New Patient

CORNERSTONE
Ob-Gyn

Welcome!

We would like to take this opportunity to welcome you to our practice and thank you for choosing our physicians to participate in your health care. We look forward to providing you with a personalized and comprehensive approach, focusing on wellness and prevention, along with all of your gynecological and obstetrical needs.

Our office is open Monday through Thursday from 8:00am to 5:00pm and on Friday from 8:00am to 12:00pm. After-hours care will be provided for emergent concerns only by calling our office directly.

Please bring a photo I.D., health insurance card, as well as a list of all your medications, strength and dose to your appointment. We kindly ask that you be able to provide this information at each and every visit. We do collect copays, deductibles and coinsurance amounts as services are rendered. We accept cash, check, credit or debit cards for payment.

Your appointment is scheduled based on the information provided at the time of scheduling. If your insurance changes prior to your initial appointment or throughout your medical care, you must contact our billing office prior to your appointment so that we may verify your new information.

Our office utilizes a safe and secure patient portal to address any non-urgent concerns, such as prescription refills, patient results and any questions you may have for our scheduling or billing staff. The patient portal can be accessed through clicking the button in the header of our website (cornerstoneobgyn.com).

Once again, we would like to thank you for choosing our office to provide your care. We look forward to working with you.

Dr. Kendra Bookout & Dr. Lauren Schaub

Consent

THIS IS A LIFETIME CONSENT. IT IS THE SOLE RESPONSIBILITY OF THE PATIENT TO MAKE CHANGES TO THIS CONSENT AS NEEDED.

CONSENT TO TREAT: I (the patient/guardian/legal representative to the patient acting on the patient's behalf) give permission for medical treatment, including radiological and laboratory procedures, to be performed by the physicians and staff of Cornerstone Ob-Gyn, PLLC.

PHARMACY/MEDICATION HISTORY: I authorize Cornerstone Ob-Gyn, PLLC to obtain all of my medication history, in any format to provide my medical care. This consent is valid from this date forward.

CONSENT FOR PHOTOGRAPHS: Photographs are taken of our patients for patient recognition purposes. If photographs are sent to the office (newborn baby pictures), these photos may be displayed in the office in a public area.

PATIENT RECORD OF DISCLOSURES: In general, the HIPAA (Health Insurance Portability and Accountability Act) privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted by phone: ☐ Yes ☐ No

If Yes, Phone#: _____

PLEASE SELECT IF APPLICABLE:

☐ Leave a message with detailed information

☐ Leave a message with call back number only

☐ Please do not leave a message

THE FOLLOWING PEOPLE MAY HAVE ACCESS TO MY MEDICAL INFORMATION:

☐ No one should have access to my medical information.

☐ Name:_____ Relationship:_____

☐ Name:_____ Relationship:_____

EMERGENCY CONTACT:

Name:_____ Phone:_____

I have reviewed the office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that it is my responsibility to notify the practice if there is someone to whom I do not wish my information released.

PLEASE BE AWARE THAT ANYONE ACCOMPANYING A PATIENT TO AN EXAM ROOM IS PRIVILEGED TO HEAR YOUR PRIVATE HEALTH INFORMATION (PHI).

FINANCIAL AGREEMENT: The person signing below agrees, whether he/she signs as a patient or representative of the patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account at the regular rates of Cornerstone Ob-Gyn, PLLC. Should the account be referred to an attorney for collection, the person signing below shall pay reasonable attorney's fees and collection expenses.

"I assign payment for the unpaid charges for certain medical treatment furnished by the physician and staff of Cornerstone Ob-Gyn, PLLC. I understand that I am responsible for any health insurance deductibles and coinsurance at the time services are rendered."

ASSIGNMENT OF BENEFITS: In consideration of services rendered, I hereby assign to Cornerstone Ob-Gyn, PLLC all rights, title and interest in any payment due for services described herein as provided in the policy or policies of insurance. I agree to pay the charges of Cornerstone Ob-Gyn, PLLC which is greater than the amount paid by the insurance company or companies.

