



**PATIENT REGISTRATION FORM**

NEW PATIENT  UPDATE  Doctor: \_\_\_\_\_ Account: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

*Please indicate, in the boxes below, which order you would like us to contact you (1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> choice)*

Home Phone # \_\_\_\_\_  Cell Phone # \_\_\_\_\_  Alternate Phone # \_\_\_\_\_

Social Security \_\_\_\_\_ Verified \_\_\_\_\_ Marital Status \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Local Friend or Relative Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

This information **MUST** be supplied.

Emergency Contact Other than Husband \_\_\_\_\_  
Name Relationship Phone

Full Address \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Referred By \_\_\_\_\_  Family  Friend  Physician  Insurance  Other

**PRIMARY INSURANCE INFORMATION**

Insurance Co Name \_\_\_\_\_

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to PT \_\_\_\_\_

Identification No \_\_\_\_\_ Group No \_\_\_\_\_

Effective Date \_\_\_\_\_ Social Security # \_\_\_\_\_

Insured Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Secondary Insurance Co Name \_\_\_\_\_

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to PT \_\_\_\_\_

Identification No \_\_\_\_\_ Group No \_\_\_\_\_

Effective Date \_\_\_\_\_ Social Security # \_\_\_\_\_

Insured Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Rel to PT \_\_\_\_\_ Sex \_\_\_\_\_

Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_

Responsible Party Employer \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS**

I hereby authorize Temecula Valley OB/GYN Medical Associates, Inc. to examine and treat the above patient and will assume full responsibility for payment of all services. In the event of default, I also agree to pay for collection costs and attorney's fees that may be required to effect collection of the amount. The undersigned hereby authorizes Temecula Valley OB/GYN Medical Associates, Inc. to furnish necessary information to the involved insurance company, and further authorizes and assigns payment and surgical benefits due under the insurance policy.

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_



Temecula Valley OB/GYN  
Medical Associates, Inc.

OBSTETRICS • GYNECOLOGY • INFERTILITY

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(951) 677-4748 FAX (951) 677-2926

## PLEASE BE ADVISED

Temecula Valley OB/GYN bills an office visit to you/your insurance if you have an injection, pregnancy test or urinalysis. Per CPT guidelines, a code of 99211 may be charged for management of an established patient that may, or may not, require the presence of a physician.

I HAVE READ THE ABOVE IN ITS ENTIRETY AND AGREE TO BEAR FULL FINANCIAL RESPONSIBILITY IN THE EVENT THAT MY HEALTH PLAN FAILS TO REMIT CLAIM REIMBURSEMENT.

\_\_\_\_\_  
PATIENT'S NAME (PLEASE PRINT)

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
DATE

*"A Practice Specializing in Women's Health Care"*

Timothy Elfelt, MD

Joseph Glaser, MD

Debra Lebo, DO

Charles Yang, MD

Tammy Hayton, MD

Lorna Laney, RNP

Nancy Ferrell, RNP

Linda Leon, RNP





### Health Systems Update

**Patient Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**Important:** In order to provide the highest quality of health care possible, it is important that we have the following information. Please complete this form as accurately as possible. If you do not understand the question, please ask for assistance. Thank you.

**Please describe the reason(s) for this visit:** \_\_\_\_\_

**Do you have any questions, problems, symptoms or concerns that you would like to discuss with us today?**

***Please mark the ones that are chronic problems or have changed since you were last seen.  
Thank you.***

**CONSTITUTIONAL**

- Fever
- Chills
- Weight loss or gain
- Fatigue

**EAR, NOSE & THROAT**

- Sinusitis
- Hearing Loss
- Ringing in the ears
- Sores

**EYES**

- Double vision
- Blurry vision
- Need for glasses
- Glaucoma

**CARDIOVASCULAR**

- Heart attack
- Chest pain
- High blood pressure
- Palpitations
- Leg swelling

**GASTROINTESTINAL**

- Loss of appetite
- Nausea
- Vomiting
- Abnormal bowel movement
- Pain

**NEUROLOGICAL**

- Stroke or TIA
- Headaches
- Dizziness
- Seizures
- Loss of balance

**RESPIRATORY**

- Shortness of breath
- Asthma
- Coughing
- Spitting up blood

**URINARY**

- Frequent or painful urination
- Incontinence
- Frequent UTI
- Blood in urine

**PSYCHOLOGICAL**

- Memory loss
- Depression
- Insomnia
- Nervousness

**ENDOCRINE**

- Diabetes
- Thyroid Problems
- Excessive thirst or urination

**MUSCULOSKELETAL**

- Joint pain or stiffness
- Weakness
- Injury or surgery
- Swelling

**SKIN/BREAST**

- Rashes
- Ulcers
- Nail Change
- Breast pain/lump / discharge

**HEMATOLOGIC**

- Bleeding or bruising tendency
- Phlebitis (infection of the injection site)
- Blood clots in legs
- Transfusions
- 
- None of the above

**GYNECOLOGICAL**

- Pain with intercourse
- Irregular menses
- Pelvic pain

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