Lauren Rodgers MD

REGISTRATION FORM

7500 Greenway Center Drive Suite 620 Greenbelt Maryland 20770 6196 Oxon Hill Rd. Suite 630 Oxon Hill Maryland 20745

PCP:	PCP phone:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Email):	Birth date: / /	Age:

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

INSURANCE INFORMATION

(Please complete the ENTIRE section, and give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone : ( )

Is this person a patient here? ❑ Yes ❑ No

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate **PRIMARY** insurance	❑ Aetna	❑ Cigna	❑ CareFirst	❑ United Healthcare	❑ Basic Medicaid

❑ Md. Physician Care	❑ Amerigroup	❑ United Healthcare (State)	❑ Self-Pay	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Member ID/Subscriber#

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

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work 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 I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Print Form

New Patient Obstetrics & Gynecology Form

This will become part of your medical record.

Today's Date:

Name: Date of Birth: Age:

Primary Care Physician: Telephone:

Pharmacy: Pharmacy Address:

Menstrual History:

First day of last menstrual period

Age at first menstrual period years

Number of days from the start of one period to the start of the next days

Number of days that you bleed days

Describe the amount of menstrual flow (circle one) light / moderate / heavy / clots

How many tampons or pads do you use on your heaviest day?

Describe the amount of menstrual discomfort (circle one) none / mild / moderate / severe

Do you bleed in between your periods? Yes ☐ No ☐

Do you bleed after intercourse? Yes ☐ No ☐

If you stopped menstruating, at what age did you stop? years

Have you had bleeding or spotting since your periods stopped? Yes ☐ No ☐

Contraceptive and Sexual History:

Present birth control method:

Birth control methods used in the past:

	METHOD	LENGTH OF USE	REASON FOR DISCONTINUATION
1)			
2)			

Have you ever been sexually active (had intercourse)? Yes ☐ No ☐

Have you had a new sexual partner in the past three months? Yes ☐ No ☐

How many sexual partners have you had in the past 3 months?

Is/Are your partner(s) male, female, or both? Male ☐ Female ☐ Both ☐

Do you experience pain or discomfort with sexual intercourse? Yes ☐ No ☐

Would you like to discuss sexual activity or birth control today? Yes ☐ No ☐

Gynecological History:

Have you been vaccinated for Human Papilloma Virus (HPV) – Gardasil Yes ☐ No ☐

Last Pap Smear

Last Mammogram

Last Bone Density (DEXA)

Last Colonoscopy

Have you ever been on hormone therapy (estrogen / progesterone)? Yes ☐ No ☐

Any personal history of:

Abnormal Pap Smears Yes ☐ No ☐

Sexually transmitted diseases Yes ☐ No ☐

List:

Fibroids Yes ☐ No ☐

Endometriosis Yes ☐ No ☐

Infertility Yes ☐ No ☐

Urinary incontinence Yes ☐ No ☐

Obstetrical History: Please record the number of:

Pregnancies ☐ Vaginal Births ☐ Ectopics ☐ Abortions ☐

Living Children ☐ C-Sections ☐ Miscarriages ☐

List any complications of pregnancies ☐

Medical History: Please check if you or a blood-relative have had any of the following:

	MYSELF	FAMILY		MYSELF	FAMILY		MYSELF	FAMILY
Anemia	☐	☐	Mental Illness	☐	☐	Liver Disease / Hepatitis	☐	☐
High Blood Pressure	☐	☐	Depression	☐	☐	Gall Bladder Disease	☐	☐
High Cholesterol	☐	☐	Anxiety	☐	☐	Blood clots in veins/lungs	☐	☐
Heart Disease	☐	☐	Eating disorder	☐	☐	Blood Transfusion	☐	☐
Stroke	☐	☐	Migraine Headaches	☐	☐	Breast Cancer	☐	☐
Diabetes	☐	☐	Urinary Tract Infection	☐	☐	Colon Cancer	☐	☐
COPD / Emphysema	☐	☐	Lupus	☐	☐	Uterine Cancer	☐	☐
Asthma	☐	☐	Arthritis	☐	☐	Ovarian Cancer	☐	☐
Seizures	☐	☐	Back Injury	☐	☐	Other Cancer, specify:		
Thyroid problems	☐	☐	Osteoporosis	☐	☐			

