Suncrest
Obstetrics & Gynecology
1272 Suncrest Towne Centre Dr
Morgantown WV, 26505
Phone: (304) 212-5423 Fax: (304) 241-4859

Dear Valued Patient:

Welcome to Suncrest Obstetrics and Gynecology! We look forward to meeting you soon. In order to provide you with the best possible care, our registration forms should be completed prior to your first visit. Please complete these forms at home or arrive at least 30 minutes prior to your appointment to allow time to complete the forms. We are located at 1272 Suncrest Towne Centre Drive, on the second floor, right above Sleep Outfitters. There are three entrances on the back side of the building. The closest entrance is near the middle of building. You can see the Kroger grocery store. It has a green awning, shrubbery, and a large street light. The other entrances, next to the breezeways, will get you to us, but you will walk more. Follow the signs to us. Allow extra time to find us, because the corridors are sometimes confusing.

The staff at Suncrest OB-GYN respects your time and will always try to maintain an on-time schedule; however, there may be situations where I may be called away for an emergency or a delivery. If this should occur, you will be notified as soon as possible so that you can return later in the day or reschedule for another day. Please call our office at 304.212.5423 should you have any questions or concerns.

Thank you for giving us the opportunity to assist with your healthcare needs. We look forward to seeing you soon.

Sincerely,

Dr. Kerri George Hall

For the latest, current information, we recommend a few websites with credible information for issues concerning your health and well-being. They are www.cdc.gov and www.acog.org.

Welcome!

REGISTRATION FORM

Section I: Patient Information Date_____

Name:_____ I Prefer to be called: _____

Address:_____City:_____State:_____Zip_____
Phone (_____)_____ Work Phone (_____) _____ Cell Phone _____)_____
Date of Birth:_____ Social Security Number:_____
OK to leave a message on my ☐ Home phone ☐ Work phone ☐ Cell phone ☐ Do Not Leave a message
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Check Appropriate Box (Race): ☐ White ☐ African American ☐ Other
Check Appropriate Box (Ethnicity): ☐ Hispanic/Latino ☐ White/Caucasian ☐ Hawaiian ☐ African American
☐ Asian ☐ American Indian ☐ Other
Check Appropriate Box (Primary Language): ☐ English ☐ Spanish ☐ _____

If Student, Name of School_____ City/State_____ ☐ FT ☐ PT
Spouse or Parent's Name: _____ Employer_____ Work Phone_____
Whom may we thank for referring you? _____
Person to contact in case of emergency_____ Phone_____
Relationship to emergency contact_____
Email Address_____ _____
Please list any individual the office is allowed to provider information regarding your care_____
:_____:_____

Section II Responsible Party

Complete ONLY if not self

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:_____ Relationship to Patient: _____
Address:_____
City:_____ State:_____ Zip:_____ Phone: (____)_____
Employer_____ Work Phone (____)_____ SSN#_____

Section III Insurance Information

Name of Policy Holder_____ Policy Holder DOB_____
Relationship to Patient _____ Phone # _____
Address _____
Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company Name_____ ID# _____Group#_____
DO YOU HAVE ANY ADDITONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING

Name of Policy Holder_____ Policy Holder DOB_____

Relationship to Patient _____ Phone# _____

Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ ID #_____ Group#_____

Welcome!

Section IV **Patient Preferred Pharmacy Information**

Pharmacy Name #1:_____ _____
Address:_____City:_____State:_____Zip_____
Phone (_____)_____

Pharmacy Name #2:_____ _____
Address:_____City:_____State:_____Zip_____
Phone (_____)_____

I HAVE READ AND UNDERSTAND THE OFFICE HIPAA POLICY AND UNDERSTAND THAT I CAN REQUEST A PAPER COPY OF THE HIPAA POLICY.

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

IF I HAVE INSURANCE COVERAGE, I HEREBY AUTHORIZE MY PHYISICIAN TO FURNISH INFORMATION TO THAT INSURANCE CARRIER CONCERNING MY ILLNESS AND TREATMENT.

I AUTHORIZE MY PHYSICIAN TO VIEW ANY MEDICAL PRESCRIPTION HISTORY DEEMED NECESSARY FOR MY TREATMENT.

I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

THERE ARE MANY LAB TESTS THAT ARE SENT OUT OF THE OFFICE TO A LAB. YOUR HEALTH INSURANCE MAY NOT COVER ALL TESTS AND THEY MAY BE SUBJECT TO YOUR DEDUCTIBLE AND CO-INSURANCE. SOME LAB TESTS HAVE A FREQUENCY SCHEDULE. OTHERS MAY NOT BE COVERED AT ALL, IN WHICH CASE YOU WILL NEED TO DECIDE HOW IMPORTANT THE LAB TEST IS. THE LAB FEES WILL BE BILLED DIRECTLY TO YOU FROM THE LAB, NOT THE OFFICE.

