Welcome to Four Corners OB/GYN!

Ph: 970-382-8800 **Fax: 970-382-0122**

1 Mercado Street, Suite 105
Durango, CO 81301

In order for your first appointment to go smoothly, please follow our easy checklist:

☑ Fill out the New Patient enrollment forms using blue or black ink only. Fax to 382-0122, or mail a copy to our office at 1 Mercado St., Suite 105, Durango, CO 81301. Please bring the originals to your appointment.

☑ We ask that you please arrive 20 minutes prior to your appointment time with your paperwork completed. Your insurance card and a photo ID must be presented at this time. We will make every effort to have you seen in a timely manner. Late arrivals may need to reschedule for a future date.

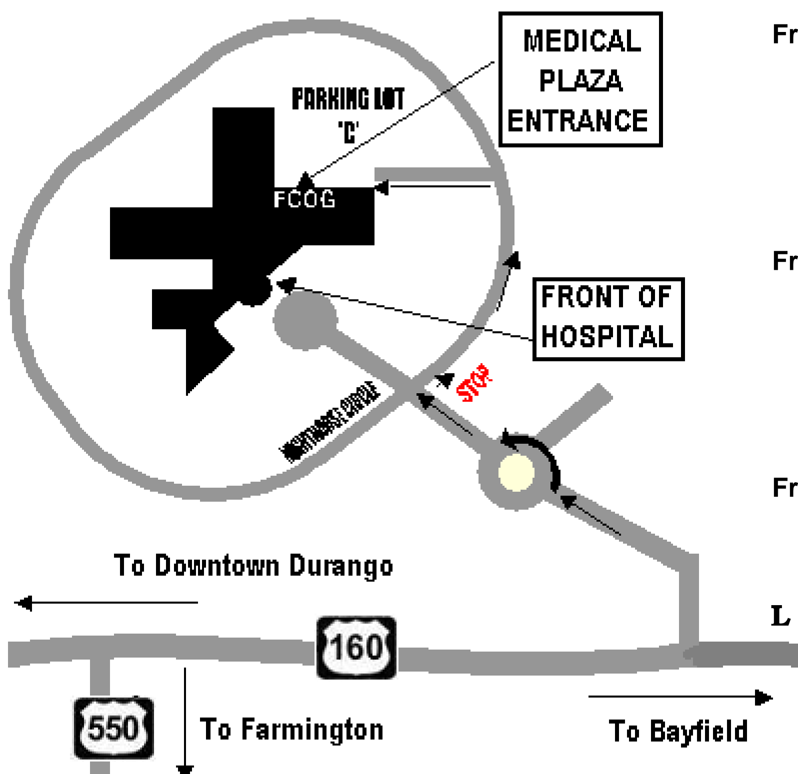
☑ Please inform our office as soon as possible if you are unable to attend your appointment. Failure to contact us will result in a $30.00 "No Show" fee.

☑ Please feel free to contact your insurance company prior to your appointment to confirm their coverage of the services being provided by our office. Our Tax ID # is **84-1451020.**

☑ Your insurance may require a co-payment for an office visit. This is collected at the time of check in.

☑ If you are insured but have not yet received an insurance card, it is *your* responsibility as the policy holder to get the necessary billing information from your insurance company in advance. If you are not able to provide proof of coverage and all of the necessary billing information, we will consider you self-pay.

☑ We offer a "prompt pay" discount for uninsured self-pay patients who pay in full on the day of service.



From Durango: Take 160 E toward Bayfield. Turn left at the stoplight onto Three Springs Blvd. Come through the roundabout and turn right at the stop sign directly in front of the hospital. Turn left at the next stop sign and park in parking lot C. We are the first office on the left as you come in the glass entryway of the Mercy Medical Plaza.

From Bayfield: Take 160 W toward Durango. Turn right the stoplight onto Three Springs Blvd. Come through the roundabout and turn right at the stop sign directly in front of the hospital. Turn left at the next stop sign and park in parking lot C. We are the first office on the left as you come in the glass entryway of the Mercy Medical Plaza.

From Farmington: Take 550 N and come down Farmington Hill. Turn right at the stoplight. Turn left at the next stop light onto Three Springs Blvd. Come through the roundabout and turn right at the stop sign directly in front of the hospital. Turn left at the next stop sign and park in parking lot C. We are the first office on the left as you come in the glass entryway of the Mercy Medical Plaza.

