Generations Ob/Gyn

RE: Insurance Benefits

Dear Patient:

Welcome to GENERATIONS OB/GYN. We will do our best to help you with the insurance process, but we need your help. It is imperative that you keep us informed of any changes in your coverage so that we may work with your insurance company to get the best coverage possible.

As the insured, you are responsible to know what your insurance plan covers and you will be responsible to pay for any charges or balances not covered by your insurance company.

Please sign below in agreement of these terms and return to our office staff. Thank you.

Patient Name (print): _____ Date of Birth _____

Patient Signature: _____ Date: _____

46 Prince Street New Haven, CT 06519 203-562-6741

2446 Whitney Avenue Hamden, CT 06518 203-248-4461

850 North Main Street Ext. Wallingford, CT 06492 203-294-1003

5 Durham Road Guilford, CT 06437 203-453-4766

GENERATIONS OB/GYN
REVIEW OF SYSTEMS

PATIENT NAME:_____ DATE: _____
DATE OF BIRTH: _____
PHARMACY: _____ PHARMACY LOCATION: _____
PREFERRED CONTACT NUMBER: _____ OKAY TO LEAVE A MESSAGE? ____YES ____ NO
EMAIL ADDRESS: _____
EMERGENCY CONTACT NAME: _____
EMERGENCY CONTACT NUMBER: _____

ARE YOU CURRENTLY (OR WITHIN THE PAST 30 DAYS) EXPERIENCING ANY OF THE FOLLOWING:

GENERAL
- ◯ WEIGHT GAIN > 10#
- ◯ WEIGHT LOSS > 10#
- ◯ CHANGE IN APPETITE
- ◯ FEVER
- ◯ NIGHT SWEATS

BREAST
- ◯ BREAST MASS
- ◯ BREAST PAIN
- ◯ NIPPLE DISCHARGE
- ◯ SKIN CHANGES

PSYCHIATRIC
- ◯ ANXIETY
- ◯ DEPRESSION
- ◯ CHANGES IN SLEEP
- ◯ INABILITY TO CONCENTRATE

SKIN
- ◯ CHANGE IN WART/MOLE
- ◯ EXCESSIVE SWEATING
- ◯ RASH
- ◯ SKIN COLOR CHANGE

GASTROINTESTINAL
- ◯ ABDOMINAL PAIN
- ◯ BLACK STOOL
- ◯ CONSTIPATION
- ◯ DIARRHEA
- ◯ RECTAL BLEEDING

ENDOCRINE
- ◯ INTOLERANCE TO HEAT
- ◯ INTOLERANCE TO COLD
- ◯ HAIR LOSS
- ◯ SEXUAL DYSFUNCTION
- ◯ CHANGE IN SEXUAL DESIRE

EAR/NOSE/THROAT
- ◯ CHANGE IN VISION
- ◯ FREQUENT COLDS
- ◯ HOARSENESS
- ◯ SWOLLEN/PAINFUL GLANDS
- ◯ DIFFICULTY SWALLOWING

GYN/UROLOGY
- ◯ ABSENCE OF MENSES
- ◯ INCREASED BLEEDING
- ◯ NON-MENSTRUAL BLEEDING
- ◯ INCONTINENCE OF URINE
- ◯ PAINFUL URINATION
- ◯ PAINFUL INTERCOURSE
- ◯ VAGINAL DISCHARGE

HEMATOLOGY
- ◯ ANEMIA
- ◯ UNUSUAL BRUISING

MUSCULOSKELETAL
- ◯ JOINT PAIN
- ◯ MUSCLE PAIN

RESPIRATORY
- ◯ COUGH
- ◯ SHORTNESS OF BREATH
- ◯ WHEEZE

CARDIAC
- ◯ CHEST PAIN
- ◯ NEW EXERCISE INTOLERANCE

NEUROLOGIC
- ◯ MEMORY LOSS
- ◯ FAINTING
- ◯ FREQUENT HEADACHE
- ◯ WEAKNESS

PHYSICIAN SIGNATURE: _____ DATE: _____

GENERATIONS OB/GYN PATIENT HISTORY QUESTIONAIRE

NAME: **DOB:**

YOUR MEDICAL HISTORY

◯ HEART DISEASE	◯ MIGRAINE	◯ HEPATITIS	◯ DEPRESSION
◯ HIGH BLOOD PRESSURE	◯ STROKE	◯ GONORRHEA	◯ ANXIETY
◯ DIABETES	◯ KIDNEY DISEASE	◯ CHLAMYDIA	◯ ALCOHOL ABUSE
◯ ASTHMA	◯ BLADDER/KIDNEY INFECTION	◯ SYPHILIS	◯ DRUG ABUSE
◯ THYROID DISORDER	◯ CONSTIPATION/DIARRHEA	◯ HERPES	◯ HIV
◯ BLOOD CLOT	◯ SEIZURES	◯ HPV/WARTS	◯ OTHER
◯ ELEVATED CHOLESTEROL	◯ CANCER	◯ ABNORMAL PAP	

