

DATE _____

PATIENT REGISTRATION



PATIENT INFORMATION

SOCIAL SECURITY # _____ HOME ADDRESS _____
 FIRST NAME _____ MIDDLE _____
 LAST NAME _____ CITY _____ STATE _____ ZIP _____
 SEX _____ DATE OF BIRTH ____/____/____
 EMAIL _____
 MARITAL STATUS MARRIED SINGLE
 DIVORCED WIDOWED
 HOME PHONE (____) _____
 WORK PHONE (____) _____
 (CHECK ONE) EMPLOYED RETIRED FULL TIME STUDENT
 REFERRING PHYSICIAN _____
 OTHER _____ HOW DID YOU HEAR OF US? _____
 EMPLOYER _____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

Commercial Medicaid Medicare Worker's Compensation Other _____
 INSURANCE COMPANY _____
 INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP _____
 POLICY # _____ GROUP # _____ PHONE (____) _____

SECONDARY INSURANCE INFORMATION

Commercial Medicaid Medicare Worker's Compensation Other _____
 INSURANCE COMPANY _____
 INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP _____
 POLICY # _____ GROUP # _____ PHONE (____) _____

WORKERS' COMPENSATION INFORMATION

COMPANY NAME _____ COMPANY PHONE (____) _____
 SUPERVISOR'S NAME _____ SUPERVISOR'S PHONE (____) _____

EMERGENCY CONTACT

SOCIAL SECURITY # _____ SEX _____
 FIRST NAME _____ MIDDLE _____ HOME PHONE (____) _____
 LAST NAME _____ WORK PHONE (____) _____

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY # _____ SEX _____ DATE OF BIRTH ____/____/____
 RELATIONSHIP _____ DAYTIME PHONE (____) _____
 FIRST NAME _____ MIDDLE _____ EMPLOYER _____
 LAST NAME _____ ADDRESS _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 CITY _____ STATE _____ ZIP _____

AUTHORIZATION TO PAY BENEFITS: I hereby authorize payment of benefits to the Physician or the Surgical and Medical Director of the Hospital or the Health Plan or the Health Plan's designated agent and I am responsible for payment of my services.
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any information acquired in the course of my treatment necessary to process my insurance claims.

 SIGNATURE (Patient or Parent if Minor) DATE

 SIGNATURE DATE



The Center for Gynecologic Oncology

Jacob Tangir M.D.
Gynecologic Oncology and Pelvic Surgery
www.centergynonc.com

CONSENT FORM

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosure) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notice of the practice/clinic.

I understand that I have the right to request a restriction of how my protection health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my request restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing except for information already used or disclosed.

Signature: _____ Date: ____/____/____

If signed by a patient representative, state relationship to patient _____



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INSURANCE FORM

Note: You need to make a choice about receiving these health care items of services.

Patient's name: _____

Date: ___/___/_____ Insurance Plan: _____

The fact that your insurance carrier may not cover a service does not mean that you should not receive the service. There is a medical reason for why your physician recommended said service(s). The purpose of this form is to help you make an informed choice about whether or not, to receive said service(s) understanding that you may have to pay for this yourself. Please read this information in its entirety prior to signing.

- You are encouraged to contact your insurance plan directly prior to services being rendered if you have any questions regarding service(s) rendered.

It is the patient's responsibility to obtain verification of their insurance plan benefits. **Verbal or On-line verifications** in **NOT** a guarantee of payment. Services are subject to the limitations and exclusions including pre-existing conditions as stated in the insurance benefit plan.

I understand that in the event my insurance determines a service does not meet their definition of medical necessity or is considered a non-covered service due to plan exclusions and limitations including pre-existing conditions, I will be financially responsible for payment of the service(s).

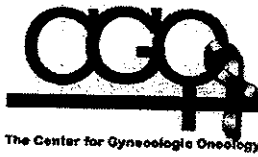
Diagnostic imaging services scheduled by our office at an outside facility

Our office makes every attempt to schedule **ALL** diagnostic testing/surgical procedures at a facility that is participating with your insurance plan. However, due to the constant addition and termination of plan affiliations it is the patient's responsibility to confirm participation prior to receiving services.

I acknowledge that the office has provided me with a copy of this disclosure and understand the contents.

