Luminis Health OB-GYN-Annapolis

2000 Medical Parkway, Suite 304
Annapolis, MD 21401
410.573.9530

Pre-Registration & Appointment Guidelines

Please fill out **ALL** forms in the enclosed Pre-Registration Packet and return to the Pre-Registration Department **at least 72 hours in advance or your appointment will be cancelled effective 10/4/21.** Completed forms should be returned in PDF format along with a copy of the front and back of your insurance card through any of the following confidential and secure ways:

Email: ***AOGpreregistration@aahs.org***
Fax: 667.204.7241
US Postal: 2000 Medical Parkway, Suite 304 Annapolis, MD 21401
In person: dropped off at any of our 4 office locations

You may also go onto our website at www.annapolisobgyn.com- the forms are under the red tab for Complete Forms. There are 2 packets to choose from on the LEFT side of the page– GYN (non-pregnant) or OB (pregnant), so please be sure to scroll down to choose the appropriate packet. **Our website now allows patients to fill out the forms right online and return them electronically.**

- If you are a pregnant patient coming from Shady Grove or another Reproductive Endocrinologist Specialist, ***please be sure to turn in your Graduate Packet with your new patient paperwork.***

- **If your insurance requires a referral, it is your responsibility to present the referral at the time of your visit – failure to do so may result in needing to reschedule the appointment – or your insurance may leave you responsible for the visit charges.**

- You are expected to arrive ***15 minutes before your appointment time.*** Allow additional time for parking when scheduled at the Annapolis office, the garage can get quite busy. **You may be asked to reschedule your appointment if you arrive late at any office!**

- Items you ***must*** bring to your appointment: photo id, current insurance card, and copay. We will also need the name/address/phone number of your primary care physician. Additionally, any labs/radiology/other records relative to your visit with Annapolis OB GYN.

- Enrollment with the patient portal, **MyChart**, will serve as your electronic chart – allowing you to view lab results, medical records, and correspond with office staff and providers after your initial visit.

- **PLEASE NOTE - A "NO SHOW" FEE IS CHARGED FOR APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS.**

Updated 09-23-2021

PATIENT REGISTRATION FORM

Last Name (Print)_____ (First) _____ (MI) ____ (Previous/Maiden)_____

DOB_____ Marital Status: _____Single _____Married _____Divorced _____Sep. _____Widow

Address _____City _____State____ Zip_____

Home#_____Work#_____Ext_____Cell#_____ **Circle best way to reach**

E-Mail _____Employer _____ Occupation_____

Race: ( )White ( )Black/African American ( )Hispanic ( )Other:_____

Ethnicity: ( )Hispanic or Latino ( )Not Hispanic or Latino ( )Decline Language: ( )English ( )Spanish ( )Other:_____

ARE YOU CURRENTLY PREGNANT: _____Yes _____No

I have been seen by Annapolis OB-GYN within the past 12 months ____Yes ____No
NOTE: If you checked "Yes", do NOT complete the rest of the form unless your information has changed. If you checked "No", please continue to complete the rest of the form below this box. YOU MUST SIGN AT THE BOTTOM.

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PRIMARY CARE DOCTOR(Other than at this practice) _____Phone_____

PHARMACY_____LOCATION_____Pharm Phone:_____

EMERGENCY CONTACT_____Relationship_____

Emergency Contact's Home #_____Work#_____Cell#_____

YOUR PARTNER'S INFORMATION **(SPOUSE /PARTNER/BABY'S OTHER PARENT) (Please circle one)**

Name (Last) _____ (First) _____(MI)____ DOB_____ SS#_____

Address_____City_____State_____Zip_____

Home# _____Work# _____Cell#_____

PRIMARY INSURANCE: Insurance Co. _____ Phone# _____

Name of Insured_____Patient Relationship to Insured _____DOB_____

Insurance Address_____Employer_____

Subscriber ID#_____ Group ID# _____ Co-Pay Amount_____

SECONDARY INSURANCE: Insurance Co. _____Phone#_____

Name of Insured_____ Patient Relationship to Insured _____DOB_____

Insurance Address_____Employer_____

Subscriber ID#_____ Group ID# _____ Co-Pay Amount_____

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I declare I have listed all the medical/health insurance plans from which I may receive benefits. I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I also understand that I am responsible for contacting Luminis Health OB-GYN Annapolis, in a timely manner, with any future changes in the above information, especially those that may affect the processing of my insurance claims.

Patient Signature _____Date_____

Parent or Guardian_____Relationship_____Date_____

For office use only

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FAX TO: 667-204-7241 or E-MAIL TO: AOGpreregistration@aahs.org

updated 09/03/2021

HISTORY AND PHYSICAL RECORD

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

Marital Status: (circle one) S Sep M D W Previously divorced?____ **Previously widowed?**___ **Where were you born:**_____

Place of Employment: _____ **Occupation:**_____

YOUR MEDICAL HISTORY: (Check off if you have had this illness, and write what type if applicable)

Disease	√	Type	Disease	√	Type	Disease	√	Type
Asthma			Kidney Dis/Infections			Epilepsy/Seizures		
Pulmonary Disease			High Blood Pressure			Hepatitis /Liver Disease		
Diabetes			Gastrointestinal Prob.			STD/HPV (list kind)		
Cancer			Depression/Anxiety			Herpes (list kind)		
Heart Disease			Chronic Bladder Infec.			Thyroid Disorder		
Hyperlipidemia			Osteoporosis			Blood Clotting Disorder		
Migraines			Addiction			Other:		

YOUR PAST SURGICAL/INJURY HISTORY: (List a D&C for a miscarriage in the OBSTETRICAL HISTORY below.)

