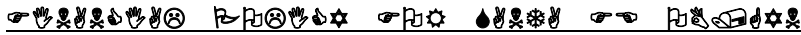


SANTA FE OB/GYN Patient Registration

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

Patient Name	Today's Date	Date of Birth	Sex	Age
Parent if Patient is a Minor				
Patient's Social Security Number		New Mexico Driver's License No.		
Home Address	City	State	Zip	
Mailing Address if Different	City	State	Zip	
Home Telephone Number	Work Telephone Number		Cellular Telephone Number	
Occupation		Employer's Name		
Employer's Address	City	State	Zip	
Spouse Name		Employer		
Other Physician's Name				
Whom May We Thank for Referring You to Our Practice?				
NOTIFY IN CASE OF EMERGENCY				
Name		Relationship		
Address	City	State	Zip	
Home Telephone	Work Telephone		Cell Telephone	
Nearest Relative (not living with your)				
Home Telephone	Work Telephone		Cell Telephone	
FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES				
Name		Telephone		
Address	City	State	Zip	
Insurance Company		Claim Address		
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#.		
Insurance ID No.:				
Secondary Insurance		Claim Address		
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#		

Please Read Our Financial Policy Statement and Agreement on Reverse



We would like to welcome you to our office. We are happy you have chosen us for your medical needs. Our goal is to provide you with the best possible care available and would like your visit to be a pleasant one. In order to meet this goal, we need your assistance and understanding of our patient policies. Our Financial Policy is a necessary part of assuring the financial resources needed to maintain this vital health care facility for our patients.

Insurance Companies

We are here to help answer any questions you may have regarding you insurance coverage and payments; however, your insurance is a contract between you, your employer, and the insurance company. Unless we are a provider with your plan, we are not a party to that contract. Unless we are participants with your plan, you may be responsible for a portion of or all charges.

If we are contracted with your insurance company, we will file your claims directly to your company. If we are not, we will supply you with the form you will need to send to your insurance company for reimbursement. You will be required to pay your bill in full at the time you are seen. Please notify us if we are not contracted with your plan and we will look into becoming a provider for your plan. It is your responsibility to verify that we are covered providers with your insurance company.

Office Visits

Full payment for services is due at the time of your visit. We accept cash, checks, and Visa/Mastercard credit cards. Co-payment and deductible amounts will be collected at the time of your visit. If you are not prepared to pay your co-pay, your visit will be rescheduled. In order to charge on a previously approved account, the account must be currently paid in full or you will be asked to pay at the time service is rendered. Any patient that has had a bill sent for collection must pay any balance owed to the practice before they will be seen in our office.

Surgical Procedures

We will file insurance claims as a courtesy for patients requiring surgery. Surgery deposits are required, and payment is to be made at your pre-op visit. The deposit consists of your deductible (if not met) and your co-payment percentage of the total cost. You should contact the business office prior to your pre-op visit to discuss the amount expected. We will do everything we can to ensure your claim is paid; however, you are the responsible party, and you will be expected to pay any remaining balance.

Obstetrical Care

Payment for OB care is discussed individually. You will meet our OB insurance representative on your first or second visit to review expected charges and payments.

Referral or Authorization

Many Health Maintenance Organizations (HMO's) require that you obtain a referral from your primary care physician (PCP) before you are seen for specialty care. If your PCP has sent you to us to evaluate a problem, we ask that prior to your visit you call our office to confirm that your PCP has provided us with a referral. You will be responsible for any visit not authorized.

Collections

Any patient that has been placed in collections must pay any balance owed to the practice in cash before the practice will see them again.

PRENATAL GENETIC SCREENING QUESTIONNAIRE

Name _____ Date of Birth _____ Date _____

The following questionnaire will help evaluate the health of your unborn baby. Your answers may indicate that certain tests would be appropriate. Please answer all questions as completely as possible. All information will be kept confidential.