FOUR CORNERS OB/GYN PATIENT REGISTRATION

PLEASE* PRINT *& FILL OUT COMPLETELY USING BLUE OR BLACK INK ONLY

Patient Name: ____ Date of Birth: _____/_____/_____
LAST FIRST MIDDLE INITIAL

Physical Address: __________________________________City:___________State:_____Zip:________

Mailing Address: __________________________________City:___________State:_____Zip:________

Home Phone: (_____)_______-_______________ Cell/Pager#: (_____)_______-_______________

May we leave a private message? YES NO At Which Number(s)? HM CELL

Email: __________________________________ Work Phone: (_____)_____-____________

Social Security # _____-_____-______ Marital Status: Married _____ Single _____

Race: ___________________________ Ethnicity (circle one): *Hispanic/Latino* or *Non-Hispanic/Latino*

Preferred Language: ____

Primary Care Physician (cannot be one of our doctors):______________________________________

Preferred means of preventative care reminder? EMAIL OR MAIL________________________________

Responsible Party/Guardian Name: ____________________________________**Social Security #** _____-_____-______

Responsible Party/Guardian Address: ____

EMERGENCY CONTACT ____

Relationship to you: _______________Home Phone: (_____)______-________Work Phone: (_____)______-________

***Note: Advanced Directives and Living Will information available upon request.**

PRIMARY INSURANCE: ____

SECONDARY INSURANCE: ____

FOUR CORNERS OB/GYN WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & NOTICE OF ELECTRONIC HEALTH INFORMATION EXCHANGE NOTIFICATION

Notice of Privacy Practices located on previous page.

Electronic Health Information Exchange Notification

Four Corners OB/GYN endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to you medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the Four Corners OB/GYN HIE, or cancel an opt-out choice, at any time.

I ______________________________, have received a copy of Four Corners OB/GYN's Notice of Privacy Practice, and understand that this practice participates in electronic HIE.
I hereby authorize the release of my medical records to any physician involved in my care, as well as any medical information necessary to process claims. I also authorize the notification of test results, reminders, and other messages regarding my care to be left by mail, courier, e-mail, and/or voicemail.

PATIENT'S SIGNATURE: ____________________________________**DATE:** ______/_____/_____

GUARDIAN'S SIGNATURE: __________________________________**DATE:** _____/_____/______

CONTINUED ON NEXT PAGE

CONTRACT OF FINANCIAL RESPONSIBILITY

In agreeing to be responsible for your medical care,
Four Corners OB/GYN requires that you be responsible for your financial obligations to us.

Please read the following carefully and initial each paragraph, then sign where indicated to acknowledge your understanding and acceptance. If you are a minor (under 18), your parent or legal guardian must accept financial responsibility on your behalf.

1. _______ I understand and accept that ultimately I am financially responsible for all services provided to me by Four Corners OB/GYN. I understand and agree to pay for all services provided to me by Four Corners OB/GYN, I *at the time of service*, unless my services are covered by a contracted insurance.

2. _______ I understand and accept that I am responsible for the verification of my insurance coverage and benefit level for services rendered by FCOG providers and providers to whom I am referred by FCOG.

3. _______ I understand and accept that my insurance company or health plan may require me to pay co-payments, co-insurance or deductibles. If I have a co-pay, I agree to pay in full *at the time of service*. **Co-Payments are collected upon check in; patients without their co-payments will be rescheduled.** I agree to pay any co-insurance or deductibles *within 30 days* of my first statement from Four Corners OB/GYN.

4. _______ I understand and accept that I will be assessed a $20.00 fee plus any additional charges allowed by CRS 13-21-109 for any returned check. Any payments thereafter must be made with cash or credit cards.

5. _______ I understand and accept that I will be charged a fee of $30.00 if I fail to keep my scheduled appointment(s) or fail to cancel my scheduled appointment(s) within 24 hours.

6. _______ I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Four Corners OB/GYN for any services furnished me by the physicians and practitioners in the office. I understand and accept that if, ***90 days*** after billing, my insurance has not paid, my account will be due and I will be responsible for payment in full of any outstanding balance.

7. _______ I understand and accept that in the event that my account becomes past due, my balance may accrue interest. If my account is sent to collections I will be responsible for all collection costs, attorney fees, court costs and any other miscellaneous fees. I consent to have the collection agency obtain my credit report for the purposes of collection on my account. I also understand my account at Four Corners OB/GYN will be locked, and no appointment(s) will be made until said debt is paid in full.

8. _______ I understand and accept that if further action must be taken on my account, I may be discharged from this practice and Four Corners OB/GYN may require me to permanently seek further care elsewhere, in accordance with guidelines set forth by the Colorado State Board of Medical Examiners.

9. _______ I understand and accept that specimens obtained in our office will be sent to outside laboratories for test. In compliance with the ACOG standard of care, contingent on clinical circumstances, some PAP results are also tested for HPV. I understand that the lab will bill separately for these test results. Any questions regarding bills for laboratory and pathology tests should be directed to the testing facility.

PATIENT'S SIGNATURE: ____DATE: _______/______/______

GUARDIAN'S SIGNATURE: ____DATE: ______/______/_______

FOUR CORNERS OB/GYN PATIENT MEDICAL HISTORY

The following questions are confidential but if any of the questions below are uncomfortable for you, you may leave them blank.