Patient Name (Printed)

Patient Signature Date

If patient is unable to sign:

Patient Representative (Printed) Relationship to Patient

Patient Representative Signature Date

Witness Signature Date

Reason patient is unable to sign:

New Patient

CORNERSTONE
Ob-Gyn

Personal Information

Full Name: _____
FIRST MI LAST

Date of Birth: _____ Race/Ethnicity: _____

Driver License#: _____ SS#: _____

Address: _____
STREET APT# CITY STATE ZIP

Phone: _____ _____ _____
CELL HOME WORK

Email Address: _____ Marital Status: _____

Spouse Name: _____ Spouse DoB: _____

Your Employer: _____ Occupation: _____

Referred By: _____

Insurance Information

Policy Holder: _____
FIRST MI LAST

Date of Birth: _____ SS#: _____

Insurance Carrier: _____ Phone: _____

Member ID#: _____ Group#: _____

Please notify staff of any secondary insurance plans.

Emergency Contact

Name: _____ Relationship: _____

Phone: _____ _____
BEST CONTACT # ALTERNATIVE #

Acknowledgment

Please review the following statements and sign/date below.

- I will call the office if I have not received my results in one month (results will be sent through the patient portal).
- I will read all medication pamphlets for risks and benefits; I understand that when taking medications, I assume my risk or reaction in the pamphlet is a possible medical complication for me.
- I am aware that any hormone therapy that is prescribed to me carries a risk of blood clots.
- Preventative/annual exams are generally covered at 100% by most insurance payers. Please be aware that if we collect a pap smear at your annual exam, there is an additional fee that will be billed from the pathologist reading your specimen.
- If you have any problems or concerns, or if the physician finds any abnormalities that are addressed at the time of your annual exam, this service is considered separate from your preventative exam and could result in a separate office visit and/or labs being billed. These guidelines are set forth by The American Medical Association and we are required to follow the guidelines. By signing below, you acknowledge that you are aware that any services not considered preventative may be applied to your responsibility. This amount will be determined by your health insurance provider.
- If your insurance company requires special handling of labs or pathology, it is your responsibility to notify our office at the time of your appointment.

Patient Signature _____ Date _____

Patient History

Please fill in all information on the front and back of this form.

Date:_____

Name: _____ Date of Birth: _____

Primary Care Physician: _____ Referred By: _____

Preferred Pharmacy: _____ Pharmacy Phone#: _____

Please describe any special problems or symptoms that you would like to discuss:_____

_____

MENSTRUAL HISTORY

First day of last period ____ /____ /____ Age at first period

Your periods occur every _____ days and last for _____ days.

Any problems with your periods? ☐ No ☐ Yes

☐ Heavy Flow
☐ Clots
☐ Pain/Cramping
☐ Irregular Periods
☐ Discharge
☐ Bleeding Between Periods
☐ Other: _____

If Menopausal: Age/year began _____

Any postmenopausal bleeding? ☐ No ☐ Yes

CONTRACEPTIVE HISTORY

Are you currently sexually active? ☐ No ☐ Yes ☐ Never

How many life time partners? _____
How many in the last year? _____

Current method of birth control? _____
(Include tubal or vasectomy)

Any problems with current method? ☐ No ☐ Yes _____

Previously used methods (Check all that apply):

☐ Birth Control Pill
☐ Diaphragm
☐ IUD
☐ Implanon
☐ Nexplanon
☐ Condoms
☐ Depo Provera
☐ NuvaRing
☐ Spermicide
☐ Sponge
☐ Other: _____
☐ None

GYNECOLOGICAL HISTORY

Have you had any of the following? (Check all that apply)

☐ Abnormal Pap Smear
☐ DES Exposure
☐ Infertility
☐ PID
☐ Recurrent Vaginitis
☐ Urinary Incontinence
☐ Breast Pain
☐ Endometriosis
☐ Ovarian Cysts
☐ PMS
☐ UTI (chronic)
☐ Chronic Pelvic Pain
☐ Genital Warts
☐ Pain with Intercourse
☐ Recurrent Miscarriage
☐ Uterine Fibroids
☐ STD _____
☐ **None of the above**

(*Additional medical history on the back of this form*)