1. Will you be 35 or older at your due date? ___ Yes No ___
2. Are you OR the baby's father from any of these ethnic backgrounds? Circle any that apply.
Italian Greek Middle Eastern Spanish Southern China Asian Indian Taiwanese Filipino
Southeast Asia
Yes ___ No ___ Don't know ___
If yes, who was tested and what were the results? _____
3. Have you, the baby's father, or anyone in your families been born with a heart defect?
Yes ___ No ___ Don't know ___
If yes, please write the diagnosis or describe the defect _____
4. Have you, the baby's father, or any relative had a neural tube defect (such as open spine, spina bifida, anencephaly)?
Yes ___ No ___
If yes, please write the diagnosis or describe the defect _____
How is the person related to you or the baby's father? _____
5. Have you, the baby's father, or anyone in your families had a pregnancy or a child diagnosed with Down syndrome?
___ Yes ___ No
If yes, how is this person related to you or the baby's father? _____
- 6/7. Are you, or the baby's father, of Jewish or French Canadian (Eastern Quebec, Cajun) background?
___ Yes ___ No ___ Don't know ___
If yes, have either you or the baby's father been tested to see if you are carriers of Tay-Sachs disease, cystic fibrosis, or Canavan disease?
___ Yes ___ No
If yes, who was tested and what were the results? _____
- 8A. Are you, or the baby's father, African-American or of African descent? ___ Yes ___ No
- 8B. Are you, or the baby's father, of Hispanic descent? ___ Yes ___ No
If yes, to either A or B, have either you, or the baby's father been tested to see if you have sickle cell trait (are a carrier of sickle cell anemia)?
Yes ___ No ___ Don't know ___
If yes, who was tested and what were the results? _____
9. Do you, the baby's father, or anyone in your families have hemophilia or another bleeding disorder?
Yes ___ No ___
If yes, please write the diagnosis or describe the disorder. _____
How is the person related to you or the baby's father? _____
10. Do you, the baby's father, or anyone in your families have a neuromuscular disease or muscular dystrophy?
___ Yes ___ No
If yes, please write the diagnosis or describe the disease. _____
How is the person related to you or the baby's father? _____
11. Do you, the baby's father, or anyone in your families have cystic fibrosis? ___ Yes ___ No
If yes, how is this person related to you or the baby's father? _____
12. Do you, the baby's father or anyone in your families have Huntington's disease?
___ Yes ___ No
If yes, how is this person related to you or the baby's father? _____
13. Do you, the baby's father, or anyone in your families have autism, mental retardation or Fragile X?
___ Yes ___ No
If yes, please write the diagnosis or describe the problem. _____
How is this person related to you or the baby's father? _____
14. Do you, the baby's father, or anyone in your families have an inherited disorder or chromosome

abnormality not listed above? Yes No Don't know

If yes, please write the diagnosis or describe the problem. _____

15. Do you have insulin dependent diabetes, PKU, lupus, or another chronic condition?

Yes No

If yes, please write the diagnosis _____

16. Do you, the baby's father, or anyone in your families have a birth defect not listed above?

Yes No

If yes, please write the diagnosis or describe the defect _____

17. Have you or the baby's father had a stillborn child or two or more pregnancy losses in this or any other relationship? Yes No

If yes, please describe _____

18. Have you taken any medications, recreational drugs, or had any alcoholic drinks since your last menstrual period, or had any rashes or infectious disease?

Yes No

If yes, please describe _____

19. Did you, the baby's father, or anyone in your families have any other serious medical condition in infancy or childhood? Yes No

If yes, please describe _____

How is the person related to you or the baby's father? _____

I have answered these questions to the best of my knowledge _____

Patient signature

Reviewed by: _____

Date: _____

SANTA FE OB/GYN NEW PATIENT HISTORY

NAME _____ **DOB** _____ **DATE** _____

Are you allergic to any medication? ___No ___Yes

Do you have any of the following medical problems?

- ___Diabetes
- ___Heart disease
- ___Arthritis
- ___Thyroid problem
- ___Asthma
- ___History of abnormal pap smear
- ___High Blood Pressure
- ___Personal history of cancer

If yes, type _____

Have you ever had surgery?

___yes ___no

If yes, please list, beginning with most recent below

Date _____ Type of surgery _____

Date _____ Type of surgery _____

Date _____ Type of surgery _____

Do you have any other medical problems not listed above? _____

Family medical history, please think back as far as grandparents, and indicate if on mother's or father's side of your family.

Type of medical problem _____, Family member _____
_____, Family member _____
_____, Family member _____
_____, Family member _____

Do you smoke cigarettes? ___No ___Yes, cigarettes/day

Do you drink alcoholic beverages? ___No ___Yes, drinks/week

Do you use nonprescription drugs such as marijuana, cocaine, heroin, methamphetamine?

___No ___Yes Type and frequency _____

Do you exercise? ___No ___Yes Times per week _____

Are you taking any medications? If yes list below:

Medication	Dose	Prescribing doctor
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently trying to become pregnant? ___No ___Yes

If not what is your birth control method? _____ Please include condoms, tubal ligation or vasectomy.

