Tepeyac OB/GYN
Something More Than Medicine™

Patient Registration Information PLEASE PRINT – COMPLETE ALL FIELDS (Front & Back)

First Name:	M.I.	Last Name:	Date of Birth:

Home Phone Number: ( )	Can we leave a msg.? (Y/N)	Cell Phone Number: ( )	Can we leave a msg.? (Y/N)	Work Phone Number: ( )	Can we leave a msg.? (Y/N)

Home Address:	City:	State:	Zip:

Email:	Marital Status: □ Married □ Single □ Divorced □ Widowed Spouse Name:

Race: ☐Caucasian (White) ☐Black/African American ☐Asian ☐Native American ☐Asian Pacific American ☐Pacific Islander ☐Subcontinent Asian American ☐American Indian or Alaskan Native ☐Native Hawaiian ☐Other Race ☐More than one race ☐Decline to answer

Ethnicity: ☐Latino/Hispanic ☐Other ethnicity ☐Decline to answer

How did you hear about Tepeyac OB/GYN?

Complete ONLY if Under 18 Years or a Student

Mother's First Name:	□ Mother □ Step-Mother	M.I.	Mother's Last Name:	Mother's Date of Birth:	Mother's Social Security Number:

Mother's Home Address:	City:	State:	Zip:

Mother's Home Phone Number: ( )	Mother's Work Phone Number: ( )	Mother's Cell Phone Number: ( )

Father's First Name:	□ Father □ Step-Father	M.I.	Father's Last Name:	Father's Date of Birth:	Father's Social Security Number:

Father's Home Address:	City:	State:	Zip:

Father's Home Phone Number: ( )	Father's Work Phone Number: ( )	Father's Cell Phone Number: ( )

Primary Insurance Policy Holder: ☐ Patient ☐ Spouse ☐ Parent ☐ Other

Policy Holder's Name:	Policy Holder's Phone Number: ( )		Policy Holder's Social Security Number :	
If Different from Patient, Policy Holder's Address:	City:	State:	Zip:	Policy Holder's Date of Birth:

Primary Insurance Company Name:	Address:	City:	State:	Zip:

Member ID Number:	Group Number:	Co-Pay:	Effective Date:

Secondary Insurance Policy Holder: ☐ Patient ☐ Spouse ☐ Parent ☐ Other

Policy Holder's Name:	Policy Holder's Phone Number: ( )			Policy Holder's Social Security Number:
If Different from Patient, Policy Holder's Address:	City:	State:	Zip:	Policy Holder's Date of Birth:

Secondary Insurance Company Name:	Street Address (located on back of card):	City:	State:	Zip:

Member ID Number:	Group Number:	Co-Pay:	Effective Date:

Emergency Contacts

Primary Emergency Contact Name:	Relationship to Patient:	Phone Number: ( )
Secondary Emergency Contact Name:	Relationship to Patient:	Phone Number: ( )

Conditions of Registration

THE PRACTICE: Tepeyac Family Center LLC, dba Tepeyac OB/GYN and/or its physicians, employees, or agents will hereafter be referred to as "The Practice".

CONSENT FOR TREATMENT: The undersigned hereby consents to the administration of such medical treatment, diagnostic and/or therapeutic procedures and surgery as required by the physician rendering care for themselves and/or their child(ren). The procedures may include, but are not limited to, surgery, laboratory and radiology procedures.

AUTHORIZATION & ASSIGMENT OF INSURANCE BENEFITS: I do hereby authorize The Practice to apply for benefits for services rendered to myself or minor child(ren) under Medicaid, Medicare, or any health insurance policies/programs providing benefits and do hereby also assign and authorize payment of benefits from my (our) insurance company to The Practice (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.) I irrevocably authorize all such payments to The Practice. I authorize The Practice to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my (our) benefits.

RELEASE OF MEDICAL INFORMATION: I authorize The Practice to release any and all of my or my minor child(ren)'s medical records and/or other information and records required by my (our) insurance company or its designated review agents who provide insurance benefits on my (our) behalf, including if applicable, my employer and/or employer's workman's compensation insurance company, the Social Security Administration, or the Centers for Medicare & Medicaid Services CMS, needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to The Practice; and authorize any hospital, lab, physician, or other healthcare provider and/or their staffs and to release my or my minor child(ren)'s medical records and/or other records and information on myself or my minor child(ren) to The Practice as required for payment of benefits and/or required for medical or any other reasons; and authorize The Practice to release the above mentioned records for any of the above reasons. I agree to pay any applicable charges for having records copied. Such charges are .50 per page up to 50 pages and .25 per page thereafter in addition to USPS postage and a $10 handling fee.

