DRS. SONDERGAARD, MINKIN, FABER, KATES, ZAFT
JACOBS & WHITE
AURORA WOMEN'S HEALTH
23 Crossroads Drive, Suite 220
Owings Mills, MD 21117
410-581-9200
FAX: 410-581-9203

Tax ID# 20-2265068
Obstetrics & Gynecology

WELCOME TO OUR PRACTICE! WE LOOK FORWARD TO MEETING YOU.

Prior to your appointment, please complete the enclosed paperwork (front and back) in full. This paperwork is in addition to any information filled out on the patient portal. To assist our physicians in seeing you in a timely fashion, we ask that you arrive 15 minutes early with your completed paperwork, a state issued photo ID and your insurance card (s). Failure to bring any one of these items may result in a delay or cancellation of your appointment.

If you have questions or require additional information, please contact us at 410-581-9200 and press 0.

We encourage you to check out our website at OMobgynMD.com

Thank you and have a great day!

DRS. SONDERGAARD, MINKIN, FABER, KATES, ZAFT, JACOBS & WHITE

23 Crossroads Drive Suite # 220 **AURORA WOMEN'S HEALTH** Telephone: 410-581-9200

Owings Mills, MD 21117 Fax: 410-581-9203

PATIENT REGISTRATION – Please Print Clearly

PATIENT NAME FIRST MIDDLE LAST	MARITAL STATUS	DATE OF BIRTH	AGE	ETHNICITY

HOME ADDRESS APT. NO	CITY	STATE	ZIP CODE	HOME PHONE CELL PHONE

PATIENT'S SOCIAL SECURITY NO.	PATIENT'S E-MAIL ADDRESS	OCCUPATION	WORK PHONE#

EMPLOYER	PRIMARY CARE PHYSICIAN: NAME/ADDRESS	PCP PHONE#	PCP FAX#

SPOUSE'S NAME	OCCUPATION	SPOUSE'S DOB	SPOUSE'S SOCIAL SECURITY NO.

SPOUSE'S EMPLOYER	SPOUSE'S WORK PHONE#	SPOUSE'S CELL PHONE#

NOTIFY IN EMERGENCY (OTHER THAN SPOUSE)	RELATIONSHIP	HOME PHONE	WORK PHONE	CELL PHONE

FINANCIALLY RESPONSIBLE PERSON ___ SELF ___ SPOUSE ___ PARENT ___ OTHER	NAME & ADDRESS IF DIFFERENT FROM PATIENT	HOME PHONE ( )	WORK PHONE ( )

PHARMACY NAME/ LOCATION/ PHONE #

MAIL ORDER PHARMACY NAME/ ADDRESS/ PHONE#	REASON FOR VISIT ___ WELL WOMAN/ CHECK UP ___ PREGNANCY ___ PROBLEM VISIT

INSURANCE INFORMATION

POLICY HOLDER SELF ___ OTHER ___ SPOUSE ___ PARENT ___	PRIMARY INSURANCE CO NAME	EFF. DATE	SUBSCRIBER'S NAME
		SUBSCRIBER'S DOB	SOCIAL SECURITY NO.

INSURANCE COMPANY ADDRESS	ID/POLICY#	GROUP NO.

SECONDARY INSURANCE COMPANY NAME AND ADDRESS	ID/POLICY#	GROUP NO.

PATIENT AUTHORIZATION

I, _____ hereby authorize Aurora Women's Health to apply for benefits on my behalf for covered services rendered by Drs. Sondergaard, Minkin, Faber, Kates, Zaft, Jacobs & White. I request payment from Blue Shield of Maryland, Medicare and/or _____ be made directly to Drs. Sondergaard, Minkin, Faber, Kates, Zaft, Jacobs & White.

Other Insurance Company Name

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance company, (or in the case of Medicare, the Social Security Administration and Health Care Financing Administration). I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.

_____ _____

Signature of Subscriber or Beneficiary **Date**

NAME: _____ DOB: _____

GENDER IDENTITY: _____ PRONOUN: _____

LAST MENSTRUAL PERIOD: ___/___/___ DAYS OF FLOW: _____

Is your cycle monthly? YES NO CRAMPING: YES NO

OR: At what age did you have your last menstrual period if over 50? _____

Are you sexually active ? YES NO What do you use for contraception? _____

Reason for visit:____Wellness ____Problem (s) describe_____ ____Both

Are you interested in having testing for STD's _____YES _____ NO

Do you have any allergies? _____

Any new surgeries or medical problems? _____

Current medications: _____

COVID Vaccination (check one): ( ) Pfizer 0.3ml ( ) Moderna 0.5ml ( ) J&J 0.5 ml
Date of first dose _____ Date of second dose_____ Date of Booster_____

TDAP (tetanus)/Date Administered _____ Flu vaccine/Date Administered _____

Last Mammogram _____ Last Colonoscopy: _____ Bone Density/DEXA_____

Alcohol Use: _____ Smoking/Vaping/Smokeless?_____ How many daily_____
Drug use _____ Former smoker? _____