What was the first day of your last menstrual period _____
Are you having any problems with your periods? ____ Yes ____ No
If yes, what kind of problem? _____

Are you currently sexually active? ____ No ____ Yes
When was your last pap smear? _____
When was your last mammogram? _____ (if >= 35 years old)
If > 50 years old, have you had a colonoscopy? ____ No ____ Yes
If > 50 years old, have you had a bone density test? ____ No ____ Yes

REVIEW OF SYSTEMS

1 Fever, chills, or weight loss? ____ No ____ Yes
2 Hearing loss or ringing or itching of the ears? ____ No ____ Yes
2 blurred or double vision, cataracts or glaucoma? ____ No ____ Yes
3 Nasal congestion or nose bleeds? ____ No ____ Yes
4 Chest pain or palpitations? ____ No ____ Yes
5 Nausea, vomiting diarrhea or abdominal pain? ____ No ____ Yes
6 Urinary frequency, urgency, or pain? ____ No ____ Yes
7 Urinary incontinence or blood in the urine? ____ No ____ Yes
8 Painful or swollen joints? ____ No ____ Yes
9 Headache, loss of consciousness, or seizure? ____ No ____ Yes
10 Signs of depression? ____ No ____ Yes
11 Skin rash or lesion? ____ No ____ Yes
12 Heat or cold intolerance, change to hair or nails ____ No ____ Yes
14 Swollen lymph nodes or easy bruising? ____ No ____ Yes

I HAVE INCLUDED ALL PERTINENT INFORMATION REGARDING MY HEALTH HISTORY ____ no ____ yes

**I HAVE ADDITIONAL HEALTH ISSUES NOT ADDRESSED ON FORM
____ no ____ yes**

SIGNATURE OF PATIENT _____ **DATE** _____
(or parent if patient is a minor)

PLEASE COMPLETE BACK SIDE

Family medical history, please think as far back as grandparents, and indicate if on Mother or Father's side.

Type of medical problem _____, _____ Family Member
_____, _____
_____, _____
_____, _____

Do you smoke cigarettes? _____ No _____ Yes _____ cigarettes/day

Do you drink alcoholic beverages? _____ No _____ Yes _____ drinks/week

Do you use nonprescription drugs such as marijuana, cocaine, heroin, methamphetamine?

_____ No _____ Yes Type and frequency _____

Do you exercise? _____ No _____ Yes _____ Times per week.

Are you taking any medication? If yes, list below:

Medication Dose Prescribing doctor

Have you ever been pregnant before? _____ No _____ Yes

Year _____ Sex _____ vaginal or c-section _____ Problems _____

Have you had a miscarriage? _____ No _____ Yes

Have you had an ectopic pregnancy? _____ No _____ Yes

Have you delivered prematurely? _____ No _____ Yes

Are you currently trying to become pregnant?

If not what is your birth control method? _____ Please include condoms, tubal ligation or vasectomy.

What was the first day of your last menstrual period _____

Are you having any problems with your periods? _____ Yes _____ No

If yes, what kind of problem? _____

Are you currently sexually active? _____ No _____ Yes

When was your last pap smear? _____

When was your last mammogram? _____ (if ≥ 35 years old)

If > 50 years old, have you had a colonoscopy? _____ No _____ Yes

If > 50 years old, have you had a bone density test? ___No ___Yes

REVIEW OF SYSTEMS

- 1 Fever, chills, or weight loss? ___No ___Yes
- 2 Hearing loss or ringing or itching of the ears? ___No ___Yes
- 2 blurred or double vision, cataracts or glaucoma? ___No ___Yes
- 3 Nasal congestion or nose bleeds? ___No ___Yes
- 4 Chest pain or palpitations? ___No ___Yes
- 5 Nausea, vomiting diarrhea or abdominal pain? ___No ___Yes
- 6 Urinary frequency, urgency, or pain? ___No ___Yes
- 7 Urinary incontinence or blood in the urine? ___No ___Yes
- 8 Painful or swollen joints? ___No ___Yes
- 9 Headache, loss of consciousness, or seizure? ___No ___Yes
- 10 Signs of depression? ___No ___Yes
- 11 Skin rash or lesion? ___No ___Yes
- 12 Heat or cold intolerance, change to hair or nails ___No ___Yes
- 14 Swollen lymph nodes or easy bruising? ___No ___Yes

I HAVE INCLUDED ALL PERTINENT INFORMATION REGARDING MY HEALTH HISTORY ___no ___yes
I HAVE ADDITIONAL HEALTH ISSUES NOT ADDRESSED ON FORM ___no ___yes

SIGNATURE OF PATIENT _____ **DATE** _____
(or parent if patient is a minor)

