LAUREN RODGERS MD
REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr. _____ ☐ Insurance Plan ☐ Hospital

☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Other family members seen here:

DO NOT LEAVE BLANK **INSURANCE INFORMATION** DO NOT LEAVE BLANK

Patient in responsible to provide ALL insurance information in this section before giving to the receptionist

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate **PRIMARY** insurance ☐ UHC/Medicaid ☐ Amerigroup ☐ Geha ☐ Md Phy Care ☐ UnitedHCare

☐ Coventry ☐ Cigna ☐ CareFirst ☐ Aetna ☐ G.Rule

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Member /Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Lauren RoDGers Md or Insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Notice to Patients of Policies and Procedures
Revised as of January 1, 2015

I understand that I am allowed 1 well women visit per year which includes a pap and or blood draw and mammogram referral with no copay. Any other issues or concerns that are addressed during my annual visit will result in copay which will be paid prior to the visit (I.E. vaginal irritation, hot flashes, fertility. Prescription for birth control pills or any other prescription.)

I understand that if I am contacted concerning a test and or pap taken in the office that **I will be subject to my copay in full.** I understand that if I a past due balance due at the time of service **I must pay a minimum of 50% of the balance and my copay before I am seen.**

I understand that there is a 0.79 per page for up to 20 pages and $50.00 over 20 pages charge and maximum 48hr wait for the request of records. (I.E. 21 pages will be $50.00) **If I request for my records through another physician they will received most recent pap and blood work only.** All records must be picked up in person on Mon, Wed, and Thur between 2pm-4pm only.

I understand that ALL prescription given by the physician will be refilled for a maximum of 6 months ONLY. I am aware that I will need to keep track of my refills so that I am able to be seen before they are out. I also understand that I will not be given a month supply of ANY prescription. I also understand that I will need to make an appointment to have my prescription refilled and also will be required to pay my copay.(I.E. I will have an office visit not walk in and pick up a prescription.) **If you are a college student please arrange to come in during your breaks!**

- **I understand that the physician does not discuss any type of abnormal test results or radiology results over the phone**. I also understand that I will need to make an appointment to discuss these results in person and I will also be subject to my FULL copay.

- **I understand that I will be charged a $50.00 no show fee if I do not call within 24hrs of my appointment and if I call after the appointment has past or a $15.00 fee if I cancel on the day of my appointment before the appointment time.**

- **There will be a 10.00 fee for any paperwork that needs to be filled out by our office. (I.E. Disability, Social Services Work Forms, Metro Forms)**

- **It is your responsibly as the patient to read the policies and procedures. If you have any questions please just ask. A copy of this form is located in all rooms and the waiting room. You may also request a copy at any time.**

Patient Sign:
Patient Date:

OB / GYN HISTORY FORM CHART #_____

Name:	Date of Birth:	Age:	Date:

PAST MEDICAL HISTORY

	Yes	No	Date		Yes	No	Date
Anemia				Elevated cholesterol			
Asthma				Hypercoagulation Syndrome			
Hospitalized for Asthma				Hypertension (High blood pressure)			
Breast Cancer				Hyperthyroidism			
Breast Cyst, Benign				Hypothyroidism			
Chickenpox				Irritable Bowel Syndrome			
Cholelithiasis (Gall Stones)				Kidney Calculus/Stone			
Coronary Artery Disease				Migraine			
Deep Vein Thrombosis				Mitral Valve Prolapse			
Depression				Osteopenia			
Diabetes Mellitus				Osteoporosis			
Diverticulosis of Colon				Peptic Ulcer Disease			
Emphysema				Previous Blood Transfusion			
Epilepsy				Why transfused?			
Fibrocystic Changes of Breast				Pulmonary Embolism			
Glaucoma				Sickle Cell Anemia			
Hepatitis				Tuberculosis			
Human Immunodeficiency Virus (HIV)				Urinary Tract Infection (UTI)			
OTHER:				OTHER:			

PAST SURGICAL HISTORY

List Surgery	Date

ALLERGIES/REACTION

Allergy to:	Reaction caused:

GYNECOLOGIC HISTORY

			Date				Date
Yes	No	Abnormal Pap Smear		Yes	No	Any Sexually Transmitted Diseases?	
Yes	No	Abnormal Bleeding/Irregular Bleeding		If yes, type:			
Yes	No	Endometriosis					
If yes, how was it diagnosed?				Yes	No	Pelvic Inflammatory Disease	
		Other:				If yes, type:	

MENSTRUAL HISTORY

Age Started Period:

Last Menstrual period:

How often : How long:

Birth control method:

Menopause? Yes No If yes, at what age?_____

PREGNANCY HISTORY

Total Number of pregnancies:

# of Full Term # of Premature

# of Miscarriages # of Abortions

Type of Delivery(s) Weight Date

If Cesarean please give reason:

Any other problems during pregnancy?

SOCIAL HISTORY

	Yes	No
Smoke If yes, _____pk/day for _____years		

FAMILY MEDICAL HISTORY

	Yes	No	Relative/Age
Breast Cancer			

Drink Alcohol If yes, _____oz/day for _____years	Yes	No
Any Drug Use If yes, then type_____	Yes	No
Caffeine	Yes	No
Wear Seat Belt	Yes	No
Get Calcium In Diet	Yes	No
Exercise	Yes	No
Domestic Violence(Past or Present)	Yes	No
Married	Yes	No
Adopted	Yes	No
Occupation:		

Colon Cancer	Yes	No	
Diabetes	Yes	No	
Heart Disease	Yes	No	
High Blood Pressure	Yes	No	
High Cholesterol	Yes	No	
Osteoporosis	Yes	No	
Ovarian Cancer	Yes	No	
Stroke	Yes	No	
Thyroid Disease	Yes	No	
OTHER:			

SCREENING TESTS			Date	Result	SCREENING TESTS			Date	Result
Colonoscopy	Yes	No			Mammogram	Yes	No		
Dexa Scan	Yes	No			Pap Smear	Yes	No		

VACCINES (Are you up to date on the following vaccinations?)

Hepatitis A	Yes	No	MMR/Rubella	Yes	No
Hepatitis B	Yes	No	Seasonal Flu	Yes	No
HPV	Yes	No	Tetanus, Diptheria, Pertussis	Yes	No

MEDICATIONS (Prescriptions, Vitamins, Herbal/Alternative Meds)

Current Medication:	Dosage	Indication	Prescribed by:

Please feel free to write down anything we may not have asked that you feel is important to include in your chart.