Marital status: M/ S/ W/ D/ other_____ How many children do you have? _____

Are you currently employed? YES NO What is your occupation? _____

While driving/riding in a car, do you wear a seatbelt: YES NO

Under life threatening circumstances, would you accept blood products and/or transfusion? YES NO

FOR STAFF USE ONLY: Account issues addressed _____

Return _____ Annual scheduled for _____

_____Mammogram/TOMO 3D _____DEXA Labs:_____
_____Diagnostic Mammogram _____
_____Breast Ultrasound STD labs _____
_____Pelvic Ultrasound I/O Labs _____
_____OB Ultrasound NIPT _____Fetal Sex Y/N
_____Anatomy OB U/S ECS/Super Panel _____
_____ BPP 28 week labs_____

AURORA WOMEN'S HEALTH

DRS. SONDERGAARD,
MINKIN, FABER, KATES,
ZAFT, JACOBS & WHITE

WELCOME TO OUR OFFICE! Please fill out this Patient History, which will become a permanent part of your medical record in our office. PLEASE PRINT.

1. IDENTIFYING INFORMATION

Date _____ Name _____ Marital Status _____

Date of Birth _____ Social Security # _____ Occupation _____

Gender Identity _____ Pronoun _____

2. MEDICAL HISTORY

Height _____ Weight _____ Blood type, if known _____

Do you have any allergies to medication? List _____

Have you gained or lost greater than 20 pounds in the last year? _____

Do you follow a special diet? If yes, specify: _____

Types of exercise you do: _____ Hours/week: _____

Do you have, or have you ever had: (check all that apply)

- ____ Anemia
- ____ Anesthesia problems
- ____ Anxiety
- ____ Asthma
- ____ Auto Immune Disease
- ____ Blood Transfusion
- ____ Breast Discharge / Disorders
- ____ Chicken Pox
- ____ Colitis
- ____ Depression
- ____ Diabetes
- ____ Endometriosis
- ____ Fibroids
- ____ Gallbladder Problems
- ____ Gastrointestinal Disorders
- ____ Headaches
- ____ Heart Disease / Mitral Valve Prolapse
- ____ Hepatitis Vaccine
- ____ Hirsutism (excessive hair growth)
- ____ High Blood Pressure
- ____ High Cholesterol
- ____ HIV
- ____ Kidney Problems / Stones
- ____ Liver Problems
- ____ Ovarian Cysts
- ____ Pelvic Infection
- ____ Pulmonary Embolus or Clotting Disorder / DVT
- ____ Vaginitis
- ____ Neuro Seizures / Epilepsy / Stroke
- ____ STD's _____
- ____ Thyroid Problems
- ____ Ulcers
- ____ Urinary Disorders
- ____ Vaccines (Hep B, HPV, Tdap)
- ____ Other _____

Have you ever been diagnosed/treated for cancer? If yes, please explain type of cancer and therapy:

_____

Have you ever had any type of surgery? If yes, please specify: _____

_____

WOULD YOU ACCEPT A BLOOD TRANSFUSION IF NEEDED? ☐ YES ☐ NO

Within the last year, have you taken any prescription medications? List all prescriptions, the dosage and the problem for which you were taking them _____

_____

_____

Are you taking any over-the-counter medications on a regular basis? If yes, list all medications and reasons:

_____

_____

- OVER -

Do you use, or have you ever used (check all that apply):

____ Alcohol - how many glasses per week? Wine _____ Beer _____ Cocktails _____

____ Cigarettes - number of packs per day _____ / ____ Former Smoker / ____ Never Smoked

____ Drugs (Marijuana, Cocaine, etc.) If you would feel more comfortable not writing anything down, please discuss this directly with your physician.

3. MENSTRUAL AND PREGNANCY HISTORY

Age at first period:_____ Are your periods regular?_____ What is the usual number of days between periods (from the first day to the first day)?_____ How many days does your period last?_____

Use: Tampons/Pads_____ Are cramps present before, during or after your period?_____

Do you have to take pain medication for cramps?_____

Did **your** mother take DES (Diethylstilbestrol) when she was pregnant with you?_____

How many pregnancies, including abortions and miscarriages, have you had? _____

	YEAR	FULL TERM	PREMA-TURE	ABORT MIS/ECTOP	LIVING	LENGTH OF LABOR	BABY'S WGT/SEX	TYPE DELIVERY	COMPLI-CATIONS
1st Preg.									
2nd Preg.									
3rd Preg.									
4th Preg.									
5th Preg.									
6th Preg.									

4. GYNECOLOGICAL HISTORY:

Any history of GYN infections, problems or abnormal PAP smears? _____

5. CONTRACEPTIVE/SEXUAL HISTORY

Do you require contraception? ☐ YES ☐ NO Do you use condoms? ☐ YES ☐ NO

Sexual Preference: Do you have sex with ☐ Men ☐ Women

5. FAMILY HISTORY

Has anyone in your family, including grandparents every had any of the following:

(Please specify which relative).

