

**WHITE ROSE OB/GYN ASSOCIATES
1225 EAST MARKET STREET
YORK, PA 17403
717-845-9639**

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WELCOME TO WHITE ROSE OB/GYN ASSOCIATES

WELCOME TO WHITE ROSE OB/GYN ASSOCIATES. WHETHER YOU ARE HERE FOR GYN CARE OR OB CARE, WE WILL DO OUR BEST TO GIVE YOU THE BEST CARE AVAILABLE.

OUR PRACTICE DOES ACCEPT MANY INSURANCE'S. IF YOU ARE NOT SURE IF WE PARTICIPATE WITH YOUR PARTICULAR INSURANCE, CALL YOUR PLAN AND INQUIRE IF OUR DOCTORS ARE PART OF YOUR NETWORK. IF YOU NEED REFERRALS FOR ANY SERVICES, THIS IS YOUR RESPONSIBILITY TO GET THE REFERRAL BEFORE YOUR VISIT.

ANY COPAY IS DUE BEFORE YOUR VISIT WITH THE DOCTOR. PLEASE SEE THE RECEPTIONIST WITH YOUR COPAY. YOU WILL BE GIVEN A RECEIPT AFTER THE DOCTOR SEES YOU.

IF YOU NEED AN EMERGENCY ROOM, YOU MUST GO TO MEMORIAL HOSPITAL, UNLESS YOUR INSURANCE SPECIFIES THAT YOU GO TO YORK HOSPITAL.

IF YOU ARE PREGNANT AND DO NOT HAVE ANY INSURANCE OR AN INSURANCE THAT WE DO NOT PARTICIPATE IN, OUR POLICY IS THAT YOU MAKE PAYMENTS DURING YOUR PREGNANCY TO HELP MAKE UP THE DIFFERENCE THAT THE INSURANCE DOES NOT COVER.

PATIENTS HAVING A CREDIT BALANCE WITH THE PRACTICE MAY REQUEST A REFUND AT ANY TIME. ANY PATIENT WITH A CREDIT BALANCE OF LESS THAN \$20.00 MAY CHOOSE TO REQUEST THE REFUND OR TO USE IT AT A LATER DATE.

IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE OFFICE AT THE ABOVE NUMBER.

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PATIENT NAME _____ **SOCIAL SECURITY #** _____

STREET ADDRESS _____ **CITY** _____

ZIP CODE _____ **BIRTH DATE** _____ **AGE** _____ **MARITAL STATUS** _____

PHONE NUMBER _____

EMPLOYER _____ OCCUPATION _____

SPOUSE/SIGNIFICANT OTHER NAME _____ SS# _____

EMPLOYER _____ BIRTH DATE _____

NAME OF PERSON RESPONSIBLE FOR PAYMENT _____

INSURANCE COMPANY NAME _____

PHARMACY NAME AND PHONE NUMBER _____

MEDICAID RECIPIENT NUMBER _____ FAMILY DOCTOR _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. ***THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.*** IT IS ALSO CUSTOMARY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE MANAGER. ***ALL COPAYS ARE EXPECTED BEFORE BEING SEEN.*** PLEASE SEE THE RECEPTIONIST TO MAKE PAYMENT.

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/OTHER INSURANCE COMPANY BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO WHITE ROSE OB/GYN ASSOCIATES FOR ANY SERVICES FURNISHED ME BY THAT PARTY WHO ACCEPTS ASSIGNMENT/PHYSICIAN. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY.