YOUR SURGICAL HISTORY

◯ HYSTERECTOMY	◯ GALLBLADDER	◯ ORTHOPEDIC	◯ COSMETIC
◯ BREAST BIOPSY	◯ APPENDECTOMY	◯ CERVICAL CONE	◯ OTHER
◯ BLADDER SURGERY	◯ CARDIAC	◯ CESAREAN	

MEDICATIONS

	NAME		DOSE		NAME		DOSE
1				4			
2				5			
3				6			

SUPPLEMENTS/ VITAMINS

1		3		5		7	
2		4		6		8	

ALLERGIES (PLEASE LIST)

1		2		3		4	

PREGNANCIES

YR	VAGINAL/CESAREAN	WKS	BIRTHWEIGHT	SEX	COMPLICATIONS		MISCARRIAGE/ABORTION

FAMILY HISTORY (PARENTS, SIBS, GRANDPARENTS, AUNTS, UNCLES)

◯ BREAST CANCER	◯ OVARIAN CANCER	◯ HEART DISEASE	◯ GENETIC DISORDERS
◯ COLON CANCER	◯ UTERINE CANCER	◯ DIABETES	
◯ LUNG CANCER	◯ HIGH BLOOD PRESSURE	◯ STROKE	

SOCIAL HABITS

◯ SMOKER #PACKS/DAY _____	◯ ALCOHOL	◯ DRUG USE	◯ EXERCISE
◯ FORMER SMOKER	#DRINKS/DAY _____	TYPE _____	DAYS/WK _____

GYN HISTORY

MENSTRUAL CYCLE

AGE FIRST MENSES: _____ LAST PERIOD: ____/_____/_____

CYCLE EVERY _____ DAYS

◯ LIGHT FLOW	◯ CRAMPS
◯ MEDIUM FLOW	◯ PMS
◯ HEAVY FLOW	

MENOPAUSE

AGE LAST MENSES: _____

◯ HOT FLASHES	◯ HORMONE USE- CURRENT
◯ VAGINAL DRYNESS	◯ HORMONE USE- PAST
◯ INSOMNIA	◯ BLEEDING/SPOTTING

SEXUALLY ACTIVE? ◯Y ◯N CONTRACEPTION: ◯CONDOMS ◯ BIRTH CONTROL PILLS ◯ IUD ◯ OTHER _____

ARE YOU IN AN UNSAFE RELATIONSHIP? ◯Y ◯N

GYN HEALTH MAINTENANCE

DATE LAST PAP:____/____/____ DATE LAST MAMMOGRAM: ____/____/____

DATE LAST BONE DENSITY:____/____/____ DATE LAST COLONOSCOPY: ____/____/____

Yale Medical Group

THE PHYSICIANS OF YALE UNIVERSITY
P.O. Box 7309 • New Haven, Connecticut 06519-0309

REGISTRATION HOURS: MON.-THURS.: 7:30 a.m.-8:00 p.m., FRI.: 7:30 a.m.-5:00 p.m., SAT.: 9:00 a.m.-1:00 p.m.

Unit No. | OFFICE USE ONLY |

APPOINTMENT SCHEDULING PLEASE COMPLETE:

Appointment Date: _____ **at** _____ **o'clock**

to see _____ **at:** _____

To save considerable time on the day of your appointment please complete this preregistration form and return it to us or call to register during above hours at 1-888-639-9253.

PLEASE COMPLETE

PRIMARY CARE PHYSICIAN: _____
(Doctor Name) (City) (State) (Zip Code)

INFORMATION ABOUT THE PATIENT: (Please complete ALL of this section)

Name: _____
(Last) (First) (Middle) (Maiden)

Address: _____
(Number & Street) (City or Town) (State) (Zip)

( ) -
(Telephone Number)

Mo | Day | Year
(Date of Birth)

___ — ___ — ____
(Social Security Number)

Male ☐ Female ☐ Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Life Partner ☐

Race: American Indian ☐ Asian ☐ Black ☐ Caucasion ☐ Spanish/Hispanic ☐ Other ☐

Patient's Mother's First Name (even if deceased) _____ Birthplace of patient _____
(needed for Medical Record)