OBSTETRICAL PATIENTS ADDITIONAL HISTORY

First day of last period _____ Was this period normal? ___No ___Yes

PREGANCY HISTORY

Total pregnancies including this one _____

Total miscarriages _____

Total ectopic pregnancies _____

Total elective terminations _____

Number of living children _____

Number of vaginal births _____

Number of cesarean births _____ Reason for cesarean births _____

Pregnancy complication such as diabetes or high blood pressure? ___Yes

PREGNANCY SYMTOMS

Nausea, or nausea and vomiting ___No ___Yes

Breast tenderness ___No ___Yes

Fatigue ___No ___Yes

Constipation ___No ___Yes

Cramps ___No ___Yes

Headache ___No ___Yes

Frequent urination ___No ___Yes

MEDICATIONS

Are you taking a prenatal vitamin? ___No ___Yes

Did you begin prior to conceiving? ___No ___Yes

Have you taken any other medications since your last period? ___No ___Yes

Have you stopped any regular medications since you found out you were pregnant?
___No ___Yes If yes what medication were you taking? _____

SOCIAL INFORMATION

Your ethnicity _____ Father's ethnicity _____

Pediatrician? _____

Do you have cats in the home? ___Yes ___No

Do you have desire for permanent sterilization after this pregnancy? ___Yes ___No

NOTICE OF PRIVACY PRACTICE FOR SANTA FE OB/GYN

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.

Uses and Disclosures There are a number of situations where we may use or disclose to other persons or entities your confidential medical information. Certain uses and disclosures will require you to sign an Acknowledgement that you received our Notice of Privacy Practices, including treatment, payment and health care operations. Any use or disclosure of your protected health information requires for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures required by law or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

Use and Disclosure without Patient Acknowledgement of this Notice

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes:

Treatment: We will use your medical information to make decisions about the provision, coordination or management of your health care, including diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your medical information with another health care provider whom we need to consult with respect to your care. We may also disclose certain information to a pharmacist for the purpose of filling a prescription for you, to a physical therapist to provide physical therapy under appropriate circumstances, or to a facility or other providers should you require surgery or other hospital care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your medical record to obtain reimbursement from you or your health insurance plan, or another insurer for our services rendered to you. This may also include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for purposes of reimbursement. This information may also be used for billing, claims management and collection purposes together with related health care data processing through our system.

Operations: Your medical records may be used in our business planning and development operations, including improvement in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, medical review activities, and arranging for legal and auditing functions.

Use and Disclosure Without Acknowledgement or Authorization

There are certain circumstances under which we may use or disclose your medical information without first obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law enforcement activities, judicial and administrative proceedings and in the event of death. Specifically, we are required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases and HIV / AIDS status. We are also required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law enforcement officials information that you or another person are in immediate threat of danger to your health or safety as a result of violent activity. We must also provide medical record information when ordered by a court of law to do so.

Authorization for Use or Disclosure

Except as outlined in the above sections, your medical information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to mental health treatment, drug and alcohol abuse, HIV/AIDS, or sexually transmitted disease information which may be contained in your medical records. We likewise will not disclose your medical record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

Additional Uses and Disclosures

We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Individual Rights

You have certain rights with respect to your medical record information, as follows:

1. You may request that we restrict the uses and disclosures of your medical records information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with respect to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.
2. You have the right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you will be charged a fee for the accommodation, and will be required to specify the alternative address or method of contact and how payment will be handled.
3. You have the right to inspect copy and request amendment to your medical records. Access to your medical records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding or for which your access is otherwise is restricted by law. We will charge a reasonable fee for providing a copy of your medical records, or a summary of those records, at your request, which includes the cost of copying, postage, or preparation of an explanation or summary of the information.
4. All requests for inspection, copying and/or amending information in your medical records must be made in writing and be addressed to "Privacy Officer" at our address. We will respond to your request in a timely fashion.
5. You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your medical records information except for disclosures required for treatment, payment and health care operations, disclosures that require an Authorization, disclosures incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any 12-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same 12-month period.
6. You have the right to obtain a paper copy of this notice if the notice was initially provided to you electronically, and to take one home with you if you wish.
7. All requests related to your rights herein must be made in writing and addressed to "Privacy Officer" at the address noted below.

Our Duties

We have the following duties with respect to the maintenance, use and disclosure of your medical records:

1. We are required by law to maintain the privacy of the protected health information in your medical records and to provide you with this Notice of its legal duties and privacy practices with respect to that information.
2. We are required to abide by the terms of this Notice currently in effect.
3. We reserve the right to change the terms of this Notice at anytime, making the new provisions effective for all health information and medical records we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

Complaints

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights with respect to confidential information in your medical records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of a complaint to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints on line at the government's website:

<http://www.hhs.gov/ocr/hipaa/>

Contact Person All questions concerning this Notice or requests made pursuant to it should be addressed to:

Santa Fe Ob/Gyn
Office Manager
405 Stereophile Way
Santa Fe, NM 87505

Effective Date This Notice is effective February 2, 2005 and applies to all protected health information contained in your medical records maintained by us.