REFERRALS AND AUTHORIZATIONS: If I have an insurance plan that requires any referrals, pre-certifications or authorizations I understand that it is my responsibility and not The Practice's to obtain approval from my insurance plan for medical services and/or procedures prior to such medical services and/or procedures being rendered. Some insurance companies may take up to 48 hours or more to obtain a referral. Additionally, if any aforementioned procedures are not done and medical services and/or procedures are rendered without the proper insurance approval, I understand that this may cause reduced or rejected coverage for which I will be held responsible and that any of these aforementioned actions do not guarantee that my insurance company will pay for the claims. Any denial of claims is between the policyholder/subscriber and their insurance. I (we) agree to inform The Practice immediately of any change in insurance coverage and/or benefits and change of personal information. I understand medical services may not be rendered without the proper referral on file.

FINANCIAL AGREEMENT: I agree that payment in full is due at the time of treatment. I also understand that I (we) may be billed separately for services rendered by other professionals including, but not limited to other physicians, radiologists, and laboratory work, as appropriate and in accordance with the services rendered. The Practice will file for insurance benefits and accept payments per The Practice's contractual agreements with the insurance company. Any questions or disputes concerning insurance coverage or payment of benefits is a matter between the insurance subscriber/policyholder and the insurance company. Any assistance in this matter granted by The Practice is given strictly as a courtesy and implies no responsibility on The Practice's part for filing, follow through or confirmation. I agree to pay a $50 fee for missed appointments that are not cancelled at least 24 hours in advance. I agree to pay a $30 fee for replacement prescription, orders, forms, or other documents previously provided by the office. If for any reason a check is returned on my account, I will be responsible for a $25.00 returned check fee in addition to the original fees for services. Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, not adding a dependent to insurance plan, non-payment at time of service and/or any other reason I agree to pay all charges within 30 days of services rendered. Interest of one and one-half percent per month, will be charged on all accounts over 60 days. If the balance is not paid within the 60 days or if agreed upon payment arrangements on my (our) account are not made, I authorize the practice to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify the credit bureaus of my (our) delinquencies. I understand that this will affect my (our) credit rating. If this account is placed for collection, I agree to pay one-third of the unpaid principal and interest as a collection or attorney fee, plus court costs and interest in the amount of one and one-half percent per month, beginning 60 days after the monies have become due or expenses have been incurred. Any expenses incurred by such collection actions, including maximum allowed interest, shall become an additional liability for which I (we) assume full responsibility. I understand and agree that the terms herein are reaffirmed each time services are received.

COPY OF SIGNATURE: I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic or telephonic.

CERTIFICATION: I certify that the information I have reported with regard to my (our) insurance coverage is correct and that the above be honored by my (our) insurance carriers. This certification will also apply to application for benefits under Title XVIII of the Social Security Act and/or any other governmental agency, if applicable. I also certify that I have read the forgoing and understand and fully accept the terms therein.

I certify that the information I have reported above is correct and that as the Patient/Parent/Guardian/Guarantor I have read, understand and fully accept the Conditions of Registration.

Print Name	Signature	DOB	Date
_____	_____	_____	_____

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4001 Fair Ridge Drive
Suite 304
Fairfax, VA 22033
(703) 273-9440
www.tepeyacobgyn.com

MEDICAL HISTORY

Date: _____

Name: Date of Birth: Age:

MENSTRUAL HISTORY	**PREGNANCY HISTORY** (include term, pre-term, miscarriage & abortion)								
First day of last period: ___ / ___ / _____	Name	DOB	Weeks pregnant	Type of delivery	Anesthesia	Hours of labor	Place of birth	Weight	Complications & Health
❒ Regular ❒ Irregular									
❒ Menopause ❒ Hysterectomy									
Age at onset:									
Days from start to start:									
Days of bleeding:									
# pads used daily:									
# tampons used daily:									
Non-menstrual bleeding: Y/N									
Severe menstrual pain: Y/N									

Family Planning method: ❒ Natural Family Planning ❒ Oral contraceptives ❒ IUD ❒ Condoms
❒ Female sterilization ❒ Male sterilization ❒ None ❒ N/A ❒ Other: _____

GYNECOLOGIC HISTORY

Last Pap Smear date: _____
❒ Normal ❒ Abnormal

Last Mammogram: _____
❒ Normal ❒ Abnormal

Last DEXA scan: _____
❒ Normal ❒ Abnormal

Last colonoscopy: _____
❒ Normal ❒ Abnormal

Check if you have **ever** had one of the following conditions:

