

# Stanton Gynecology, LLC

REGISTRATION FORM/GCOBII 10012012

(Please Print)		Today's Date: / /	
Patient's last name:		First:	Middle:
Birth date: / /	Age:	Marital status (circle one)	Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name?	
Street address:		P. O. Box:	Email Address:
City:	State:	ZIP Code:	SS#:
Cell Phone:	Home Phone:	Work Phone:	
Occupation:	Employer:		
How did you hear about our office?		<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Internet/Webpage
		<input type="checkbox"/> Other	

## INSURANCE INFORMATION

(Please give your insurance card and photo identification to the receptionist.)

Please indicate primary insurance:			
Insurance ID#:	Group #:	Co-pay: \$	
Subscriber's name:		Subscriber's Birth date: / /	
Subscriber's S.S. #:	Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse
		<input type="checkbox"/> Child	<input type="checkbox"/> Other
Name of secondary insurance:		Subscriber's name:	
Group #:	Policy #:		

## IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):		
Home phone #:	Work phone #:	Relationship:

## AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

May we call you at home?	Yes	No	May we send a yearly recall to your home?	Yes	No
May we leave a message at your home?	Yes	No	May we call you at work?	Yes	No
May we leave a message on your cell?	Yes	No	May we obtain your Medication History?	Yes	No
Health Communication Preferences: (please circle)					
Health Notifications:	Email	Phone	Text Message	Appointments:	Email
					Phone
					Text Message
Announcements:	Email	Phone	Text Message	Billing:	Email
					Phone
					Text Message
You may release / disclose information to:			Please Circle: All Medical Info Limited to: _____		
Name:	Relationship:		Phone:		
Name:	Relationship:		Phone:		
Name:	Relationship:		Phone:		
This Authorization will expire on: _____					

I acknowledge and agree to adhere to the Notice of Privacy Practices as required by federal and state guidelines. I understand I may request and review a copy of these Practices at any time from the office staff. I permit the release of any information, including my medical records that may be requested by my insurance company to process any claims or as I have indicated above.

<i>Patient/Guardian signature</i>	<i>Date</i>
<b>CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION</b>	
<p><b>I have completed this form and certify that I am the patient or duly authorized agent of the patient. I authorize the providers of Stanton Gynecology, LLC to provide medical care and treatment for me. I understand that any overpayment I make will be refunded if the credit amount is over \$19.99. Otherwise, the credit will be held for 18 months for future balances unless a request for refund is received.</b></p> <p><b>I hereby authorize payment of benefits to be made directly to Stanton Gynecology, LLC and/or any of the providers individually. I understand, as the recipient of services, regardless of insurance coverage, that I am ultimately responsible for payment within 30 days of the date of service or statement and billing fees may be assessed.</b></p>	
<i>Patient/Guardian signature</i>	<i>Date</i>
<i>Printed Name:</i>	<i>Relationship:</i>

Dear Patients,

Our medical providers are participating in a government program that encourages the adoption of electronic health records. This technology is supposed to lead to reduced health care costs but it will also improve the quality of your care and our ability to communicate with you, our patients. As part of this program, the government requires us to record the following demographic information about you:

- Preferred language · Race · Ethnicity ·

The U.S. Centers for Disease Control and Prevention (CDC) provides the options for the race and ethnicity fields that match the data collection standards defined by the U.S. Office of Management and Budget (OMB) and the U.S. Bureau of the Census (BC). We maintain secure records and assure you that this information will remain confidential. You can help us by reviewing the list of options below and providing your race and ethnicity information during registration or check-in. If you do not wish to provide this information, you may simply decline.

Thank you for your assistance!

Please identify your Race from the following CDC-defined options:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> African                                   | <input type="checkbox"/> African American | <input type="checkbox"/> Alaska Native             | <input type="checkbox"/> American Indian |
| <input type="checkbox"/> American Indian or Alaska Native          | <input type="checkbox"/> Arab             | <input type="checkbox"/> Bangladeshi               | <input type="checkbox"/> Asian           |
| <input type="checkbox"/> Asian Indian                              | <input type="checkbox"/> Bahamian         | <input type="checkbox"/> Black or African American | <input type="checkbox"/> Barbadian       |
| <input type="checkbox"/> Bhutanese                                 | <input type="checkbox"/> Black            | <input type="checkbox"/> Dominica Islander         | <input type="checkbox"/> Burmese         |
| <input type="checkbox"/> Cambodian                                 | <input type="checkbox"/> Chinese          | <input type="checkbox"/> Haitian                   | <input type="checkbox"/> Dominican       |
| <input type="checkbox"/> European                                  | <input type="checkbox"/> Filipino         | <input type="checkbox"/> Jamaican                  | <input type="checkbox"/> Hmong           |
| <input type="checkbox"/> Indonesian                                | <input type="checkbox"/> Iwo Jiman        | <input type="checkbox"/> Madagascar                | <input type="checkbox"/> Japanese        |
| <input type="checkbox"/> Korean                                    | <input type="checkbox"/> Laotian          | <input type="checkbox"/> Micronesia                | <input type="checkbox"/> Malaysian       |
| <input type="checkbox"/> Maldivian/N African                       | <input type="checkbox"/> Melanesian       | <input type="checkbox"/> Nepalese                  | <input type="checkbox"/> Middle Eastern  |
| <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | <input type="checkbox"/> Pakistani        | <input type="checkbox"/> Polynesian                | <input type="checkbox"/> Okinawan        |
| <input type="checkbox"/> Other Race                                | <input type="checkbox"/> Taiwanese        | <input type="checkbox"/> Thai                      | <input type="checkbox"/> Singaporean     |
| <input type="checkbox"/> Sri Lankan                                | <input type="checkbox"/> Vietnamese       | <input type="checkbox"/> West Indian               | <input type="checkbox"/> Tobagoan        |
| <input type="checkbox"/> Trinidadian                               |   |  | <input type="checkbox"/> White           |

Please identify your Ethnicity from the following CDC-defined options:

- |   |                                   |   |   |
|---|-----------------------------------|---|---|
| <input type="checkbox"/> Central American     | <input type="checkbox"/> Cuban    | <input type="checkbox"/> Dominican              | <input type="checkbox"/> Hispanic or Latino/Spanish |
| <input type="checkbox"/> Latin American/Latin | <input type="checkbox"/> Mexican  | <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> Puerto Rican               |
| <input type="checkbox"/> South American       | <input type="checkbox"/> Spaniard |   |   |