Other Medical Problems (list all):

Surgical History: Please list any operations, including the year, or your age when you had it:

Personal / Social History:

Occupation ☐ Marital Status ☐

Do / Did you use tobacco products? Yes ☐ No ☐ How much? ☐

Do / Did you drink alcohol? Yes ☐ No ☐ How many drinks per week? ☐

Do / Did you use illicit/street drugs? Yes ☐ No ☐ Which drugs? ☐

Have you ever been tested for HIV? Yes ☐ No ☐ Year and result: ☐

Have you ever been a victim of physical, verbal, emotional or sexual abuse? Yes ☐ No ☐

Medications: Please list any medications you take, including over-the-counter medicines

MEDICINE	DOSE	HOW OFTEN	MEDICINE	DOSE	HOW OFTEN

Please list any allergies to medications: ☐

Current Medical Concerns: Please circle if you have had any of the following this week: ☐

Weight change	Yes ☐ No ☐	Nausea / Vomiting	Yes ☐ No ☐	Trouble sleeping	Yes ☐ No ☐
Abnormal bleeding	Yes ☐ No ☐	Bowel changes	Yes ☐ No ☐	Night sweats / Hot flashes	Yes ☐ No ☐
Abnormal hair growth	Yes ☐ No ☐	Anxiety / Panic	Yes ☐ No ☐	Breast problems	Yes ☐ No ☐
Problems with urination	Yes ☐ No ☐	Depression	Yes ☐ No ☐		

How did you hear about us? ☐

Is there any other information you feel we should have?

☐

Patient Signature _____ Date _____

Provider Signature _____ Date _____

Notice to Patients of Policies and Procedures
Revised as of January 1,2019
PLEASE READ BEFORE YOU SIGN

I understand I am allowed one (1) well woman visit per year, which includes a Pap smear, blood draw, and mammogram referral with no copay. **Any other issues or concerns that are addressed during my annual visit will result in the collection of my FULL copay (i.e. vaginal irritation, birth control, hot flashes, fertility or any prescriptions.)**

I understand that if I am contacted concerning a test and/or Pap smear taken in the office, the physician and staff do not discuss abnormal results over the phone. I will need to make an appointment to discuss these in person, and will be subject to my full copay.

I understand that if I have a past due balance at the time of service, I must pay a minimum of 50% of the total due in order to be seen.

I understand there is a $0.79 per page fee for up to 20 pages and $50.00 over 20 pages charge and maximum wait of 48 hours for my medical records. If I request my records through another physician they will receive my most recent Pap smear and blood work only. **Any records picked up in person must be arranged ahead of time, and are available for pick-up Mon, Wed and Thurs between 2-4pm at the Oxon Hill office location or Tues and Fri between 9-1pm at the Greenbelt location.**

I understand that ALL prescriptions given by the physician will be refilled for a maximum of 6 months only. I am aware I need to keep track of my refills so that I am able to come in for an appointment before they run out. I will not be given a month supply of any medications, and **will not receive refills by calling the office- an appointment must be made and I must be seen by the physician during an office visit to receive my refill. If you are a college student, please arrange to come in during your breaks.**

I understand I will be charged a no-show fee of $50.00 if I do not show up or call to cancel/ re-schedule my appointment. This fee is non-negotiable, and must be paid before I can schedule any further appointments.

There will be a $15.00 fee for any forms that need to be filled out by this office. (i.e. FMLA, disability, social services or Metro forms.)

It is your responsibility as the patient to read and understand the policies and procedures. A copy of this form is located in the waiting room, and you may request a copy at any time. Please feel free to ask any questions.

Print Name: _____

Sign Name: _____

Date: _____