Has the patient ever received medical treatment at Yale-New Haven Medical Center Yes ☐ No ☐

Patient's Employer: _____ Occupation: _____ ( ) _____
(Telephone Number)

Employer's Address _____
(Street) (City) (State) (Zip)

PERSON RESPONSIBLE FOR BILL (If patient is a child or a legal dependant)

Mo | Day | Year
(Date of Birth)

Name: _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip)

Relationship to Patient: _____

___ — ___ — ____
(Social Security Number)

Employer: _____ ( ) _____
(Telephone Number)

Employer's Address _____
(Street) (City) (State) (Zip)

CONTINUED ON OTHER SIDE

PLEASE COMPLETE APPLICABLE SECTIONS FOR YOUR INSURANCE

1 DEPARTMENT OF INCOME MAINTENANCE (T19), HMO/T19 OR CITY WELFARE

Medicaid (T19) ID: _____

Is this an HMO/T19? Yes No

If Yes, Name of Insurance _____

ID #_____ Group # (if any) _____

City Welfare Name & No.: _____

EFFECTIVE DATE

Mo	Day	Year

2 MEDICARE

Medicare No.: | | | | – | | | – | | | | | |

Please refer to your medical card – Do you have?

Hospital Part A ____

Medical Part B ____

or Both ____

EFFECTIVE DATE (s)

Mo	Day	Year

Is this Insurance: Primary ☐ or Secondary ☐

3 ALL OTHER INSURANCE

Insurance Co. Name: _____

Plan Name/Contract Type: _____

Ins. Co. Address from Ins. card: _____

Phone No.: _____

City, State, Zip: _____

Policy/Membership/ID No.: _____

Group Number (If any): _____

If Policyholder Other Than Patient

Subscriber's Name: _____

Subscriber's Employer: _____

Subscriber's SS#: _____

Subscriber Date of Birth: _____ ☐ Male ☐ Female

Sub Relation to Patient: _____

Is this Insurance: Primary ☐ or Secondary ☐

EFFECTIVE DATE

Mo	Day	Year

Does This Insurance Cover Hospital Services? Yes ☐ No ☐

4 ALL OTHER INSURANCE

Insurance Co. Name: _____

Plan Name/Contract Type: _____

Ins. Co. Address from Ins. card: _____

Phone No.: _____

City, State, Zip: _____

Policy/Membership/ID No.: _____

Group Number (If any): _____

If Policyholder Other Than Patient

Subscriber's Name: _____

Subscriber's Employer: _____

Subscriber's SS#: _____

Subscriber Date of Birth: _____ ☐ Male ☐ Female

Sub Relation to Patient: _____

Is this Insurance: Primary ☐ or Secondary ☐

EFFECTIVE DATE

Mo	Day	Year

Does This Insurance Cover Hospital Services? Yes ☐ No ☐

5 IS THIS A WORKMAN'S COMPENSATION CLAIM? YES ☐ NO ☐

Case Number: _____ Date of Injury

Mo	Day	Year

Injury Description (Neck Injury, etc.) _____

Employer at time of injury: (If different from current employer) _____

Employer Address: _____ Phone: _____

Complete section 3 with insurance carrier information.

PLEASE PROVIDE US WITH A CONTACT NAME AND PHONE NUMBER IN CASE THERE IS NEED FOR ADDITIONAL INFORMATION REGARDING YOUR WORKMAN'S COMPENSATION CLAIM.

Contact Name: _____ Phone Number: _____

Pt. Name:
Birth Date:
Unit No.
Visit No.

Yale New Haven Health System* & Yale Medical Group
Patient Acknowledgement and Financial Authorization

A. CONSENT FOR TREATMENT: I[1] consent to being admitted/treated as a patient of Yale New Haven Health System ("YNHHS") and Yale Medical Group ("YMG") for the purpose of receiving medical care and treatment and/or diagnostic procedures. I understand and agree that: (i) YNHHS and YMG are teaching institutions and students may be involved in observing and giving care unless I disagree; (ii) all attending physicians have privileges to practice at YNHHS facilities, but not all physicians are agents or employees of YNHHS or YMG; (iii) I have the right to consent or refuse to consent to any proposed procedure or therapeutic treatment, and that discussion of the risks, benefits and alternatives to each procedure or treatment is available to me; (iv) as part of my medical care and treatment I may be tested for HIV, and that this testing is voluntary. I will notify my care provider if I do not agree to HIV testing; and (v) photographs, videotaped images or other images may be made of me for purposes of medical documentation or education as YNHH, YMG or its medical staff deem appropriate. I understand that these images will be stored in a secure manner that will protect my privacy. Images that identify me will be released and/or used outside the institution only with my written authorization or that of my legal representative; (vi) leftover blood, fluids or tissue may be used for scientific research or teaching by appropriate persons and that I will no longer have any rights to them.