PREVENTATIVE CARE HISTORY

Last Pap Smear Date: _____ ☐ Norm ☐ Abnorm
Last Mammogram Date: _____ ☐ Norm ☐ Abnorm
Last Colonoscopy Date: _____ ☐ Norm ☐ Abnorm
Last DEXA (Bone Scan) Date: _____ ☐ Norm ☐ Abnorm
Last Cholesterol Test Date: _____ ☐ Norm ☐ Abnorm

Vaccinations (year received)

Gardasil _____ Flu _____
Herpes Zoster (Shingles) _____ TDAP (Tetanus) _____

TOTAL PREGNANCIES	FULL TERM DELIVERIES	PREMATURE DELIVERIES	ELECTIVE TERMINATIONS	MISCARRIAGES	ECTOPICS	MULTIPLES	LIVING

DATE	GESTATION AGE #Wks @ Delivery	HOURS IN LABOR	BIRTH WEIGHT	SEX	TYPE OF DELIVERY	TYPE OF ANESTHESIA	EARLY LABOR	COMMENTS / COMPLICATIONS GESTATIONAL DIABETES	HOSPITAL

SURGICAL HISTORY

☐ None

Please list all surgical procedures.

Surgery *Date*

CURRENT MEDICATION HISTORY

☐ None

Please include current prescriptions and over the counter medications.

Prescription/Medication *Dose*

ALLERGY HISTORY

☐ None

Please list all allergies and reactions.

Medication/Environmental/Food Allergy *Reaction (if known)*

SOCIAL & LIFESTYLE HISTORY

Marital Status _____ Occupation _____

Tobacco Smoker ☐ N/A ☐ Former ☐ Current: _____ /day

Caffeine Use ☐ No ☐ Yes

Alcohol Use ☐ No ☐ Yes If yes, _____ drinks per week

Exercise ☐ No ☐ Yes Type _____ Amt/wk _____

Domestic Abuse ☐ No ☐ Yes If yes, ☐ Current or ☐ Past

Drug Use ☐ No ☐ Yes If yes, type: _____

Number of years? _____ How Often?: _____

Have you had Chicken Pox ☐ No ☐ Yes

Monthly Breast Exam ☐ No ☐ Yes

Do you have a Health Care Directive *(living will)* ☐ No ☐ Yes

PAST MEDICAL HISTORY CONTINUED

Please check all that apply.

MEDICAL PROBLEM	SELF	FAMILY	RELATIONSHIP
Anemia	☐	☐	
Anxiety	☐	☐	
Asthma	☐	☐	
Blood Clotting Disorder	☐	☐	
Cancer; Breast	☐	☐	
Cancer; Cervical	☐	☐	
Cancer; Colon	☐	☐	
Cancer; Ovarian	☐	☐	
Cancer; Skin-type: _____	☐	☐	
Cancer; Uterine	☐	☐	
Cancer; Other: _____	☐	☐	
Cardiac Arrhythmia	☐	☐	
Coronary Artery Disease	☐	☐	
Crohn's Disease	☐	☐	
Cystic Fibrosis	☐	☐	
Deep Vein Thrombosis (DVT)	☐	☐	
Depression	☐	☐	
Diabetes-type: _____	☐	☐	
Eating Disorder-type: _____	☐	☐	
Gastric Ulcer	☐	☐	
Gastroesophageal Reflux Disease	☐	☐	
Gestational Diabetes	☐	☐	

MEDICAL PROBLEM	SELF	FAMILY	RELATIONSHIP
Glaucoma	☐	☐	
Hepatitis-type: _____	☐	☐	
Hyperlipidemia (High Cholesterol)	☐	☐	
Hypertension (High Blood Pressure)	☐	☐	
Irritable Bowel Syndrome	☐	☐	
Kidney Stones	☐	☐	
Lupus	☐	☐	
Migraines	☐	☐	
Multiple Sclerosis	☐	☐	
Osteoporosis	☐	☐	
Parkinson's Disease	☐	☐	
Pulmonary Embolism	☐	☐	
Rheumatoid Arthritis	☐	☐	
Scoliosis	☐	☐	
Seizures	☐	☐	
Sickle - Cell Disease	☐	☐	
Sleep Apnea/Disorder	☐	☐	
Stroke	☐	☐	
Thyroid Disorder-type: _____	☐	☐	
Tuberculosis	☐	☐	
Ulcerative Colitis	☐	☐	
Other: _____	☐	☐	