Registration for OB/GYN and Hospital Care

Patient Information Please print and press firmly with a ball-point pen

Please provide the following:

Name: _____ _____
Last First MI Prefer to be called

Address: _____ Age: _____ Birth Date: ___/___/___
Month day year

Apartment or P.O. Box Number _____ Marital Status: S M D W Sep
(circle one)

City: _____ State: _____ Zip: _____ Home Phone: (_____) _____

Employer: _____ Work Phone: (_____) _____
(Name) (City) (Occupation)

Who referred you to our office: _____ Soc Sec: _____

OB/GYN Physician: _____ Family or Primary Care Physician: _____

Have you had services at Evergreen Hospital before? Yes No Were you seen under a different name? If yes, former name:
(including lab, x-ray or ER) (circle one) _____

Family Information

Husband/Partner or Parent Name _____ Relationship to Patient: _____ Birth Date: _____/____/____

Soc Sec _____ Employer: _____ Wk Phone: (_____) _____
(Name) (City) (Occupation)

Hm Phone: (_____) _____ If patient is a minor, with whom does child live? _____

Financial and Insurance Information Please present Insurance Card(s) to Receptionist

Primary Insurance: _____ **Secondary Insurance:** _____

Group #: _____ Group #: _____

Subscr. #: _____ Subscr. #: _____

Policyholder Name: _____ Policyholder Name: _____

Ins. Co. Phone # (_____) _____ Ins. Co. Phone # (_____) _____

Newborn Information (if applicable)

Baby's Last Name: _____ Name of Baby's Doctor: _____

Due Date: _____ Baby's Insurance: Primary _____ Secondary _____ Other _____

Persons to Call In Case of Emergency

Next of Kin: _____ Home Phone: (_____) _____
(or legal guardian, if same as family information, note same)

Relationship to Patient: _____ Work Phone: (_____) _____

Emergency Contact: _____ Home Phone: (_____) _____
(other than a relative or person living with you)

Relationship to Patient: _____ Work Phone: (_____) _____

The hospital requests the following information to include as a part of your medical record:

Advance Directives: Do you have a living will? Yes_____ No_____ Do you have a Healthcare Power-of-Attorney? Yes_____ No _____

Religion: If you would like it included in your record, what is your religious preference? _____

Release of Benefits & Information: I authorize my insurance benefits be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for processing insurance claims. I understand this may include information regarding HIV, sexually transmitted diseases, mental health, drug and/or alcohol use.

SIGNED: _____ DATE: _____

OFFICE USE ONLY:
Registration to Admitting at 12 weeks Date sent: _____ Initials: _____ Pre-Natal to Admitting at 36 weeks Date sent: _____ Initials: _____

White - physicians office Yellow - admitting office

Patient Name: _____ Date of Birth: _____
Please Print

I agree I may be contacted for appointment reminders and follow up information about my care at the primary telephone number designated below:

_____
Primary Telephone Number for medical care information

Is it OK to leave a detailed message at this primary telephone number? ☐ YES ☐ NO

Is it OK to leave results of Lab or other medical tests at this number? ☐ YES ☐ NO

Please read the following and complete the information requested

You have the right to identify individuals, other than yourself and your health care providers, to be involved in your care (family members, friends, others). We may **verbally share your medical information** to an individual you have identified as involved in your medical care. We may also give information to someone who helps pay for your care. EvergreenHealth will only share your health information with the individuals you designate, except as required or permitted by law. You may add to or change this list of individuals at any time by completing a new form.

Information related to Mental Health, Chemical Dependency, HIV testing and/or therapy will only be shared with you unless you specifically authorize to include **Sensitive Information** on the form below.

☐ **I DO NOT authorize EvergreenHealth to verbally share information with anyone, other than myself.**

I have read the above disclaimer and I DO authorize EvergreenHealth to **verbally share medical information/billing information** with the individuals listed below:

Name	Relationship to Patient	Information to Share
		☐ All, including sensitive information ☐ All, not including sensitive information ☐ Specific:_____
		☐ All, including sensitive information ☐ All, not including sensitive information ☐ Specific:_____
		☐ All, including sensitive information ☐ All, not including sensitive information ☐ Specific:_____

These designations will remain in effect indefinitely or until otherwise revoked by me in writing.

Signature: _____ Date: _____
(if signed by a personal representative of the patient, please complete the following:)

Personal Representative's Name: _____
Relationship to Patient: ☐ Parent ☐ Legal Guardian* ☐ Holder of a Medical Power of Attorney*
* Please attach Legal Documentation if you are the Legal Guardian or Holder of Power of Attorney

EvergreenHealth Kirkland, WA 98034
INDIVIDUALS INVOLVED IN CARE
OB&GYN CARE AMBULATORY
FORM ID ARM 710 OBG AMB

APPLY PATIENT LABEL HERE

Original - Medical Record

EvergreenHealth
Midwifery Care

Medication List

Name: _____ **DOB:** _____ **Date:** _____

It is very important for your Midwives to know all the medications you are taking. We will need the following detailed medication information in **addition to what you supplied in your Patient Portal online history.** Please complete this list with **all medications**, including prescribed medications, over the counter and herbal medications, vitamins and home remedies. Your Midwife will need this list at the time of your appointment. (Use back if additional space is needed.)

Medication	Dose	Why Taken	How Long	Prescribed by

Medication Allergies:

_____

_____

_____

_____

Please identify your preferred Pharmacy with location and phone numbers below:

Pharmacy Name: _____
Street Address: _____
City, State _____
Phone #: _____
Fax #: _____
Mail order RX? ___ Yes ___ No

060614-MH