B. AUTHORIZATION FOR PAYMENT/FINANCIAL AGREEMENT: I agree to pay YNHHS and YMG for all services and supplies provided to me, and for any other applicable charges. I authorize and direct my insurance carrier to make payment to YNHHS and YMG of all insurance benefits, including authorized Medicare benefits, and assign my rights to YNHHS and YMG. I agree to pay any remaining balance not covered by my insurance plan. If I receive payment from my insurance company or other third party payor for services provided to me by YNHHS and YMG, I agree to submit the payment to the hospital and/or YMG. If my account is not paid, I will pay all costs incurred as a result of YNHHS's and/or YMG's collection efforts, including, without limitation, attorneys' fees and court costs. As a courtesy, YNHHS or YMG may assist me in processing insurance claims, however, YNHHS and YMG accept no responsibility for any processing procedures, acts, omissions or neglect. Any amounts not paid by my insurer become due and payable when the bill is mailed or on demand. **If my bill is not paid in full, YNHHS and YMG reserve the right not to provide any future non-emergency medical services to me.** YNHHS has a Charity Care program for eligible persons who do not have insurance or cannot pay bills. To be considered for Charity Care, I may need to apply to Medicaid and meet other requirements.

C. SEPARATE HOSPITAL & PHYSICIAN SERVICES: I understand that when I am treated in a Hospital or in a Hospital Outpatient Department that I will receive separate bills for hospital services and physician services, which I would not receive if the services were provided in an office that is not hospital-based. I understand that I will be subject to separate coinsurance liabilities for each separate bill, and that additional information, including an estimate of my out-of-pocket liability, is available to me at each Hospital facility. I understand that this consent and authorization applies to physician services, as applicable, to the same extent as it applies to YNHHS and YMG.

D. RELEASE OF INFORMATION: I understand that YNHHS and YMG can release all necessary health information for purposes of treatment, payment and healthcare operations. I authorize the release of any HIV/AIDS-related information, drug and alcohol abuse treatment information, and information about diagnosis or treatment of mental illness, to other treating providers and to third-party payers, including but not limited to insurance companies, managed care organizations, Medicare, Medicaid, and other governmental payors. I understand that YNHHS and YMG may release any and all necessary information with respect to my treatment when required to do so by law, including the mandatory reporting of certain communicable diseases (including but not limited to tuberculosis and HIV) to the State Department of Public Health.

I understand that refusal to consent to release of health information will not jeopardize my right to obtain present or future treatment, except where disclosure is necessary for the treatment. I understand that I may revoke this authorization at any time, in writing, except to the extent that action has been taken in reliance on it. The authorization provided in this Section D expires one year from the date of discharge from the Hospital if inpatient, or one year from the last date of treatment in an outpatient department or physician office. I understand that if I refuse to authorize release of information and this results in a refusal by my insurance company or other responsible payor to pay YNHHS or YMG for my treatment, I will be responsible for the entire unpaid portion of my bill.

E. COMMUNICATIONS VIA PHONE: If I have provided a telephone number as a primary telephone contact, I hereby authorize YNHHS and YMG, along with their respective employees, agents, and business associates, to contact me via phone or text message for any reason, including, without limitation, automated notifications and appointment reminders.

F. PERSONAL VALUABLES: I hereby understand and acknowledge the following: (i) I accept sole responsibility for all personal property retained by me in a YNHHS or YMG facility; (ii) I have been advised not to keep any valuables with me while I am a patient of a YNHHS or YMG facility; (iii) neither YNHHS nor YMG is responsible for any lost items; (iv) for inpatient or outpatient stays, the use of a security vault may be available upon my request, and I must sign an additional form for its use; and (v) YNHHS and YMG reserve the right to inspect and to prohibit inappropriate or unsafe items, such as drugs, alcohol, weapons, cellular phones, etc.

Signature of patient/patient representative	Relationship if other than patient	Date	Time

Printed Name of patient/patient representative

F7066

[1] "I" shall mean the patient or the individual authorized to sign on behalf of the patient

* Yale New Haven Health System includes Yale-New Haven Hospital, Bridgeport Hospital, Greenwich Hospital, Northeast Medical Group, and their respective affiliates.