- ❒ Abnormal Pap smear
- ❒ Breast Cancer
- ❒ Breast Lump
- ❒ Chlamydia
- ❒ Ectopic pregnancy
- ❒ Endometriosis
- ❒ Gonorrhea
- ❒ Herpes
- ❒ HIV
- ❒ Osteoporosis/Osteopenia
- ❒ Ovarian Cyst
- ❒ Polycystic Ovarian Syndrome
- ❒ Pelvic Inflammatory Disease
- ❒ STI/STD (other)

PERSONAL MEDICAL HISTORY (check if you have had any of the following)

- ❒ Allergies (seasonal)
- ❒ Anemia
- ❒ Anxiety
- ❒ Asthma
- ❒ Blood clot (DVT or PE)
- ❒ Cancer (specify) _____
- ❒ COPD
- ❒ Depression
- ❒ Diabetes, Type 1
- ❒ Diabetes, Type 2
- ❒ Ear disease/impairment
- ❒ Eating disorder
- ❒ Eye disease/impairment
- ❒ GERD/Reflux
- ❒ Head injury/concussion
- ❒ Heart disease
  - ❒ Coronary artery disease
  - ❒ Heart attack
  - ❒ Heart murmur
- ❒ Hepatitis
- ❒ High cholesterol
- ❒ High blood pressure
- ❒ Kidney disease
  - ❒ Kidney infection
  - ❒ Kidney stones
  - ❒ Kidney failure
- ❒ Lyme disease
- ❒ Meningitis
- ❒ Migraines, with aura
- ❒ Migraines, without aura
- ❒ Peptic ulcer
- ❒ Pneumonia
- ❒ Rheumatic fever
- ❒ Rheumatoid arthritis
- ❒ Skin disease
- ❒ Stroke
- ❒ Thyroid disease
  - ❒ Hyperthyroidism
  - ❒ Hypothyroidism
- ❒ Trauma (physical or emotional)
- ❒ Tuberculosis
- ❒ Other: _____

CURRENT MEDICATIONS	ALLERGIES	PREVIOUS SURGERY & YEAR

FAMILY HISTORY

	Age & Medical conditions		Age & Medical conditions
Father		Children 1	
Mother		2	
Siblings 1		3	
2		4	
3		5	
4		6	
5		7	

Check & write **who** in your family has:

- ❒ Cancer
  - ❒ Breast
  - ❒ Endometrial
  - ❒ Ovarian
  - ❒ Colon
- ❒ Diabetes
- ❒ Heart disease
- ❒ High blood pressure
- ❒ DVT/PE
- ❒ Stroke
- ❒ Epilepsy
- ❒ Thyroid Disease
- ❒ Osteoporosis

SOCIAL HISTORY

Tobacco use? Y/N	Do you exercise regularly? Y/N
# Cigarettes daily: _____	Do you eat dairy or take calcium? Y/N
Alcohol use? Y/N	Occupation:
# beverages weekly: _____	Religion:
Sexually active: Current / Past / Never	Marital Status:

Are you currently experiencing any of the following symptoms?

CONSTITUTIONAL:
- ❒ Fatigue
- ❒ Fever
- ❒ Weight Gain
- ❒ Weight Loss

HEENT:
- ❒ Change in hearing
- ❒ Nose bleeds
- ❒ Sore throat
- ❒ Worsening vision

RESPIRATORY:
- ❒ Cough – productive or dry
- ❒ Shortness of Breath
- ❒ Wheezing

CARDIOVASCULAR:
- ❒ Chest Pain
- ❒ Leg or ankle swelling
- ❒ Palpitations

BREAST:
- ❒ Breast Lump/Mass
- ❒ Breast Pain
- ❒ Nipple Discharge

GASTROINTESTINAL:
- ❒ Constipation
- ❒ Dark/bloody stools
- ❒ Diarrhea
- ❒ Nausea/Vomiting

REPRODUCTIVE
- ❒ Painful Intercourse
- ❒ Vaginal discharge
- ❒ Vaginal itching/burning

URINARY:
- ❒ Painful Urination
- ❒ Blood in Urine
- ❒ Urinary frequency
- ❒ Loss of urine with cough/sneeze

MUSCULOSKELETAL:
- ❒ Back Pain
- ❒ Joint Pain, Stiffness, Swelling
- ❒ Weakness

NEUROLOGIC:
- ❒ Headaches (new onset)
- ❒ Memory Loss
- ❒ Numbness
- ❒ Tremors

PSYCHIATRIC:
- ❒ Anxiety
- ❒ Depression
- ❒ Insomnia
- ❒ PMS/Mood Swings

ENDOCRINE/HORMONAL:
- ❒ Excessive Thirst
- ❒ Hot flashes, night sweats
- ❒ Hot/Cold Intolerance

