Grande Dunes ObGyn & Facial Aesthetics

913 Medical Circle, Myrtle Beach, SC 29572
Tel 843.839.2229 Fax 843.839.2230

Patient Registration Form

Date:_____

First Name:_____ MI:_____ Last Name:_____

Date of Birth:_____ Age:_____ Race:_____ Social Security #:_____

Address:_____ Apt/Unit#:_____

City:_____ State:_____ Zip Code:_____

Primary Phone#:_____ Other Phone #:_____

Driver's License #:_____ Marital Status (circle): Single / Married / Divorced / Widow

Email:_____

Employment (circle): Full Time / Part Time / Student / None May we contact you at work? Yes / No

Employer/School name:_____ Employer Phone #:_____

Emergency Contact:_____ Relationship to you:_____ Phone#:_____

Spouse Information or Responsible Party (if Minor)

First Name:_____ MI:_____ Last Name:_____

Date of Birth:_____ Age:_____ Race:_____ Social Security #:_____

Address:_____ Apt/Unit#:_____

City:_____ State:_____ Zip Code:_____

Primary Phone#:_____ Other Phone #:_____

Email:_____ Relationship to Patient:_____

Employer:_____ Employer Phone #:_____

May we contact them at work? Yes / No

Primary Insurance Information

Name of Policy Holder:_____ Date of Birth:_____

Policy Holder's Relationship to Patient (circle): Self / Spouse / Parent

Name of Insurance Company:_____ Insurance Co. Phone#:_____

Policy Number:_____ Group Number:_____

Policy Holder's Employer:_____ Employer Phone #:_____

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices for the patient listed above.

_____ _____

Signature of Patient / Guardian Date

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COMPOUND AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____ **Date of Birth**:_____

Grande Dunes ObGyn & Facial Aesthetics is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Please CHECK entities / persons that YOU approve to receive information:

1.) **Can we leave information on your voicemail?** YES _____ NO _____

Telephone #:_____

If yes to the above, what information may we leave?

Lab Results ___ Pap Results ___ Imaging Results ___ Financial Info ___ Billing Info ___ Appts ___

Medical as follows: _____

2.) **Can we email information to you?** YES _____ NO _____

Email:_____

If yes to the above, what information may we leave?

Lab Results ___ Pap Results ___ Imaging Results ___ Financial Info ___ Billing Info ___ Appts ___

Medical as follows: _____

3.) **Please list anyone else you authorize us to leave information with:** (ie: **spouse / significant other / parent / etc)**

Name: _____ Telephone #: _____ Relationship to you:_____

Name: _____ Telephone #: _____ Relationship to you:_____

Name: _____ Telephone #: _____ Relationship to you:_____

What information may we leave?

Lab Results ___ Pap Results ___ Imaging Results ___ Financial Info ___ Billing Info ___ Appts ___

Medical as follows: _____

Rights of the Patient:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending written notification to Grande Dunes ObGyn & Facial Aesthetics. I understand that a revocation is not effective in cases where information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative Date

Description of Personal Representative (attach necessary documentation) _____

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Tatiana Vu-Molaschi, MD
ABOG Board Certified

FINANCIAL POLICY

PATIENT RESPONSIBILITY:

Patients are responsible for payment in full on their account regardless of insurance coverage. Patients are responsible for presenting current insurance information at the time of service, and for understanding the provisions and limitations of their insurance plan. The Doctor neither knows, nor can she adjust billing according to what is or not covered.

If Grande Dunes ObGyn & Facial Aesthetics is a participating provider with the patient's insurance, the patient will be responsible for payment of any deductible and co-payment at the time of service. Grande Dunes ObGyn & Facial Aesthetics will accept and bill the insurance company for the contracted fee. However, if the insurance company denies the charges or fails to pay any portion of the bill, the patient agrees to pay that portion immediately.

If Grande Dunes ObGyn & Facial Aesthetics is not a participating provider with the patient's insurance company, the patient will be responsible for payment in full of all charges at the time of service. As a courtesy, Grande Dunes ObGyn & Facial Aesthetics will bill the insurance company on the patient's behalf.

- Many insurance companies DO NOT cover preventative services (routine annual exams). Patients are responsible for payment pf all non-covered services at the time of service.
- We are frequently asked to call in prescriptions. There is a $10.00 administrative fee for refills outside of an office visit. This charge is not covered by any insurance company and will be billed to the patient.
- There is a $20.00 fee for all forms that patients request our office to complete. This charge is not covered by any insurance company and will be billed to the patient.
- Medical appointments require at least 24 hour cancellation prior to appointment time otherwise will incur a $25.00 fee.
- Cosmetic appointments require at least 48 hour cancellation prior to appointment time otherwise will incur a $50.00 fee.
- Refunds for overpayment will be subject to a 3% service charge if original payment was made by credit card.

MEDICAID:

Medicaid is s federal and state funded program designed to provide coverage of medically necessary services for individuals that meet a minimum income criteria. We do not accept Medicaid when the patient has any other primary insurance coverage.

We DO NOT accept or file insurances (including Medicaid) retroactively from the date of services rendered.

NOTE: ***The waiver of deductibles and co-pays is unlawful and may be construed by the Federal Government as Insurance Fraud***

YOU WILL BE RESPONSIBLE FOR ALL COLLECTION FEES.

I have read and agree to the above terms and conditions. I authorize the release of any medical information necessary to process insurance claims. I authorize payment of medical benefits directly to Grande Dunes ObGyn & Facial Aesthetics for services rendered.

