Temecula Valley OB/GYN
Medical Associates, Inc.
OBSTETRICS • GYNECOLOGY • INFERTILITY

PATIENT REGISTRATION FORM

Medical Center Drive, Suite 100
Murrieta, CA 92562
(951) 677-4748 FAX (951) 677-6529

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 (1st, 2nd and 3rd 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 spouse ______________ ______________ ______________
Name Relationship Phone

Would you like access to our patient portal? (To view your health records) _____ YES _____ NO

If **YES** please provide your email address ______________________________

Please confirm your email **(print clearly)** ______________________________

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 ______________

DEMOGRAPHIC QUESTIONS (FEDERALLY MANDATED THAT WE ASK BY LAW)

What do you consider your race to be? ____American Indian or Alaska Native ____Filipino ____Asian ____Caucasian ____Hispanic/Latina ____African American ____Native Hawaiian/Pacific Islander ____Other

Marital Status: ____Single ____Married ____Divorced ____Widow ____Domestic Partner ____Other

What is your preferred Language? ______________

Preferred Method of contact: ____Cell ____Home ____Mail Only Decline to specify the above____

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 ______________________________

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In order for us to notify you in an expedient manner, we would like to notify you by phone with any questions, appointment confirmation calls, and any normal results that we may have.

I give Temecula Valley OB/GYN Medical Associates permission to leave a **CONFIDENTIAL** voice message on the telephone number below.

( ) - ______________________________

Signed: ______________________________ Date Signed: ____/____/____

Printed: ______________________________ Date of Birth: ____/____/____

Witness Signature: ______________________________ Date: ____/____/____

"A Practice Specializing in Women's Health Care"

Joseph Glaser, MD Debra Lebo, DO Charles Yang, MD Tammy Hayton, MD Kendra Jones, MD
Elizabeth Locascio, DO Emily Thomson, DO Nancy Ferrell, RNP Robin Robbins, RNP

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25460 Medical Center Dr, 100
Murrieta, CA 92562
(951)677-4748 fax (951)677-6529

THIRD PARTY RELEASE OF INFORMATION

____ _____________________

PATIENT NAME (PRINT) ACCOUNT NUMBER

I,____, give Temecula Valley ob/gyn permission to release any and all medical/billing/and personal information including HIV results to the following…

(Example… Spouse, parent, guardian, agency, or insurance)

NAME____ PHONE______________________________

NAME____ PHONE______________________________

NAME____ PHONE______________________________

COMPANY NAME_____________________________________ PHONE______________________________

I may be contacted at ________________________________ with any questions.

_____________________________ _________________

Social Security Number Date of Birth

_____________________________ _________________

Patient Signature Today's Date

_____________________________ _________________

Witness Signature Today's Date

Joseph Glaser, MD

Debra Lebo, DO Charles Yang, MD Tammy Hayton, MD

Kendra Jones, MD Elizabeth Locascio, DO Emily Thomson, DO

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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

GYNECOLOGICAL
( ) Pain with intercourse
( ) Irregular menses
( ) Pelvic pain

( ) None of the above

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