Patient /Insured Signature: _____ Date: ___/___/_____

If signed by a patient representative, state relationship to patient _____



NOMBRE _____

FECHA DE NACIMIENTO: ____/____/____

FECHA: ____/____/____

TEL CELLULAR: _____

TEL TRABAJO: _____

DR. QUE LA REFIERE _____

TEL #: _____

DIRECCION DEL DR. QUE LA REFIERE: _____

REVISION DE LOS SISTEMAS

POR FAVOR MARQUE (X) SI ALGUNO DE LOS SIGUIENTES APLICA A USTED EN EL PASADO O AMENUDO

	No	SI	NOTAS
1. CONSTITUCIONAL			
Perdida de Peso	<input type="checkbox"/>	<input type="checkbox"/>	
Aumento de Peso	<input type="checkbox"/>	<input type="checkbox"/>	
Fiebre	<input type="checkbox"/>	<input type="checkbox"/>	
Fatiga	<input type="checkbox"/>	<input type="checkbox"/>	
2. OJOS			
Vision Doble	<input type="checkbox"/>	<input type="checkbox"/>	
Puntos en la vision	<input type="checkbox"/>	<input type="checkbox"/>	
Cambios en la vision	<input type="checkbox"/>	<input type="checkbox"/>	
3. GARGANTA, NARIZ Y OIDOS/ BOCA			
Dolor de oidos	<input type="checkbox"/>	<input type="checkbox"/>	
Ruidos en los oidos	<input type="checkbox"/>	<input type="checkbox"/>	
Problemas con los sinuses	<input type="checkbox"/>	<input type="checkbox"/>	
Dolor de garganta	<input type="checkbox"/>	<input type="checkbox"/>	
Llagas en la boca	<input type="checkbox"/>	<input type="checkbox"/>	
Problemas dentales	<input type="checkbox"/>	<input type="checkbox"/>	
4. CARDIOVASCULAR			
Dolor al respirar	<input type="checkbox"/>	<input type="checkbox"/>	
Dolor en el pecho	<input type="checkbox"/>	<input type="checkbox"/>	
Dificultad respirando cuando hace ejercicios	<input type="checkbox"/>	<input type="checkbox"/>	
Piernas hinchadas	<input type="checkbox"/>	<input type="checkbox"/>	
Palpitaciones en el corazon	<input type="checkbox"/>	<input type="checkbox"/>	
5. RESPIRATORIO			
Sonido en el pecho	<input type="checkbox"/>	<input type="checkbox"/>	
Escupé sangre	<input type="checkbox"/>	<input type="checkbox"/>	
Falta de aire	<input type="checkbox"/>	<input type="checkbox"/>	
Tos, crónica	<input type="checkbox"/>	<input type="checkbox"/>	
6. GASTROINTESTINAL			
Diarrea, frecuente	<input type="checkbox"/>	<input type="checkbox"/>	
Sangre en las heces fecales	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea/vomitos	<input type="checkbox"/>	<input type="checkbox"/>	
Estreñimiento	<input type="checkbox"/>	<input type="checkbox"/>	
7. GENITOURINARIO			
Sangre en la orina	<input type="checkbox"/>	<input type="checkbox"/>	
Dolor al orinar	<input type="checkbox"/>	<input type="checkbox"/>	
Urgencia al orinar	<input type="checkbox"/>	<input type="checkbox"/>	
Orina frecuentemente	<input type="checkbox"/>	<input type="checkbox"/>	
Residuo de orina en la vejiga	<input type="checkbox"/>	<input type="checkbox"/>	
Incontinencia	<input type="checkbox"/>	<input type="checkbox"/>	
Menstruaciones anormales	<input type="checkbox"/>	<input type="checkbox"/>	
Dolor en el acto sexual	<input type="checkbox"/>	<input type="checkbox"/>	
8. MUSCULOESQUELETAL			
Debilidad muscular	<input type="checkbox"/>	<input type="checkbox"/>	