HEMATOLOGIC/LYMPHATIC:
- ❒ Easy Bruising
- ❒ Swollen Lymph Glands/Nodes

SKIN:
- ❒ Dry skin
- ❒ Rash
- ❒ New/changing skin lesion
- ❒ Hair loss
- ❒ Excessive body/facial hair

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Name: _____ Date of Birth:_____ Today's Date: ____ _____

Obstetric Medical & Genetic Survey

Thank you for choosing Tepeyac Family Center for your pregnancy. We look forward to walking with you through this exciting time and aim to provide you and your pre-born baby with comprehensive and excellent medical care. To do so, we must assess your risk for various medical conditions, genetic disorders, and infectious diseases. Your answers, like your entire medical record, are kept strictly confidential. Please provide as accurate and complete information as possible so we may best serve you.

OB/GYN History

Please list all previous pregnancies including term, preterm, miscarriage & abortion.

First day of last period: ___ / ___ / _____ ❒ Regular ❒ Irregular	Name	DOB	Weeks pregnant	Vaginal or C-section	Anesthesia	Hours of labor	Place of birth	Weight	Complications & Health
Date of ovulation (if known): ___ / ___ / _____									
Weight prior to pregnancy: _____									

Personal & Family Medical History

Please check if any of the following medical conditions apply to **you** or to a member of **your family**.

Condition	√	Comments	Condition	√	Comments
Allergies (seasonal)			Liver disease		
Anemia/blood disorder			Neurologic disorder		
Asthma/pulmonary disorder			Kidney/renal disease		
Autoimmune disorders			Rh-negative		
Abnormal Pap Smear			Thyroid disorder		
Previous Blood Transfusion			Previous trauma/accident		
Breast disorder			Reproductive abnormality		
Depression			Varicosities or blood clot		
Other psychiatric disorder			Anesthesia complications		
Diabetes (gestational, other)			Other medical condition		
Heart Disease					
High blood pressure			Tobacco use & packs/day		
Infertility			Alcohol use & drinks/day		
			Recreational or IV drug use		

Turn over →

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Genetic Screening

Please check if any of the following genetic conditions apply to **you**, the **father of the baby**, or **either of your families**. Provide further details in the comments section.

Condition	√	Comments	Condition	√	Comments
Your age >35 at due date			Autism		
Neural tube defect (ie. spinal bifida)			-- If Yes, were they tested for Fragile X?		
Down Syndrome			Mental Retardation		
Congenital Heart Defect			-- If Yes, were they tested for Fragile X?		
Cystic Fibrosis			Muscular Dystrophy		
Tay-Sachs			Sickle cell disease or trait		
Thalassemia			Other genetic disorder		
Canavan Syndrome			Maternal metabolic disorder (ie. PKU)		
Hemophilia or hematologic disease			3+ miscarriages, or previous stillborn		
Huntington's Chorea			Other birth defects		

Exposure to Infectious Diseases

	Yes/No	Comments
Are you or your partner HIV-positive? - Have either of you ever used IV drugs? - Have either of you had other partners in the past 5 years? - Have either of you had sexual contact with men who have sex with men?	Y / N Y / N Y / N Y / N	
Have you or your partner had genital herpes?	Y / N	
Have you ever been exposed to active tuberculosis? - Have you lived with someone with TB? - Have you lived in a country with high rates of TB? - Have you lived in a communal home, shelter or prison?	Y / N Y / N Y / N Y / N	
Since your last period, have you had a rash or viral illness?	Y / N	
Have you ever been diagnosed or treated for a sexually transmitted infection? (ie. chlamydia, gonorrhea, syphilis)	Y / N	
Have you had the chicken-pox in the past? - If not, have you received the vaccine?	Y / N Y / N	
Have you been previously diagnosed with any other infectious disease?	Y / N	
Do you own or regularly come in contact with a cat?	Y / N	

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Records Release TO Tepeyac OB/GYN

Please note that processing records for release requires 5-10 business days.

I hereby authorize the release of my medical records to:

Tepeyac OB/GYN

4001 Fair Ridge Dr., Ste. 304

Fairfax, VA 22033

Phone: 703-273-9440 Fax: 703-273-9445

□ All Records □ X-Ray/Sonogram Reports □ Prenatal Reports □ Discharge Summary

□ Operative Reports □ Lab Reports □ Other: _____

PATIENT INFORMATION:

Name:		Date of Birth:	
Address:	City:	State:	Zip Code:
Phone:	Signature of Patient or Legal Guardian:		

PROVIDER INFORMATION:

Requesting Records From:			
Address:	City:	State:	Zip Code:
Phone:	Fax:		

To avoid delay in processing your request, please complete this form with the correct information. Call your prior doctor's office and obtain their address and fax number if you do not know it.