Name: ____ DOB: ______________ Today's Date: ______________

Primary reason for visit today: ☐ Annual Exam, ☐ OB, ☐ Emergency, ☐ Consultation, ☐ Other

Please give more information if needed: ____

____

____

MENSTRUAL HISTORY

First day of last menstrual period: ______________ Age at first menstrual period: _________

Are your periods usually: ☐ Regular ☐ Irregular ☐ No longer menstruating

Periods last _______ days Periods occur every _______ days

Bleeding is: ☐ heavy ☐ moderate ☐ light Do you have bleeding between periods? ☐ Yes ☐ No

Do you have cramps/pain with your periods? ☐ Yes ☐ No If yes, do you use pain med? ☐ Yes ☐ No

Do you have pain or bleeding with intercourse? ☐ Yes ☐ No Are you having problems with your sex drive? ☐ Yes ☐ No

Is your partner: ☐ Male ☐ Female ☐ Both (bi-sexual)

PERSONAL HISTORY: Do you currently have or have you ever had any of the following? Please check appropriate boxes and explain if needed.

Menstrual dysfunction		**Lung problems**		**Cancer**		**Diabetes**	
If yes, what type?		If yes, what type?		If yes, what type and year diagnosed:		**High cholesterol**	
						High blood	
Abnormal pap smear		**Heart problems**		Treatment:		**Bladder leaking**	
If yes, treatment?		If yes, what type?		Chemotherapy		**Thyroid disease**	
				Radiation		**Pituitary disease**	
STD exposure		**Liver disease**		Other		**Hemorrhoids**	
If yes, what type?		If yes, what type?				**Arthritis**	
				Stomach problems		**Osteoporosis**	
Vaginal problems		**Hepatitis A, B, or C**		If yes, what type?		**Adult fractures**	
If yes, what type?						**Neck/back**	
		Blood disorder		**Changing moles**		**Seizure disorder**	
Sexual dysfunction		If yes, what type?		If yes, where?		**Depression**	
If yes, what type?						**Psychiatric history**	
		Blood transfusion		**Skin problems**		**Drug addiction**	
Uterine fibroids		If yes, year given:		If yes, what type?		**Alcohol addiction**	

Please add other pertinent diagnoses or more information if needed:____

____

____

MEDICATION ALLERGIES: *Please specify reaction.*

☐ Penicillin, ☐ Sulfa, ☐ Codeine, ☐ Morphine, ☐ Latex, ☐ Aspirin, ☐ Tylenol,

Other: ____

Reaction: ____

IMMUNIZATIONS: *Please check all that are current.*

☐ Diphtheria/Tetanus (every 10 yrs), ☐ Hepatitis B, ☐ Hepatitis A, ☐ MMR (Measles, Mumps, Rubella), ☐ Flu (yearly), ☐ Varicella (Chicken Pox), ☐ Pneumonia

Updated 10/1/14 ACZ

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FAMILY HISTORY: *Please check the box and write which family member what side of your family they are on (maternal or paternal):*

		Family Member(s)			Family Member(s)			Family Member(s)
Breast cancer			High blood pressure			Alzheimer's		
Cervical cancer			Heart Attack			Mental Illness		
Ovarian cancer			Stroke			Other:		
Uterine cancer			Diabetes					
Colon cancer			Osteoporosis					
Other cancer			Thyroid					

SOCIAL HISTORY:

Tobacco use: □ Never

□ Now: Packs per day: _______ How many yrs: _______/□ Past: Packs per day: _______ How many yrs? ________ Date quit: ________

Alcohol use: Drinks per week: _______ Type: _________________

Caffeine use: Quantity per day: _______ Type: __________________

Do you exercise? □ Yes, □ No. If yes, how often and what type? ____

CONTRACEPTIVE HISTORY

Current method of birth control: □ Vasectomy, □ Tubal ligation, □ Birth Control Pills, □ Diaphragm, □ Foam/gel, □ Condoms, □ Natural Family Planning/Rhythm, □ Depo Provera injections, □ IUD: Type:_______________________, □ Norplant, □ Nuva Ring, □ None, □ Abstinence, □ Plan future pregnancy, □ Other: ____

Have you ever had a problem with any of the above contraceptives? □ Yes □ No. If yes, state which method and what the problem was: __
____

CURRENT MEDICATIONS, SUPPLEMENTS, VITAMINS, OR HERBALS:

Med/Sup/Herbal	Dose & Frequency	Med/Sup/Herbal	Dose & Frequency	Med/Sup/Herbal	Dose & Frequency

PREGNANCY HISTORY:

Total # of pregnancies: _______ Miscarriages: _______ Abortions: _______ Preterm deliveries: _______ Term deliveries: ______

Year	# Weeks at delivery	Length of Labor	Vaginal or Cesarean	M/F	Birth Weight	Complications

SURGICAL HISTORY:

Year	Type of surgery	Reason	Complications

SCREENINGS: *Please specify month and year*

Last Pap smear date: ____________ Last mammogram date: ____________ Last colonoscopy date: ___________

Last cholesterol testing date: ____________ Last DEXA (osteoporosis screening) date: ____________