POR FAVOR MARQUE (X) SI ALGUNO DE LOS SIGUIENTES APLICA A USTED EN EL PASADO O AMENUDO

	NO	SI	NOTAS
9. PIEL/SENOS			
Dolor en los senos	<input type="checkbox"/>	<input type="checkbox"/>	
Secrecion en los senos	<input type="checkbox"/>	<input type="checkbox"/>	
Masas en los senos	<input type="checkbox"/>	<input type="checkbox"/>	
Salpullidos en la piel	<input type="checkbox"/>	<input type="checkbox"/>	
Úlceras en la piel	<input type="checkbox"/>	<input type="checkbox"/>	
10. NEUROLOGICO			
Mareos	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsia	<input type="checkbox"/>	<input type="checkbox"/>	
Adormecimiento	<input type="checkbox"/>	<input type="checkbox"/>	
Problemas caminando	<input type="checkbox"/>	<input type="checkbox"/>	
11. PSIQUIATRICO			
Depresion	<input type="checkbox"/>	<input type="checkbox"/>	
Llora, frecuentemente	<input type="checkbox"/>	<input type="checkbox"/>	
12. ENDOCRINOLOGICO			
Sequedad en la piel	<input type="checkbox"/>	<input type="checkbox"/>	
Sed anormal	<input type="checkbox"/>	<input type="checkbox"/>	
Fogajes	<input type="checkbox"/>	<input type="checkbox"/>	
13. HEMATOLOGICO/LINFATICO			
Morados, frecuentes	<input type="checkbox"/>	<input type="checkbox"/>	
Heridas no coagulan rapido	<input type="checkbox"/>	<input type="checkbox"/>	
Nodulos linfaticos inflamados	<input type="checkbox"/>	<input type="checkbox"/>	
14. ALLERGICO/INMUNOLOGICO			
Alergias	<input type="checkbox"/>	<input type="checkbox"/>	
Drogas, otros	<input type="checkbox"/>	<input type="checkbox"/>	

HISTORIA PERSONAL

ENFERMEDADES MAYORES		SI	NO			SI	NO
Asma				Cancer			
Pneumonia				Úlceras			
Enfermedad cronica de los pulmones				Depresion/ansiedad			
Infeccion de los rinones/ piedras				Anemia/transfusiones de sangre			
Tuberculosis				Convulsiones/epilepsia			
Enfermedades venereas				Problemas Intestinales			
Problemas en el Corazon/murmullo				Glaucoma			
Diabetes				Artritis/dolor en las articulaciones			
Presion alta				Fracturas			
Embolia cerebral				Hepatitis/se ha puesto amarilla			
Fiebre reumatica				Enfermedad de la tiroides			
HOSPITALIZACIONES							
Razon				Fecha	Razon		Fecha
OPERACIONES							
Tipo				Fecha	Tipo		Fecha
ULTIMAS INMUNIZACIONES Y PRUEBAS							
				Date			Fecha
Tetanus					Pneumonia		
Vacuna del Flu					Prueba de Tuberculosis en la piel		

HISTORIA DE OB-GYN

Nacimientos		Abortos	
Abortos espontaneos		Hijos/hijas vivos	
Edad de la primera menstruacion		Ultima menstruacion	
MEDICINAS QUE TOMA ACTUALMENTE			
Nombre	Dosis	Nombre	Dosis

HISTORIA FAMILIAR

Enfermedades	Si	Parentesco	Enfermedades	Si	Parentesco	Edad
Diabetes			Cancer de senos			
Embolias			Cancer de colon			
Enfermedades cardiacas			Cancer de ovario			
Presion Alta			Cancer de utero			

SOCIAL HISTORY

Habitos						
Fumar	S	<input type="checkbox"/>	No	<input type="checkbox"/>	Cajetillas diarias _____	anos _____
Tomar Alcohol	Si	<input type="checkbox"/>	No	<input type="checkbox"/>	Tragos diarios _____	Tragos semanales _____
Usar drogas	Si	<input type="checkbox"/>	No	<input type="checkbox"/>		
Uso del cinturon de seguridad	Si	<input type="checkbox"/>	No	<input type="checkbox"/>		
Ejercicios regularmente	Si	<input type="checkbox"/>	No	<input type="checkbox"/>		
Datos Personales						
Estado Civil	Casada	<input type="checkbox"/>	Soltera	<input type="checkbox"/>	Viuda	<input type="checkbox"/>
					Divorciada	<input type="checkbox"/>
Numero de hijos/hijas vivos	_____					
Numero de personas en su casa	_____					
Educacion	Secundaria	<input type="checkbox"/>	Universidad	<input type="checkbox"/>	Escuela de Graduados	<input type="checkbox"/>
					Otra	<input type="checkbox"/>
Empleo actual o el mas reciente	_____					

ESTUDIOS PREVENTIVOS

Estudio	Ultima Fecha	Resultados
Pruebas de PAP		
Colonoscopia		
Mamografia		
Densidad osea		

Completado por: Paciente Enfermera Medico

Firma del paciente: _____

Fecha que lo revisaron el paciente y el medico: _____

Firma del Medico: _____

Historia de su consulta anual

Fecha de la Consulta: _____ Firma del Medico: _____

Fecha de la Consulta: _____ Firma del Medico: _____

Fecha de la Consulta: _____ Firma del Medico: _____

Fecha de la Consulta: _____ Firma del Medico: _____