25 Cross
Suite 22 Nov. 14. 2018 4:45PM Pearlman & Zaft No. 0915 Tele P. 2
Owings Mills, MD 21117

PEARLMAN, SONDERGAARD,
MINKIN, FABER, KATES, ZAFT & JACOBS

Fax: 410-581-9200
Fax: 410-581-9203

**PATIENT REGISTRATION** - *Please Print Clearly*

| PATIENT NAME *FIRST* *MIDDLE* *LAST* | | MARITAL STATUS | DATE OF BIRTH | AGE | ETHNICITY |
|---|---|---|---|---|---|
| HOME ADDRESS | APT. NO. | CITY | STATE | ZIP CODE | HOME PHONE / CELL PHONE |
| PATIENT'S SOCIAL SECURITY NO. | PATIENT'S E-MAIL ADDRESS | | | OCCUPATION / WORK PHONE # | |
| EMPLOYER | PRIMARY CARE PHYSICIAN: NAME / ADDRESS | | | PCP PHONE # | PCP FAX # |
| SPOUSE'S NAME | OCCUPATION | SPOUSE'S DOB | | SPOUSE'S SOCIAL SECURITY NO. | |
| SPOUSE'S EMPLOYER | | SPOUSE'S WORK PHONE # | | SPOUSE'S CELL PHONE # | |
| NOTIFY IN EMERGENCY (OTHER THAN SPOUSE) | RELATIONSHIP | HOME PHONE | | WORK PHONE | CELL PHONE |
| FINANCIALLY RESPONSIBLE PERSON ☐SELF ☐SPOUSE ☐PARENT ☐OTHER | NAME & ADDRESS IF DIFFERENT FROM PATIENT | | | HOME PHONE ( ) | WORK PHONE ( ) EXT. |
| PHARMACY NAME / LOCATION / PHONE # | | | | | |
| MAIL ORDER PHARMACY NAME / ADDRESS / PHONE # | | REASON FOR VISIT ☐ WELL WOMAN / CHECK UP ☐ PREGNANCY ☐ PROBLEM VISIT | | | |

**INSURANCE INFORMATION**

| POLICY HOLDER SELF ☐ SPOUSE ☐ PARENT ☐ OTHER ☐ | PRIMARY INSURANCE CO. NAME | EFF. DATE | SUBSCRIBER'S NAME |
|---|---|---|---|
| | | SUBSCRIBER'S DOB | SOCIAL SECURITY NO. |
| INSURANCE COMPANY ADDRESS | | ID / POLICY # | GROUP NO. |
| SECONDARY INSURANCE COMPANY NAME AND ADDRESS | | ID / POLICY # | GROUP NO. |

**PATIENT AUTHORIZATION**

*I, _____ hereby authorize Drs. Pearlman, Sondergaard, Minkin, Faber, Kates, Zaft & Jacobs to apply for benefits on my behalf for covered services rendered by Drs. Pearlman, Sondergaard, Minkin, Faber, Kates & Jacobs. I request payment from Blue Shield of Maryland, Medicare and/or _____ be made directly to Drs. Pearlman, Sondergaard, Minkin, Faber, Kates, Zaft & Jacobs.*
Other Insurance Company Name

*I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance company, (or in the case of Medicare, the Social Security Administration and Health Care Financing Administration). I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.*

_____ _____
*Signature of Subscriber or Beneficiary* *Date*

**Patient Account Number** [ ]

#43 - Rev 2/14

# MEDICAL GROUP

**DRS. SONDERGAARD, MINKIN, FABER, KATES, ZAFT & JACOBS**

## FINANCIAL POLICY

Thank you for choosing us as your health care providers. We are committed to your receiving the best quality medical care possible and the best service possible. The following is a statement of our Financial Policy which we ask that you read and sign prior to any treatment.

FULL PAYMENT OF YOUR COINSURANCE OR COPAY IS DUE PRIOR TO SERVICE.
FULL PAYMENT IS DUE AT TIME OF SERVICE FOR SERVICES NOT COVERED BY YOUR INSURANCE, OR WHEN YOUR DEDUCTIBLE HAS NOT BEEN MET.

