



Patient Registration Form

Today's Date: ___/___/___
Last Name: _____ First Name: _____ Middle: _____
Address: _____ APT# _____
City _____ State: _____ Zip _____
Home Ph: (____) _____ Work Ph: (____) _____ Other Ph: (____) _____
SSN: _____ - _____ - _____ Date of Birth: ___/___/___ Age: _____
Status: Single Married Widow Divorced Sex: Male Female Occupation: _____
Employer: _____ Employer Phone:(____) _____
Emergency Contact Person: _____ Phone: (____) _____

Insurance Information

(If insurance information is incorrect or incomplete, the patient will be responsible for bill)

Primary Insurance Name: _____ Phone: (____) _____
Address: _____ City/State _____ Zip _____
Subscriber Name: _____ Employer: _____
SSN: _____ - _____ - _____ Date of Birth: ___/___/___ Relationship to patient _____
ID#: _____ Group #: _____

Secondary Insurance Name: _____ Phone: (____) _____
Address: _____ City/State _____ Zip _____
Subscriber Name: _____ Employer: _____
SSN: _____ - _____ - _____ Date of Birth: ___/___/___ Relationship to patient _____
ID#: _____ Group #: _____

Guarantor Information (patients age 18 and under)

Last Name: _____ First Name: _____ Middle: _____
Address: _____ APT# _____
City _____ State: _____ Zip _____
Home Ph: (____) _____ Relationship to Patient: _____
SSN: _____ - _____ - _____ Date of Birth: ___/___/___
Status: Single Married Widow Divorced Sex: Male Female Occupation: _____
Employer: _____ Employer Phone:(____) _____

Parent / Guardian Signature if Patient is Under 18: _____

Consent/Release/Authorization

The insurance information listed on page one is current and correct. If any information is incorrect, I understand that I will be held responsible for any unpaid balance. I also understand and I agree that I will be responsible for any collection or legal fees associated with the collection of overdue balances that are my responsibility. It is my responsibility to notify Healthy Woman of any changes that occur in my insurance coverage.

I authorize Healthy Woman to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physicians all payment for medical services rendered to myself or my dependants. I understand that I am responsible for any amount not covered by insurance. In order to evaluate my present health status, I hereby consent, voluntarily, to undergo examination and necessary treatment by Healthy Woman. I authorize Healthy Woman to disclose my health information for treatment, payment and health care operations. I have read and understand the above and hereby, voluntarily give my consent and authorization.

Patient Signature _____ Date ___/___/___



How did you hear about our practice? _____

Primary Care Physician's information: Name: _____

Address: _____

Phone: _____ Group Name: _____

Medical Problems: (chronic or serious illness, past or present) _____

Past surgeries or hospitalizations: _____

Medications you are presently taking: _____

List Allergies:

Allergies to Medication: _____

Other allergies (food, seasonal, etc.) _____

Ob/Gyn History:

Date of your last menstrual period: ____ / ____ / ____ Menstrual Problems? _____

Number of Deliveries _____ Miscarriages: _____

Social History:

Do you use tobacco now?: _____ In the past?: _____ How much?: _____

Do you use alcoholic beverages?: _____ Weekly amount?: _____

Family History:

Yes No Diabetes Yes No Tuberculosis

Yes No Kidney Disease Yes No Cancer Type: _____

Yes No Heart Disease Yes No Skin Disorder

Yes No Stroke Yes No Glaucoma

Yes No High Blood Pressure Yes No Thyroid Disorder

Present Complaint: _____



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Susan Pacana, M.D. FACOG
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Medical Services Waiver

I understand that I am presenting myself in the office today for medical services to be performed. While many insurance companies cover the services that may be performed such as an annual exam (including pap smear, breast exam, other age appropriate screenings), biopsies, colposcopies and injections, I have been informed that some insurance companies do not. If my insurance company does not pay Healthy Woman for the services performed today I understand that any charges incurred during my exam will be my financial responsibility.

I understand that I will also be responsible for any copay or coinsurance payment due to Healthy Woman at the time of service, per the requirements of my health insurance plan contract.

I also understand that I will be responsible for payment of charges in full if I do not have any health insurance coverage.

Lastly, I understand that if I require a referral or preauthorization for Healthy Woman's services or any additional services recommended by Healthy Woman (including but not limited to radiology and lab work), I am responsible for either obtaining the correct referral OR notifying the office within 48 hours of the date of service to obtain an authorization. If I fail to do so, I will be responsible for the balances billed by Healthy Woman or outside parties for these services.

X _____

Patient Signature

Patient Printed Name

If patient is under 18:

X _____

Parent / Guardian Signature

Patient Printed Name

____/____/____

Date



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Authorization for Release of Protected Health Information

I authorize the staff and/or physicians at Healthy Woman to discuss my healthcare, diagnosis, test results, procedures, prognosis, insurance and billing information with the following person(s) for the purpose of my treatment or payment of services rendered *:

Name of designated person Relationship to patient

Name of designated person Relationship to patient

I DO **NOT** wish to designate any person(s) *

***Please note for children under 18 years of age, information will be released to the parent or legal guardian.**

I authorize the release of my Protected Health Information to the following physician(s) or facility(s) upon request of the physician(s) or facility(s) for the purpose of my treatment:

Name of designated Physician or Facility Type of Physician or Facility

Name of designated Physician or Facility Type of Physician or Facility

I DO **NOT** wish to designate any physician(s) or facility(s)

I understand that in order to ensure continuation of care, the staff and/or physicians at Healthy Woman may need to leave messages on the answering machine at my home or with any individual(s) who may answer my home phone. These messages may include but are not limited to: appointment confirmations, lab results, radiology results, pathology results, etc.

I DO wish to have messages left I DO **NOT** wish to have messages left

I also understand that by designating the above individual(s) or facility(s), I am allowing my Protected Health Information (medical records/ information) to be discussed or released to them. I know that this is my personal choice and I have not been forced to designate any individual(s) or facility(s) if I have chosen not to.

Patient Printed Name X Patient Signature

____/____/____
Date

Privacy Practices Acknowledgement

I have reviewed / received the Notice of Privacy Practice for Healthy Woman

Patient Printed Name X Patient Signature

____/____/____
Date



Patient Name: _____

Phone: _____

Email: _____

Age: _____

Health Questionnaire

HEALTH & FITNESS

1. Are you happy with your current weight? Yes No
2. Are you interested in finding out about a medically supervised weight loss program?
 Yes No

MENSTRUAL CYCLE

1. How would you describe the volume of your menstrual bleeding?
 Light Normal Heavy
2. Do your heavy periods affect your social life, fitness or sexual intimacy?
3. Do you miss work because of your periods?

BIRTH CONTROL

1. Are you happy with your current form of birth control? Yes No
2. Are you interested in permanent sterilization? Yes No

(NOTE: if you are not done with childbearing, this option is not for you)

GYN HEALTH

1. Have you suffered with ovarian cysts or fibroids? Yes No
2. Do you have irregular bleeding or pelvic pain? Yes No
3. Do you suffer from any of the following?

<input type="checkbox"/> Problems Emptying Your Bladder Completely	<input type="checkbox"/> Problems Starting to Urinate
<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Recurrent Urinary Tract Infections
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Sudden, Strong Urges to Urinate
<input type="checkbox"/> Frequent Urination	