PATIENT REGISTRATION FORM

(Please Print)

Today's date:	Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Name you wish to be called:	Marital status (circle one) Single / Mar / Div / Sep / Widow / Domestic Partner

Home Phone #	Cell Phone #	OK to leave message? ❑ Yes ❑ No	Birth date: / /	Age:	Social Security #:

Street address:	City:	State & Zip:

Email address:	Primary Language:	Race:	Ethnicity

Occupation:	Employer: (If retired please indicate here)	Employer phone no.: ( )

Referred by:	PCP:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Guarantor of Account:	Relationship to patient:	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Primary insurance:		Effective date:			
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Emergency Contact:	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that this is not a guarantee of payment and that I am financially responsible for any balance. I also authorize **Pacific Gynecology and Obstetrics Medical Group** or my insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Pacific Gynecology and Obstetrics Medical Group
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TEL (415) 923-3123
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HIPAA
PRIVACY CONSENT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consents for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding treatment, payment or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you chose to refuse to disclose your Personal Health Information. If you chose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our Privacy Notice (Compliance Assurance Notification to Our Patients), to request restrictions and revoke consent in writing.

_____ _____

Print Name Date

_____

Signature

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ **Date of Birth:** _____

Please mark below if there is a **personal or family history** of any of the following cancers. If yes, then indicate family relationship and **age at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

Example: Colon Cancer *Brother 36 yrs* *Aunt 44 yrs* *Grandfather 65 yrs* *Cousin 58 yrs*

BREAST AND OVARIAN CANCER

			You	Siblings / Children	Mother's Side	Father's Side
Y	N	Breast cancer				
Y	N	Ovarian cancer				
Y	N	Breast cancer in both breasts OR multiple primary breast cancers				
Y	N	Male breast cancer				
Y	N	Are you of Ashkenazi Jewish descent?				

COLON AND UTERINE CANCER

			You	Siblings / Children	Mother's Side	Father's Side
Y	N	Uterine (endometrial) cancer				
Y	N	Colon cancer				
Y	N	Ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer				
Y	N	10 or more colon polyps found in a lifetime				

MELANOMA:

			You	Siblings / Children	Mother's Side	Father's Side
Y	N	Melanoma				
Y	N	Pancreatic Cancer				

OTHER CANCERS

		Type of cancer	You	Siblings / Children	Mother's Side	Father's Side
Y	N					

For Office Use Only:

☐ Patient offered genetic testing: ☐ **ACCEPTED** ☐ **DECLINED**

Patient's Signature: _____ Date: _____

Health Care Provider's Signature: _____ Date: _____

PLEASE BE INFORMED:

It is our policy that all patients must have a signed Arbitration Agreement on file in our office in order to receive any medical services or advice. You will be asked to sign an original Arbitration Agreement form in our office. Please read the following information before your visit.

PATIENT EXPLANATION SHEET

IMPORTANT FACTS ABOUT ARBITRATION

1. The California Legislature specifically authorized the use of arbitration in the Medical field in 1976. The legislation has been upheld by the California Supreme Court.

2. The Arbitration Agreement provides that all disputes arising from the medical treatment you receive will be submitted to arbitration rather than trial by jury.

3. The arbitration process is similar to the court process except that proceedings are more informal, and you and your lawyer participate in the selection of the panel of arbitrators who will decide the case.

4. Arbitration is generally a faster process than a court suit.

5. The arbitration panel has the same power to award monetary damages as a judge or jury. The decision of the arbitrators is final and binding on all parties.

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Please read the Arbitration Agreement completely before signing.