Peter G. Geddes, M.D., F.A.C.O.G.
Obstetrics and Gynecology

705 W. La Veta Ave., Ste 115
Orange, CA 92868
(714) 535-7400
FAX (714) 535-7420

PATIENT REGISTRATION

Patient Name____ Date______________
First MI Last

Birth Date____________________ SS#____________________ Marital Status__________

Address____
Street Apt # City State Zip

Home Phone #________________ Cell #________________ Email________________

Employer________________________ Work Phone #________________ Ext______

Emergency Contact______________________________ Phone #________________
Name Relationship

Primary Care Doctor (PCP)________________________ Phone #________________

Insurance________________________________ HMO PPO POS OTHER (circle one)
Health Plan Medical Group

Insured Name________________________________ SS#________________

Patient's Relationship____________________________ ID #________________

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Do we have permission to leave messages on your answering machine? Yes No
2. Do we have permission to leave messages with the person who answers the phone? Yes No
3. Do we have permission to contact you by Email? Yes No
4. What is the best time of day to reach you? __________ am pm
5. Where do you prefer to receive calls? Home Cell Pager Email
6. If you bring someone with you to your appointment, do we have permission to discuss your medical care while this person is in the room? Yes No
7. Please list any restrictions to the above______________________________
8. Who may we thank for referring you? ______________________________

ASSIGNMENT OF BENEFITS, FINANCIAL DISCLAIMER AND RELEASE OF MEDICAL RECORDS

*Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-payment, or any balance not paid by your insurance within 60 days of the date we submit your claim.

*IN ORDER TO CONTROL YOUR COST OF BILLING, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

*If this account is assigned for collection and/or suit, collection costs and/or interest, and/or attorney fees, and/or court costs will be added to the total amount due.

*To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records.

*I authorize payment of medical benefits be made directly to **Peter G. Geddes, M.D.**

*This assignment will remain in effect until revoked by the provider in writing. A photocopy of this assignment is be considered as valid as an original. I understand that I am financially responsible for all charges, whether or not they are paid by insurance. I hereby authorize said assignee to release all information necessary to secure payment. Charges for the above named patient will be my responsibility as if I received treatment.

X____
Signature (Insured or Authorized) Relationship Date

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NEW PATIENT HISTORY

NAME:______________________________**DOB:**________**Age:**______

Date_________

Reason for visit:

____

____

Medical History ☐ None

Please list any medical problems that you have.

____

____

Have you ever had:

☐ Alcohol abuse ☐ Anesthetic reaction ☐ Bleeding disorder
☐ Asthma ☐ Anemia ☐ Chronic lung condition
☐ Blood clots ☐ Drug and/or substance abuse ☐ Depression/anxiety
☐ Diabetes ☐ Heart disease ☐ High blood pressure
☐ High cholesterol ☐ Hepatitis/jaundice ☐ Lupus or autoimmune disorder
☐ Irritable bowel syndrome ☐ Kidney stones ☐ Hypothyroidism
☐ Seizure disorder ☐ Stroke ☐ Tuberculosis
☐ Stomach ulcers ☐ Mitral valve prolapse ☐ Rheumatic fever
☐ Transfusion reaction ☐ Eating disorder ☐ Cancer

MEDICATIONS

List all medications that you take (with the strength & frequency) ☐ None

Drug	Dose	Frequency	Reason for medication

Allergies: ☐ None

____

Surgical History ☐ None

List all surgeries you have had:

Date	Operation	Diagnosis

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General Health

Do you drink alcohol? ☐ No ☐ Yes
Do you smoke? ☐ No ☐ Yes How much? ___________________
Do you use recreational drugs or street drugs? ☐ No ☐ Yes Type___________________________
Do you exercise regularly? ☐No ☐ Yes How many days a week? ___________________________

Gynecologic History

Date of last Pap Smear: ☐ None __________________________________
Date of last mammogram: ☐ None _________________________________
When was the **FIRST** day of your last menstrual period? _______________ ☐ Menopausal ☐ Hysterectomy
Is your period ☐ Regular ☐ Irregular How many days does it last? ______________ Days
Is your flow ☐ Heavy ☐ Moderate ☐ Light
What do you use to keep from getting pregnant?
☐ Nothing ☐ Vasectomy ☐ Condoms ☐ Nuvaring ☐ Rhythm ☐ IUD
☐ Tubal ligation ☐ Diaphragm ☐ Birth Control Pills/Patch ☐ Abstinence ☐ Withdrawal