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION, OR ITS INTERMEDIARIES OR CARRIERS, ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM/OTHER INSURANCE COMPANY CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. I UNDERSTAND IT IS MANDATORY TO NOTIFY THE HEALTH CARE PROVIDER OF ANY OTHER PARTY WHO MAY BE RESPONSIBLE FOR PAYING FOR MY TREATMENT. ***(SECTION 1128B OF THE SOCIAL SECURITY ACT AND 31 U.S.C. 3801-3812 PROVIDES PENALTIES FOR WITHHOLDING THIS INFORMATION)***

SIGNATURE _____ DATE _____

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NEW PATIENT HISTORY

NAME _____ DATE _____ AGE _____

CURRENT PROBLEM OR REASON FOR VISIT: _____

PAST FEMALE PROBLEMS _____

PAST SURGERIES	DATE	ANESTHESIA	HOSPITAL
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LIST ANY PROBLEMS YOU HAVE HAD WITH SURGERY OR ANESTHESIA:

LIST ANY OTHER HOSPITALIZATIONS AND THE REASON FOR HOSPITALIZATION:

MEDICATIONS

NAME _____ **DATE** _____

LIST ANY ALLERGIES TO MEDICATIONS OF FOODS:

SOCIAL HISTORY:

DO YOU SMOKE: _____ **HOW MANY YEARS** _____ **HOW MANY PACKS** _____

DID YOU QUIT _____ **IF YES, WHEN?** _____

DO YOU DRINK ALCOHOL? _____ **HOW MUCH?** _____

MEDICAL HISTORY

LIST ANY MEDICAL PROBLEMS THAT YOU HAVE:

CURRENT BIRTH CONTROL METHOD _____
AGE PERIOD STARTED _____ **AGE PERIOD STOPPED** _____
HOW MANY DAYS DO YOUR PERIODS LAST? _____
DESCRIBE YOUR PERIOD, LIGHT, HEAVY OR FLOODING _____
WHAT WAS THE FIRST DAY OF YOUR LAST PERIOD _____
DO YOU TAKE MEDICATION FOR RELIEF OF CRAMPING DURING YOUR PERIOD _____
DO YOU HAVE ANY FEMALE/PELVIC PAIN? _____ **IF YES, EXPLAIN** _____

DO YOU GET REGULAR PAP SMEARS? _____
WHEN AND WHERE WAS YOUR LAST PAP SMEAR _____
DO YOU HAVE PAIN WITH INTERCOURSE _____
DO YOU HAVE ANY ABNORMAL DISCHARGE _____
DO YOU HAVE FREQUENT FEMALE INFECTIONS _____ **HOW HAVE THEY**
TREATED _____
WERE YOU EVER TREATED FOR:
A PELVIC INFECTION _____
ENDOMETRIOSIS _____

DID YOU HAVE TROUBLE GETTING PREGNANT _____
HAVE YOU EVER MISSED A LOT OF PERIODS _____
DO YOU HAVE ABNORMAL HAIR GROWTH _____
DID YOU EVER HAVE:
BREAST PAIN _____
BREAST DISCHARGE _____
BREAST CYST _____

DO YOU HAVE A HISTORY (YOURSELF OR FAMILY) OF BREAST OR OVARIAN
CANCER _____

NAME _____ **DATE** _____

HAVE YOU HAD A MAMMOGRAM _____ **IF YES, WHERE AND**
WHEN _____

PREGNANCY HISTORY

NUMBER OF TIMES PREGNANT _____
DATES OF DELIVERIES _____
NUMBER OF MISCARRIAGES _____
NUMBER OF PREMATURE BIRTHS _____
HOW MANY LIVING CHILDREN DO YOU HAVE _____

COMPLICATIONS OF CHILDBIRTH (PLEASE CHECK ANY THAT APPLY)

DIABETES _____ **HYPERTENSION** _____ **INFECTIONS** _____

BLEEDING _____ **MEDICAL PROBLEMS** _____

C-SECTION _____ **STILLBORN** _____ **FETAL DISTRESS** _____

FORCEPS _____ **VACUUM** _____

ANY CHILDREN WITH COMPLICATIONS _____

MY HEALTH IS

GOOD _____ FAIR _____ POOR _____

IF YOU HAVE CHECKED POOR OR HAVE ANY HEALTH PROBLEMS OR ISSUES YOU WOULD LIKE TO DISCUSS, PLEASE LIST IT HERE.