viva eve

THE WOMEN'S HEALTH EXPERTS

PATIENT REGISTRATION INFORMATION FORM (PLEASE PRINT)

Name:		I prefer to be called:	
Date of Birth:	Sex:	SSN:	Marital Status:
Address:	City:	State:	Zip Code:
Cell#	Home#	Work#	

The best time to contact you: A.M. ☐ P.M. ☐ On my: Cell phone ☐ Home phone ☐

Email Address:

Race: Ethnicity: (Please check) Hispanic ☐ Non-Hispanic ☐ Unknown ☐ Do not wish to provide ☐

Referring Provider:	Address:	Phone:
Primary Care Provider:	Address:	Phone:
Emergency Contact Name:	Relationship:	Sex:

Address:	Home#	Work#	Cell#

How did you find us?	Do you have a Health Savings or Flex Account?

EMPLOYMENT INFORMATION

Employer:		Employment Status: F/T P/T or Unemployed	
Employer Address:	City:	State:	Zip Code:

PRIMARY INSURANCE INFORMATION

Insurance Name:		
Subscriber ID#:	Group#:	
Subscriber Name:	Date of Birth:	SSN:

SECONDARY INSURANCE INFORMATION

Patient Relationship to Subscriber: (Please check) Self ☐ Spouse ☐ Father ☐ Mother ☐ Other ☐

Subscriber ID#:	Group#:	
Subscriber Name:	Date of Birth:	SSN:

108-16 63rd Road, Forest Hills NY 11375 • T: (718) 897-5331 • F: (877) 389-3130 • info@vivaeve.com
FHMS, PC, 1986 Medical, PLLC, 9909 Medical, PLLC

viva eve

THE WOMEN'S HEALTH EXPERTS

PATIENT PORTION WAIVER APPLICATION

(i.e. deductibles, co-insurance, etc.)

You may use this form if you believe you have experienced financial hardship and feel you may qualify for a waiver of your copayment and/or deductible. You may seek a waiver only for financial hardship and this document is considered an attestation of such. You also acknowledge that there are no guarantees, neither explicit nor implicit, that Viva Eve will grant such a waiver.

Signature of Patient	Printed Name	Date

FOR OFFICIAL USE ONLY

Please do not mark or write anything below this line.

☐ Approved. Comments:

☐ Not Approved. Comments:

108-16 63rd Road, Forest Hills NY 11375 • T: (718) 897-5331 • F: (877) 389-3130 • info@vivaeve.com
FHMS, PC, 1986 Medical, PLLC, 9909 Medical, PLLC

viva eve

THE WOMEN'S HEALTH EXPERTS

OB/GYN HISTORY FORM

Please take the time to fill out the entire form

Name:	Date of Service:
Preferred / Chosen name (If different from above):	Preferred Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them
Date of Birth:	
Reason for Visit:	
Pharmacy:	Pharmacy Phone #:
Address: (Street, City, Zip)	

MEDICATIONS

Please list any medications you are currently taking including birth control, creams, aspirin, vitamins, and hormones:

Name of Medication	Strength	How often you take it

MEDICATION ALLERGIES

Please list any medications you are allergic to:

Medication	Your Reaction

Are you allergic to Latex? ☐ Yes ☐ No

108-16 63rd Road, Forest Hills NY 11375 • T: (718) 897-5331 • F: (877) 389-3130 • info@vivaeve.com
FHMS, PC, 1986 Medical, PLLC, 9909 Medical, PLLC

viva eve

THE WOMEN'S HEALTH EXPERTS

MEDICAL CONDITIONS

Do you have or have you had any of the following conditions?

Anemia	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Stomach Ulcers	☐ Yes	☐ No	Migraines	☐ Yes	☐ No
Seizures	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Anxiety / Depression	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	HIV	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Hepatitis B or C	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Intestinal Disease	☐ Yes	☐ No	Bleeding Disorders	☐ Yes	☐ No
Clotting Disorders	☐ Yes	☐ No	Osteoarthritis	☐ Yes	☐ No
Endometriosis	☐ Yes	☐ No	Polycystic Ovarian	☐ Yes	☐ No

If yes, please specify:

Please list any personal history of sexually transmitted illnesses - such as Chlamydia, Gonorrhea, Trichomonas, Syphilis, Herpes, HPV, etc:

DIAGNOSTIC / HEALTH MAINTENANCE

Date of your last Pap smear:	Location where you had your last Pap smear:	Were the results normal? ☐ Yes ☐ No
Date of your last Mammogram:	Location where you had your last Mammogram:	Were the results normal? ☐ Yes ☐ No
Have you ever had a colonoscopy?	If yes, what year?	Location where you had the colonoscopy done:

MENSTRUAL HISTORY

Do you still have a menstrual cycle?	When was the first day of your last menstrual cycle?	
What age did you begin your menstrual cycle?	# of days between periods:	How many days of flow?