Urologic History: (Complete if indicated) ☐ None

Do you have trouble with urine leakage? ☐ Yes ☐ No
Do you leak urine when coughing, sneezing, laughing, exercising or lifting? ☐ Yes ☐ No
Do you feel an urgency to urinate just before leaking urine? ☐ Yes ☐ No
Do you have to wear a pad to protect against urine loss? ☐ Yes ☐ No

Pregnancy History: ☐ No pregnancies

How many times have you been pregnant? ______ How many live births? _________ Stillbirth?________
How many miscarriages? _______ How many abortions? ______ How many ectopic pregnancies? ______

Family History: ☐ Adopted

Have you or any family members ever had:
Breast cancer: ____________________________ Asthma: ______________________________
Ovarian cancer: ___________________________ Stroke: _______________________________
Colon cancer: _____________________________ High cholesterol: ______________________
Other cancers: ____________________________ Bleeding disorders: ____________________
Diabetes: ________________________________ Heart disease__________________________
High blood pressure:_______________________ Anesthesia problems ____________________

Patient Signature: ______________________________________ Date_______________________

Doctor Signature: _______________________________________ Date_______________________

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize:

Peter G. Geddes, M.D., F.A.C.O.G.
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Orange, CA 92868
(714) 535-7400 Fax (714) 535-7420

To (choose one) Release medical information to ( ) Obtain medical information from ( )

____
(Name of healthcare facility or physician)

____
(Address, city, state and zip code)

Telephone______________________________Fax______________________________

Information that may be released: Check (✓) appropriate boxes

( ) History & Physical ( ) Prenatal Records ( ) Operative Reports ( ) Discharge Summaries
( ) PAP Reports ( ) Mammogram Reports ( ) Pathology Reports

( ) Lab Tests. Specify: ______________________________

( ) Other. Specify: ______________________________

The above information may be used for the following purpose(s):
( ) At the request of the patient
( ) Other. Specify: ______________________________

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described previously may be re-disclosed and no longer protected by these regulations.
I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization.

Date of Expiration of this Authorization: ______________________________

______________________________ ______________
Signature of Patient or Representative Date

______________________________ ______________
Print Patient Name DOB

______________________________ ______________
Name of Personal Representative (if applicable) Relationship to Patient

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PHARMACY INFORMATION

PATIENT NAME: DOB: AGE: Y/O

To our valued patient:

In order to improve our services for you, we can send your prescriptions electronically to your pharmacy. Please provide us with your complete pharmacy information and your prescriptions will be transmitted for your convenience.

Pharmacy Name: ____

Address:____

Telephone:____

Fax:____

Please inform us of any changes in your pharmacy information so we can update your records and avoid delay in dispensing of your medications.

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FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to providing you with the highest quality of care. The following is a statement of our financial policy, which we request that your review and sign prior to treatment.

INSURANCE

You, as the patient is responsible to know your insurance plan and benefits, at the time of appointment. This includes co-payment, deductible and guidelines (prior authorization, etc.). It is also your responsibility to know if Peter G. Geddes, M.D. is a contracted preferred provider. Benefits and provider information can be obtained by calling customer service of your plan.

BILLING

- If we are a preferred provider of your insurance plan then we will bill your insurance company.
- If we are **NOT** a preferred provider of your insurance plan then payment is due at the time of service. A receipt of charges and payment will be provided for you to submit to your insurance plan.
- If we find after the appointment that your insurance was not valid, effective or they do not cover services according to your plan, then you will be responsible for all fees.

PAYMENT POLICY

Payment is due in full for cash patients and any co-insurance. We do not accept monthly payments. But circumstantial approval for payments on a high balance may be arranged. Interest will accrue monthly at 3% of existing balance.

We accept cash, check, Visa, MasterCard, and Discover. Laboratory charges will be billed separately by the servicing lab.

A $30.00 fee will be charged for each non-sufficient check.

Thank you for understanding our financial policy. Please let us know if you have any questions.

I UNDERSTAND AND AGREE TO THE ABOVE POLICY.

Patient Signature ____________________ Date ____________

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