have you had:
A mammogram? ☐ Yes ☐ No When?________
A bone density scan? ☐ Yes ☐ No When?________
A colonoscopy? ☐ Yes ☐ No When?________
Your cholesterol checked? ☐ Yes ☐ No When?________

PERSONAL MEDICAL HISTORY
☐ No known medical history
☐ High blood pressure
☐ High cholesterol
☐ Heart disease or murmur
☐ Blood clot/Pulm. Embolus
☐ Stroke
☐ Diabetes (what type?)_________
☐ Thyroid problems
☐ Cancer (what type?)__________
☐ Depression/Anxiety
☐ Osteoporosis
☐ Asthma
☐ Migraine
☐ Other ______________[Grab

SUBSTANCE USE
Alcohol ☐ Y ☐ N
Amt______/week
Tobacco
☐ Current every day
☐ Current some days
☐ Never
☐ Former
*Quit Date:*_______
Street Drugs ☐ Y ☐ N

EXERCISE
☐ No
☐ Yes days/week

VACCINES
☐HPV ☐Tetanus
☐Flu ☐MMR

SURGICAL HISTORY
Month/Year Surgery Complications
____
____

FAMILY MEDICAL HISTORY
Please indicate which Relative (M, F, S, B, GMA, GPA, etc.)
☐ No known medical history ________
☐ High blood pressure ________
☐ Heart disease or murmur ________
☐ Blood clot/Pulm. Embolus ________
☐ Stroke ________
☐ Diabetes ________
☐ Cancer (what type?)____________
☐ Other ____________________

To the best of my knowledge, I have answered every question accurately and completely. I will inform my physician of any change in my health history.

____

Patient/Guardian Signature **Date**

FOR OFFICE USE ONLY

Labs	Screening	Dx
Lipid	☐	______
TSH	☐	______
Free T4	☐	______
FSH	☐	______
Glucose	☐	______
CBC	☐	______
CBC w diff	☐	______
CMP	☐	______
BMP	☐	______
Hct	☐	______
Hgb	☐	______
PRL	☐	______
Prog	☐	______
Quant HCG	☐	______
A1C	☐	______
Blood STD	☐	______

Radiology	Screening	Dx
Mammo	☐	______
Dexa	☐	______
Colonoscopy	☐	______
TVUS	☐	______
Breast U/S	☐	______

Pap	Screening	Dx
Pap	☐	______
HPV	☐ Yes ☐ No ☐ Reflex	
GC/Chlam	☐	______
Trich	☐	______

Biopsy	Screening	Dx
Endometrial	☐	______
Cervix	☐	______
Vulvar	☐	______

Injection
- ☐ DMPA
- ☐ Tdap
- ☐ Flu
- ☐ Gardasil

Misc
- ☐ UPT
- ☐ Hemoccult
- ☐ Wet Prep
- ☐ KOH

Cultures
- ☐ Urine
- ☐ Yeast
- ☐ HSV