TO THE PROVIDER: Protected Health Care Information is personal and sensitive information related to a person's healthcare. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

Receipt of Notice of Privacy Practices

I have received and reviewed a copy of Tepeyac OB/GYN's Notice of Privacy Practices either online at www.tepeyacobgyn.com or by receiving a copy at the Tepeyac's office. The notice provides information about the use and disclosures of my protected health information by Tepeyac, my individual rights, and The Practice's duties with respect to my protected health information.

I understand that Tepeyac OB/GYN reserves the right to change the terms of its Notice of Privacy Practices and to make new versions effective for all protected health information it maintains, and that I can obtain Tepeyac OB/GYN's current Notice of Privacy Practices on request from Tepeyac OB/GYN and on its website.

Name: _____ Signature: _____ DOB: _____ Date: _____
Print name of person signing if other than patient and relationship to patient: _____

HIPAA Authorization: Health & Financial Disclosure

Persons Authorized to Receive Information:

Name:	Emergency Contact? (Y/N)	Relationship to Patient:	Phone No.:	Information Authorized: (e.g. All, medical only, financial only, emergency contact only)

□ Yes, sign me up for Tepeyac's Patient Portal. Email: _____

I authorize Tepeyac OB/GYN to leave a detailed message regarding my healthcare issues or test results on my answering machine, voice mail, or text messaging attached to the following numbers specified below:

Home Phone _____ Cell Phone _____ Work Phone _____

I acknowledge that all of the above information will remain in effect for one year from today's date and I may revoke the(se) authorizations (except to the extent that action was already taken in reliance on the(se) signed authorizations) at any time by notifying Tepeyac OB/GYN in writing.

I acknowledge that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment.

I understand that I may inspect or copy any information used or disclosed under this agreement to someone who would not otherwise be entitled to use or disclose for payment, treatment, or Tepeyac operations, or as otherwise described in the Notice of Privacy Practices.

I understand that if the person or organization that received the information is not a healthcare provider, healthcare plan of Tepeyac covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.

Signature: _____ Date Signed: _____

Privacy Notice

Notice of Patient Privacy Practices
For Tepeyac OB/GYN. Effective August 1, 2014

4001 Fair Ridge Drive Suite 304, Fairfax, VA 22033
Phone: (703) 273-9440 ● Fax: (703) 934-9445
www.tepeyacobgyn.com ● info@tepeyacobgyn.com

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.

Safeguarding your private health information under the Health Insurance Portability and Accessibility Act (HIPAA), as amended, the HIPAA Privacy and Security Regulations, and other federal and state laws is very important to us. We keep your health and financial information private, as required by law, and our rules. This notice explains your rights, our legal duties and privacy practices. We are required by law to give you this notice and to follow the duties and practices described in it. We will let you know promptly if a breach occurs that may compromise the privacy or security of your information. We willnot use or share your information other than as described here, in which case you need to let us knowof the change in writing to stop our future disclosures of your health information. Information disclosed before you have revoked your authorization will not be returned and any actions that we have already taken based on prior authorization will not be affected.

Please review this notice carefully and sign the acknowledgment form.

You may contact us to address any concerns or questions about the privacy of your health information or financial information provided to us. If you believe your privacy has been violated, you may contact us to discuss your concerns or to file a complaint. Please contact the Privacy Officer, Tepeyac OB/GYN, attn. Practice Administrator at the telephone number 703-273-9440, www.tepeyacobgyn.com, or 4001 Fair Ridge Drive, Fairfax, VA 22033. You may also file a complaint with the Secretary of the United States Department of Health and Human Services. You will not be penalized or retaliated against for filing a complaint or voicing a privacy concern.

We may change this notice at any time. Changes will apply to the protected health information we already have about you and any protected health information about you we obtain in the future. We must tell you about any changes to our privacy notice and follow the notice in effect. We may tell you about changes by posting the revised privacy notice on our websites, posting a summary in the waiting room at our practice, and making copies available upon your request.

Your Protected Health Information

Your protected health information (sometimes abbreviated “PHI”) is information that identifies you or can be used to identify you; that either comes from you or has been created or received by a healthcare provider, a healthcare plan, your employer, or a healthcare clearinghouse; and has to do with your physical or mental health or condition, providing healthcare to you, or paying for providing healthcare to you.

How We Collect Other Information About You: Tepeyac OB/GYN (Tepeyac) and its employees collect data through a variety of means including but not necessarily limited to letters, phone calls, emails,