Disease/Diagnosis/Injury	Procedure or Surgery Type	Date	Physician/Surgeon	Hospital

GYN HISTORY:

Menstrual Cycle:	Response	Menopause/Gyn:	Response
Age when period started?		Are you having peri-menopausal symptoms?	
Last menstrual period?		What are your symptoms?	
Periods are how many days apart?		Are you post-menopausal?	
How long does your period last?		Your age at menopause?	
Pain with menstrual period?		Type: Natural, Surgical, Premature, Chemo, Other?	
Do you bleed in between periods?		Pain with intercourse?	
Is your flow heavy, moderate or light?		Vaginal Dryness?	
Do you have pain between periods?		Bleeding with intercourse?	
Do you have a vaginal discharge?		Vaginal itching or odor?	
Is this normal for you?		Are you sexually active?	
Color and consistency of discharge?		Sexual orientation?	
		State method of contraception:	

RECENT SCREENINGS:

Screening	Date	Result	Screening	Date	Result	Screening	Date	Result
Bone Density			Colonoscopy			Pap		
Chest X-Ray			Cholesterol			Mammogram		

SOCIAL HISTORY:

SMOKING:	Response	CAFFEINE	Response	DRUGS:	Response
Do you smoke?		Do you drink caffeine?		Do you use drugs?	
How much do you smoke?		Amount/frequency?		Recovering from addiction	
Did you quit smoking?		Type of caffeine?		What type of addiction?	
How many years did you smoke?		**EXERCISE/SAFETY**			
		Do you exercise?		**MISC:**	
ALCOHOL		Exercise frequency?		Have you traveled outside of the US in the past year?	
Do you drink alcohol?		Wear seat belts?			
Amount/frequency?		Have a Living Will?		Where did you visit?	
Recovering from addiction?		Do you feel safe at home?			

OBSTETRICAL HISTORY: **Patient's Name:**_____

Date of Delivery	Weeks of gest.	Type of Delivery	Physician	Sex	Wt.	Abortion (Elective)	Miscarriage	List other problems/complications, outcome, and/or infertility history.

TOTALS: Enter totals below:

Total Pregnancies	# of Full Term	# of Premature	Elective Abortions	Miscarriages	Ectopic Pregnancy	Live Children

ALLERGIES:

Allergy	Reaction	Allergy	Reaction

MEDICATIONS: (Include medications, birth control, vitamins & herbal supplements)

Name	Strength	Dosage	Reason	Name	Strength	Dosage	Reason

CHECK BELOW ANY DISEASE A BLOOD RELATIVE OF YOURS MAY HAVE, OR HAD: (Please write maternal or paternal side.)

Disease	Relative	Outcome	Disease	Relative	Age of Diagnosis
Addiction (list type)			Alzheimers		
Blood Disorder			Mental Illness (list type)		
Pulmonary			Epilepsy		
Depression			Cancer:		
Diabetes			Breast		
Osteoporosis			Colon		
Thyroid Disease			Ovarian		
High Blood Pressure			Uterine		
High Cholesterol			Skin		
Heart Disease (list type)			Other:		

Luminis OB-GYN ANNAPOLIS

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please read this form carefully. You will be asked to sign this form electronically upon arrival to your appointment. There is no need to bring this form to your visit.

I hereby give my consent for Luminis Health OB-GYN Annapolis to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Luminis Health OB-GYN Annapolis Notice of Privacy Practices provides a more complete description of such disclosures)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Luminis Health OB-GYN Annapolis reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Luminis Health OB-GYN Annapolis Privacy Official at **2000 Medical Parkway Ste. 304, Annapolis, MD 21401.**

With this consent, Luminis Health OB-GYN Annapolis may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Luminis Health OB-GYN Annapolis may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Luminis Health OB-GYN Annapolis restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Luminis Health OB-GYN Annapolis use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Luminis Health OB-GYN Annapolis may decline to provide treatment to me.

NOTE: If you would like anyone else (spouse, partner, parent, etc.) to have access to your health information please ask for the appropriate form.

Luminis Health

Our Locations

The Belcher Pavilion
2000 Medical Parkway,
Ste. 304
Annapolis, MD 21401
(Park in Garage E)

AAMC Health Services Bldg.
1630 Main Street, Ste. 211
Chester, MD 21619

AAMC Health Services Bldg.
2401 Brandermill Blvd.,
Ste. 350
Gambrills, MD 21054

Pasadena Office
18 Magothy Beach Rd,
Ste. A
Pasadena, MD 21122

09/03/21