REGARDING INSURANCE

Your insurance policy is a contract between you and your insurance company. Please be aware that some and perhaps all of the services provided may be non-covered services (or not considered "medically necessary" under the Medicare program) and are therefore your responsibility. If your insurance company has not paid your bill within 45 days, the balance will be billed to you. **THIS IS TO ADVISE YOU THAT WE DO NOT ACCEPT MEDICAL ASSISTANCE OR ANY MEDICAL ASSISTANCE HMO/ MCO PRODUCT.**

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best care for our patients, and we charge what is usual and customary for our area. You are responsible for ALL deductibles, copays, and coinsurance amounts. *We cannot "write off" any amount that is your responsibility.* Your copay and/or deductible is due at the time of service. **If you do not have your copay with you, we reserve the right to reschedule your appointment.**

ANNUAL WELLNESS EXAMS: If you require additional service or treatment at the time of your annual exam a deductible and/or copay may apply.

MISSED APPOINTMENTS:

You will be charged $100 for office appointments and $200 for surgery not cancelled at least 24 hours in advance. Please help us serve you better by keeping scheduled appointments.

PAST DUE ACCOUNTS:

Accounts are considered past due after 30 days. Bills are turned over to our Collection Agency after 90 days and will be subject to a **Collection Fee of $20.** Other fees will apply if the account is forwarded to an attorney for a collection lawsuit. **Any additional medical services will be suspended until your account is paid in full.** Checks returned from your bank for any reason will be charged a fee of $45.00.

CARD ON FILE: You will be asked for a credit card when you check in. This data will be securely held until your insurance has processed your claim. You will receive advance notification of the amount due that will be charged to your card and will have the right to dispute a charge or set up a payment plan.

ADMINISTRATIVE OFFICE FEE

There is a voluntary $10 Administrative Fee for non-medical services, including, but not limited to, Medical Records copying, Disability and other work related forms, Annual Statements for tax purposes, copies of receipts and Wellness Forms. If you choose not to pay our Administrative Fee you will be billed per occurrence for these non-medical services. All fees must be paid before completion of forms or release of medical records.

I have read, understand and agree to this Financial Policy

X _____ _____

Patient and/or Guarantor Date

X _____

Print Name

# DRS. GABBAY, FELDMAN, PEARLMAN, SONDERGAARD, MINKIN, FABER, KATES, ZAFT & JACOBS

## PATIENT AUTHORIZATION

We at Drs. Gabbay, Feldman, Pearlman, Sondergaard, Minkin, Faber, Kates, Zaft & Jacobs are dedicated to preserving your privacy and personal health information. Our employees are trained in the proper handling of your medical and financial records. We are requesting this Patient Authorization in order to continue to provide the finest medical care possible. Thank you for your assistance.

I authorize Drs. Gabbay, Feldman, Pearlman, Sondergaard, Minkin, Faber, Kates, Zaft and Jacobs and their staff to:

1. Call my home and/or work to remind me of upcoming appointments; in the event I am not there, they may leave a message on an answering machine.
2. Send Post Card reminders when it is time to schedule an appointment.
3. Call my home and/or work concerning Lab, XRay or other test results and leave a message on my answering machine if necessary; receive Pathology and Radiology reports by FAX; make and/or receive calls from pharmacies on my behalf, including electronic prescriptions and/or prescriptions by FAX .
4. Update my personal demographic information either on the phone or in the office at the time of my appointment.
5. At my request, discuss my personal health with my parent or other designated person.
6. Discuss my financial account with my parent, insurance policy holder, or other financially responsible person that may be calling to clarify billing or other financial matters.
7. Electronically verify my prescription medications with my pharmacy.

☐ Accept/ initials Decline/ Initials ☐

I have read and agree to the above policies of Drs. Gabbay, Feldman, Pearlman, Sondergaard, Minkin, Faber, Kates, Zaft & Jacobs with regards to the treatment, payment and healthcare operations of their practice. I also certify that I am aware that I am entitled to receive a copy of this Privacy Policy if I so desire.

_____ _____

Signature of Patient Date

_____

Print Name

# AURORA WOMEN'S HEALTH
## DRS. SONDERGAARD, MINKIN, FABER, KATES, ZAFT, JACOBS & WHITE

WELCOME TO OUR OFFICE! Please fill out this Patient History, which will become a permanent part of your medical record in our office. PLEASE PRINT.