IT IS IMPORTANT TO KNOW YOUR HEALTH PLAN AND IT'S BENEFITS.

_____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN (IF MINOR) DATE

Name _____ **Birth Date** _____

Medical History/Family History

Circle diseases in you or in the family	**Me**	**Family: who has this disease**
Diabetes Type I or Type II		
High Blood Pressure		
Heart disease/Heart attack		
Stroke		
High Cholesterol		
Autoimmune disorder		
Kidney disease/UTI		
Headaches		
Psychiatric		
Hepatitis/ Liver disease		
Gall bladder disease		
Varicose veins		
Hypothyroidism/ Hyperthyroidism		
Trauma/Violence		
Blood transfusion		
Lung disease		
Abnormal pap/Cervical cancer		
Uterine anomaly/DES exposure		
Infertility		
Osteoporosis		
Breast cancer/Breast disease		
Ovarian cancer		
Uterine cancer		
Colon cancer		
Other cancer (what kind)		
Diverticulitis/losis		
Bleeding problems		
Blood clots in legs or lungs (DVT or PE)		
Glaucoma		
Substance abuse		

Surgery	**Year**	**Complication(s)**

Name _____ **Birth Date** _____

Social History				
Are you sexually active?	Yes	No		
Partners with	Men	Women	Both	
Tobacco	Never used	Quit using	Currently using	Quit when I found out I was pregnant
If you use tobacco:	_____years	__ Packs/day		
Alcohol	Never used	Quit using	Currently using	Quit when I found out I was pregnant
If you drink alcohol:	less than 7 a week	7 or more a week	more than 3 in one sitting	
Drug use	Never used	Quit using	Currently using	Quit when I found out I was pregnant
Which drugs are you currently using?				
Which drugs have you used in the past?				

Medications	**Dose**	**How often**	**Dr. who Rx's**

Allergies (medication, food, environmental)	**Reaction**

Menstrual History				
Age at first period?				
First day of last menstrual period?				
Are you in menopause? If yes, skip the rest.	Yes	No		
How often do you have periods				
How would you describe the flow?	Heavy	Normal	Light	
Are your periods painful?	Yes	No		
Do you bleed between periods?	Yes	No		
Do you have PMS symptoms?	Yes	No		

Obstetrical History	**Year/ How far along**	**Hrs in Labor**	**Type of Del / Anesthesia**	**Sex / Baby's Weight/Preterm labor**
Pregnancy 1				M or F/ # oz / yes or no
Complications of baby or mother:				
Pregnancy 2				M or F/ # oz / yes or no
Complications of baby or mother:				
Pregnancy 3				M or F/ # oz / yes or no
Complications of baby or mother:				
Pregnancy 4				M or F/ # oz / yes or no
Complications of baby or mother:				
Pregnancy 5				M or F/ # oz / yes or no
Complications of baby or mother:				
Pregnancy 6				M or F/ # oz / yes or no
Complications of baby or mother:				

How did you hear about our practice? Phonebook Website Newspaper Ad Radio Ad
Other: _____

Patients Name: _____ **D.O.B.** _____

CONSTITUTIONAL	N/A	NO	YES
Night Sweats			
Chills			
Fever			
Fatigue			
Change in weight			
EYES			
Blindspots			
Vision Change			
Glaucoma			
HEART			
Chest pain or pressure			
Shortness of breath			
Shortness of breath with activity			
Leg pain with walking			
Swelling in legs			
RESPIRATORY			
Cough			
Coughing up blood			
Wheezing			
GASTROINTESTINAL			
Feeling full easily			
Gas/bloating			
Increased abdominal girth			
Hemorrhoids			
Constipation			
Diarrhea			
Black or bloody stool			
Nausea			
Vomiting			

GENITOURINARY/NEPHROLOGY	N/A	NO	YES
Leakage of urine			
Waking up to urinate			
Breast lump			
Irritation			
Vaginal discharge			
Genital lesion			
Bleeding after sex			
DERMATOLOGIC			
Increase in hair			
Changing moles			
Rash			
NEUROLOGIC			
Headache			
Passing out			
Numbness			
Shakiness			
PSYCHIATRIC			
Sleep disturbance			
Anxiety			
Depression			
ENDOCRINE			
Cold or heat intolerance			
Increased hunger			
Increased thirst			
Increased urination			
Breast discharge			
HEMATOLOGIC/LYMPHATIC			
Abnormal bleeding/bruising			
Anemia			
Lymph node enlargement/mass			
Allergy/Immunology			
Steroid use			
Itching			

When was the last time you saw Dr. Kerri Hall?_____