_____ _____

PATIENT SIGNATURE DATE

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Tatiana Vu-Molaschi, MD
ABOG Board Certified

The American Congress of Obstetrics and Gynecology recommends HPV co-testing with pap smears on patients 30-65 years old. An HPV test may be done at the time of your pap smear as a result. Standard of care may involve HPV testing once every three years or more frequently. Please be aware of your insurance coverage regarding this testing. Ie: some insurance companies will only cover testing once every 5 years.

If you are 21-29 years of age, an HPV test may be done depending on the results of your pap smear.

Please sign below to acknowledge that you have read and understand this information.

_____ _____

Signature Date

GRANDE DUNES OBGYN & FACIAL AESTHETICS
1021 CIPRIANA DR. SUITE 250
MYRTLE BEACH, SC 29572
TEL 843.839.2229 FAX 843.839.2230

Prenatal Questionnaire

Name: _____ DOB: _____ Date: _____

Race: ___ Caucasian ___ Black ___ Latin ___ Asian ___Other:_____

Marital Status: ___Married ___Single ___Separated ___Divorced ___Widowed

Father of Baby: _____ _____Age: _____Race:_____

Are you employed? ___Yes ___No If YES, who is your Employer? _____

Primary Language: _____

Menstrual History

What was the first day of your last menstrual period? _____/_____/_____

Do you have regular monthly periods? ___Yes ___No

Were you on birth control when you got pregnant? ___Yes ___No

Have you had any significant Nausea? ___Yes ___No Vomiting? ___Yes ___No

Any other symptoms you are concerned about since your positive pregnancy test? _____

_____

Past Pregnancies

How many times have you been pregnant? _____ How many full term deliveries have you had? _____

How many premature deliveries (before 37weeks) have you had? _____ How many miscarriages? _____

How many abortions have you had? _____ Have you ever had an ectopic pregnancy? _____

Have you ever had twins or triplets? _____ How many living children do you have? _____

Have you had recurrent miscarriages? _____ Or ever had a stillbirth? _____

Past Pregnancies

Year of Birth	How many weeks pregnant?	Birth Wt	M/F	Vaginal/ C-section	Premature Labor?	Place of Delivery	Any problems with delivery or baby?

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Prenatal Questionnaire Continued

Medical History

Do you have a history of any of the following medical problems?

Diabetes	Y	N
Hypertension	Y	N
Heart Disease	Y	N
Autoimmune Disease	Y	N
Kidney Disease	Y	N
Frequent Urinary tract Infections	Y	N
Seizures/Epilepsy	Y	N
Migraine Headaches	Y	N
Psychiatric Disorders	Y	N
Depression	Y	N
Hepatitis/Liver disease	Y	N
Blood Clots in Legs or Lungs	Y	N
Thyroid Disease	Y	N
Lung Disease/Asthma	Y	N
Seasonal Allergies	Y	N
Breast problems	Y	N
Uterine Fibroids/abnormalities	Y	N
Ovarian Cysts	Y	N
Polycystic Ovarian Syndrome	Y	N
Hx of ABNORMAL pap smear	Y	N

If you answered YES to any of the above, please give details: _____

_____

Please list any prescription or over the counter medications you have taken since your last menstrual period:

_____

Allergies to medication?_____

LATEX ALLERGIC? Y N

Please list any surgeries in the past with dates:

_____

_____

Have you had any problems with anesthesia in the past? Y N

If YES, please give details: _____

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Prenatal Questionnaire Continued

Have you ever received a blood transfusion? Y N When:_____

Are you a cigarette smoker? Y N How much per day? _____ How many years of use? _____

Do you drink alcohol? Y N How often do you drink? _____

Do you use any illicit drugs? Y N If yes, which ones?_____

Do you have any problems with violence or abuse at home? Y N

Your Family Medical History

Has anyone in your family been diagnosed with the following medical problems (grandparents, parents, children, siblings)?

Diabetes	Y	N
Heart Disease	Y	N
Stroke/Blood Clots	Y	N
Hypertension	Y	N
Cancer-breast, uterine, ovarian, colon	Y	N
Autoimmune Disease	Y	N
Thyroid Disorder	Y	N

Genetic History

Has anyone in your family or the father of the baby's family ever been diagnosed with the following?

Anemia /Blood Disorders	Y	N
Italian, Greek, Mediterranean descent	Y	N
Jewish, French Canadian, Cajun	Y	N
Tay-Sachs	Y	N
Spina Bifida	Y	N
Canavan's Disease	Y	N
Sickle Cell Anemia/Trait	Y	N
Hemophilia	Y	N
Muscular Dystrophy	Y	N
Cystic Fibrosis	Y	N
Huntington's Chorea	Y	N
Mental Retardation/Autism	Y	N
Fragile X Syndrome	Y	N
Inherited or Chromosomal Disorders	Y	N

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Prenatal Questionnaire Continued

Genetic History Continued

Metabolic Disorders(PKU)	Y	N
Cleft Lip/Palate	Y	N
Deafness or Blindness at birth	Y	N
Birth Defects	Y	N

Will you be **35 or older** when you deliver? Y N

History of Infections

Have you ever been diagnosed with any of the following sexually transmitted infections?

___ Chlamydia	___Hepatitis B	___Syphilis
___Gonorrhea	___Hepatitis C	___Genital Warts
___Trichimonas	___HIV	___Herpes (you or your partner)

Have you ever been exposed to Tuberculosis or ever had a positive TB test? Y N

Have you had chicken pox? Y N

Do you have cats in your home? Y N

Do you have a history of **MRSA** infection within the last 3 years? Y N

Summary

Do you have any additional information you would like to share or any questions for your provider?

_____

_____

_____

_____

_____

Are you considering adopting out? Y N

Please Provide Pharmacy you would like prescriptions escribed to:_____