### 1. IDENTIFYING INFORMATION

Date _____ Name _____ Marital Status _____

Date of Birth _____ Social Security # _____ Occupation _____

### 2. MEDICAL HISTORY

Height _____ Weight _____ Blood type, if known _____

Do you have any allergies to medication? List _____

Have you gained or lost greater than 20 pounds in the last year? _____

Do you follow a special diet? If yes, specify: _____

Types of exercise you do: _____ Hours/week: _____

Do you have, or have you ever had: (check all that apply)

- ____ Anemia
- ____ Anesthesia problems
- ____ Anxiety
- ____ Asthma
- ____ Auto Immune Disease
- ____ Blood Transfusion
- ____ Breast Discharge / Disorders
- ____ Chicken Pox
- ____ Colitis
- ____ Depression
- ____ Diabetes
- ____ Endometriosis
- ____ Fibroids
- ____ Gallbladder Problems
- ____ Gastrointestinal Disorders
- ____ Headaches
- ____ Heart Disease / Mitral Valve Prolapse
- ____ Hepatitis Vaccine
- ____ Hirsutism (excessive hair growth)
- ____ High Blood Pressure
- ____ High Cholesterol
- ____ HIV
- ____ Kidney Problems / Stones
- ____ Liver Problems
- ____ Ovarian Cysts
- ____ Pelvic Infection
- ____ Pulmonary Embolus or Clotting Disorder / DVT
- ____ Vaginitis
- ____ Neuro Seizures / Epilepsy / Stroke
- ____ STD's _____
- ____ Thyroid Problems
- ____ Ulcers
- ____ Urinary Disorders
- ____ Vaccines (Hep B, HPV, Tdap)
- ____ Other _____

Have you ever been diagnosed/treated for cancer? If yes, please explain type of cancer and therapy:

_____

Have you ever had any type of surgery? If yes, please specify: _____

_____

WOULD YOU ACCEPT A BLOOD TRANSFUSION IF NEEDED? ☐ YES ☐ NO

Within the last year, have you taken any prescription medications? List all prescriptions, the dosage and the problem for which you were taking them _____

_____

_____

Are you taking any over-the-counter medications on a regular basis? If yes, list all medications and reasons:

_____

_____

**- OVER -**

Do you use, or have you ever used (check all that apply):

____ Alcohol - how many glasses per week? Wine ____ Beer ____ Cocktails ____

____ Cigarettes - number of packs per day ____/____ Former Smoker / ____ Never Smoked

___ Drugs (Marijuana, Cocaine, etc.) If you would feel more comfortable not writing anything down, please discuss this directly with your physician.

3. MENSTRUAL AND PREGNANCY HISTORY

Age at first period:_____ Are your periods regular?_____ What is the usual number of days between periods (from the first day to the first day)?_____ How many days does your period last?_____

Use: Tampons/Pads_____ Are cramps present before, during or after your period?_____

Do you have to take pain medication for cramps?_____

Did your mother take DES (Diethylstilbestrol) when she was pregnant with you?_____

How many pregnancies, including abortions and miscarriages, have you had? _____

| | YEAR | FULL TERM | PREMA-TURE | ABORT MIS/ECTOP | LIVING | LENGTH OF LABOR | BABY'S WGT/SEX | TYPE DELIVERY | COMPLI-CATIONS |
|---|---|---|---|---|---|---|---|---|---|
| 1st Preg. | | | | | | | | | |
| 2nd Preg. | | | | | | | | | |
| 3rd Preg. | | | | | | | | | |
| 4th Preg. | | | | | | | | | |
| 5th Preg. | | | | | | | | | |
| 6th Preg. | | | | | | | | | |

4. GYNECOLOGICAL HISTORY

Any history of GYN infections, problems or abnormal PAP smears? _____

5. CONTRACEPTIVE/SEXUAL HISTORY

Do you require contraception? ☐ YES ☐ NO Do you use condoms? ☐ YES ☐ NO

Sexual Preference: Do you have sex with ☐ Men ☐ Women

5. FAMILY HISTORY

Has anyone in your family, including grandparents every had any of the following:

(Please specify which relative).

Birth Defects (Down's etc.) _____ Diabetes _____

Bleeding Disorder _____ Heart Disease _____

Breast Cancer _____ High Blood Pressure _____

Breast Disorders _____ Multiple Gestation (twins) _____

__ Gyn Cancer, __ Cervical, __ Ovarian, __Uterine Sickle Cell Disease _____

Other form of cancer (specify type) _____ Thyroid Disease _____

Blood Clots / DVT / Pulmonary Embolus _____ Other _____

_____

7. ADVANCE DIRECTIVE (Living Will) ☐ YES ☐ NO

THANK YOU FOR COMPLETING THIS FORM. WE APPRECIATE YOUR EFFORTS!