Cramping: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Flow: ☐ None ☐ Mild ☐ Moderate ☐ Heavy

Are you sexually active? ☐ Yes ☐ No ☐ Never

If yes, what type of birth control do you use?

108-16 63rd Road, Forest Hills NY 11375 • T: (718) 897-5331 • F: (877) 389-3130 • info@vivaeve.com
FHMS, PC, 1986 Medical, PLLC, 9909 Medical, PLLC

viva eve

THE WOMEN'S HEALTH EXPERTS

OBSTETRICAL HISTORY

No. of Pregnancies	No. of living children	No. of vaginal deliveries
No. of full term births	No. of miscarriages	No. of Cesarean sections
No. of premature births	No. of abortions	No. of Ectopic Pregnancies

FAMILY HISTORY (Please mark one)

Mother:	☐ Living	☐ Deceased	Father:	☐ Living	☐ Deceased
Brother:	☐ Living	☐ Deceased	Sister:	☐ Living	☐ Deceased
Brother:	☐ Living	☐ Deceased	Sister:	☐ Living	☐ Deceased

Consider the following relatives when answering these questions: Mother, Father, siblings, children, aunts/uncles, grandparents

Have any family members listed above been diagnosed with the following:

	Relative	Maternal / Paternal	Age of Diagnosis
☐ Breast Cancer			
☐ Uterine Cancer			
☐ Ovarian Cancer			
☐ Pancreatic Cancer			
☐ Colon Cancer			

List any medical conditions and cause of death:

Mother:

Father:

Sister(s):

Brother(s):

108-16 63rd Road, Forest Hills NY 11375 • T: (718) 897-5331 • F: (877) 389-3130 • info@vivaeve.com
FHMS, PC, 1986 Medical, PLLC, 9909 Medical, PLLC

viva eve

THE WOMEN'S HEALTH EXPERTS

SOCIAL HISTORY

Do you exercise?	What type of exercise?	How many times a week?
Occupation / Place of Employment:		

Relationship Status:			Partner's Name:
Do you use illicit/street drugs?	☐ Yes	☐ No	How often?
Do you drink alcohol?	☐ Yes	☐ No	How often?
Do you currently smoke cigarettes?	☐ Yes	☐ No	How many per day:
Have you smoked cigarettes in the past?	☐ Yes	☐ No	If yes, when did you quit?

SEXUAL ORIENTATION / GENDER IDENTITY

We are asking for the following information because we want to understand your individual needs, and improve your care.
We are commited to diversity and inclusion.

What is you current gender identity?	Sexual Orientation:
☐ Female	☐ Bisexual
☐ Male	☐ Gay
☐ Non-binary/GNC/Genderqueer	☐ Heterosexual
☐ Transfemale / Male to female	☐ Lesbian
☐ Transmale / Female to male	☐ Don't know
☐ Decline to answer	☐ Decline to answer

SURGICAL HISTORY

Please list any surgeries you have had:

Surgery	Date

108-16 63rd Road, Forest Hills NY 11375 • T: (718) 897-5331 • F: (877) 389-3130 • info@vivaeve.com
FHMS, PC, 1986 Medical, PLLC, 9909 Medical, PLLC

viva eve

THE WOMEN'S HEALTH EXPERTS

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name:	Date of Birth:	Social Security Number:

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form.

In accordance with applicable law, I understand that:

This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE**, **MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line below. In the event the health information described below includes any of these types of information, and I initial the line on the box below, I specifically authorize release of such information to the person(s) indicated below.

If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Information disclosed under this authorization might be redisclosed by the recipient and this redisclosure may no longer be protected by federal or state law.

A **COPY** of this Authorization shall have the same force and effect as original.

Name and address of health provider or entity to release this information:

Viva Eve - 108-16 63rd Road, Forest Hills, NY 11375 Tel: (718) 897-5331 Fax: (877) 389-3138

Name and address of person(s) or category of person to whom this information will be sent:

Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____
☐ Abstract: (all tests, labs, EKGs, echocardiograms, procedure reports, discharge summary etc.)
☐ Entire Record
☐ Other:

☐ Include: (Indicate by initialing)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Reason for release of information:	Date or event on which this authorization will expire:
☐ At request of individual ☐ Other:	
If not the patient, name of person signing form:	Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ _____

Signature of patient or representative authorized by law. Date

***Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**