Birth Defects (Down's etc.) _____ Diabetes _____

Bleeding Disorder _____ Heart Disease _____

Breast Cancer _____ High Blood Pressure _____

Breast Disorders _____ Multiple Gestation (twins) _____

__ Gyn Cancer, __ Cervical, __ Ovarian, __Uterine Sickle Cell Disease _____

Other form of cancer (specify type) _____ Thyroid Disease _____

Blood Clots / DVT / Pulmonary Embolus _____ Other _____

_____

7. ADVANCE DIRECTIVE (Living Will) ☐ YES ☐ NO

THANK YOU FOR COMPLETING THIS FORM. WE APPRECIATE YOUR EFFORTS!

PRIVIA MEDICAL GROUP

DRS. SONDERGAARD, MINKIN, FABER, KATES, ZAFT, JACOBS & WHITE
AURORA WOMEN'S HEALTH

FINANCIAL POLICY

Thank you for choosing us as your health care providers. We are committed to your receiving the best quality medical care possible and the best service possible. The following is a statement of our Financial Policy which we ask that you read and sign prior to any treatment.

FULL PAYMENT OF YOUR COINSURANCE OR COPAY IS DUE PRIOR TO SERVICE
FULL PAYMENT IS DUE AT TIME OF SERVICE FOR SERVICES NOT COVERED
BY YOUR INSURANCE, OR WHEN YOUR DEDUCTIBLE HAS NOT BEEN MET.

REGARDING INSURANCE: Your insurance policy is a contract between you and your insurance company. Please be aware that some and perhaps all of the services provided may be non-covered services (or not considered "medically necessary" under the Medicare program) and are therefore your responsibility. If your insurance company has not paid your bill within 45 days, the balance will be billed to you. **THIS IS TO ADVISE YOU THAT WE DO NOT ACCEPT MEDICAL ASSISTANCE OR ANY MEDICAL ASSISTANCE HMO/MCO PRODUCT.**

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best care for our patients, and we charge what is usual and customary for our area. You are responsible for ALL deductibles, copays and coinsurance amounts. We cannot "*write off*" any amount that is your responsibility. Your copay and/or deductible is due at the time of service. **If you do not have your copay with you, we reserve the right to reschedule your appointment.**

ANNUAL WELLNESS EXAMS: If you require additional service or treatment at the time of your annual exam, a deductible and/or copay may apply.

MISSED APPOINTMENTS: You will be charged $50 for office appointments and $200 for surgery not cancelled at least 24 business hours in advance. Please help us serve you better by keeping scheduled appointments.

PAST DUE ACCOUNTS: Accounts are considered past due after 30 days. Bills are turned over to our Collection Agency after 90 days. Other fees will apply if the account is forwarded to an attorney for collection lawsuit. **Any additional medical services will be suspended until your account is paid in full.** Checks returned from your bank for any reason will be charged $45.00.

CARD ON FILE: You may be asked to have your credit card on file. This data is securely held until your insurance has processed your claim. You will receive advanced notification of the amount due that will be charged to your card and will have the right to dispute a charge or set up a payment plan.

ADMINISTRATIVE FEE: There is a voluntary $15 administrative fee for non-medical services, including, but not limited to Medical Records copying, Disability and other work related forms, annual statements for tax purposes, copies of receipts and wellness forms. If you choose not to pay our Administrative fee, you will be billed per occurrence for these non-medical services. All fees must be paid before completion of forms or release of medical records.

I have read, understand and agree to this Financial Policy

_____ _____

Patient and/or Guarantor SIGN & PRINT Date

DRS. SONDERGAARD, MINKIN, FABER, KATES, ZAFT
JACOBS & WHITE
AURORA WOMEN'S HEALTH

PATIENT AUTHORIZATION

We at Drs. Sondergaard, Minkin, Faber, Kates, Zaft, Jacobs & White are dedicated to preserving your privacy and personal health information. Our employees are trained in the proper handling of your medical and financial records. We are requesting this Patient Authorization in order to continue to provide the finest medical care possible. Thank you for your assistance.

I authorize Drs. Sondergaard, Minkin, Faber, Kates, Zaft, Jacobs, White and their staff to:

1. Call my home/and or work to remind me of upcoming appointments; in the event I am not there, they may leave a message on an answering machine.
2. Call my home and/or work concerning Lab, Xray or other test results and leave a message on my answering machine if necessary; receive Pathology and Radiology reports by FAX; make and/or receive calls from pharmacies on my behalf, including electronic prescriptions and/or prescriptions by FAX.
3. Update my personal demographic information either on the phone or in the office at the time of my appointment.
4. At my request, discuss my personal health with my parent or other designated person.
5. Discuss my financial account with my parent, insurance policy holder, or other financially responsible person that may be calling to clarify billing or other financial matters.
6. Electronically verify my prescription medications with my pharmacy.

☐ Accepts/Initials ☐ Decline/Initials

I have read and agree to the above policies of Drs. Sondergaard, Minkin, Faber, Kates, Zaft, Jacobs & White with regards to the treatment, payment and health-care operations of their practice. I also certify that I am aware that I am entitled to a receive a copy of this Privacy Policy if I so desire.

_____ _____
Signature of Patient Date

_____
Print Name