CENTRAL PARK SOUTH OBSTETRICS AND GYNECOLOGY ASSOCIATES

SAMUEL RAFALIN, M.D., F.A.C.O.G. RAHELA SACHEDINA WHNP-BC

NEW PATIENT REGISTRATION FORM:

Have you been here before? ☐ Yes ☐ No

Demographic information

Today's Date (MM/DD/YYYY): ____________________Date of Birth (DOB) (MM/DD/YYYY): ____________________Age: _______

Last Name: ______________________________________ First Name: ______________________________________

Preferred Name: _________________________________ Preferred Pronouns: _________________________________

Personal EMAIL Address: ____

Mobile #: (_________) ________________ Home #: (_________) __________________ Work #: (_________) ________________

Address: ____ Apt: _______ City: ____________ State: _______ Zip: ___________

Pharmacy #: (_________) ________________ **OR** Pharmacy Address: ____

Marital Status: (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact: ____ Relationship: ________________________________

Emergency Cell / Home #: (_________) ____________________ Emergency Contact Work # (_________) ____________________

Employer: ______________ Address: ________________________________ City: ____________ State: _______ Zip: ___________

Insurance Information

Primary insurance: _______________________________________ Phone: (___________) ______________________

ID Number: ____ Group Number: ___________________________________

Address: ____ City: ______________________ State: _______ Zip: ___________

Guarantor / Policy Holder ☐ Self ☐ if other name: ___________________ SSN of Policy Holder: ______________________

Relationship to you: _________________________ (DOB) of Policy Holder (MM/DD/YYYY): ________________________

Secondary insurance? ☐Yes ☐ No Name: ______________________ ID Number: ________________________

Referral Information

Physician Name: _______________ Phone: (___________) ____________________ Fax: (___________) _____________________

Address: ____ City: ______________________ State: _______ Zip: ___________

If not referred by physician, how did you find us? ☐ ZOCDOC ☐ Website ☐ Friend/Relative ☐ Other

Guarantee of Payment /Assignment of Benefits

I hereby authorize assignment of my medical insurance payment(s)directly to *Samuel Rafalin, M.D., F.A.C.O.G./ Rahela Sachedina WHNP-BC* for gynecological care. I understand that if for any reason, medical claims are rejected by my insurer or the insurance does not adequately cover the practice's standard fee, I shall pay the standard fees charged *Samuel Rafalin, M.D., F.A.C.O.G./ Rahela Sachedina WHNP-BC.* I understand if for any reason my claims should go into collection status, I will be liable for any collections and/or legal fees incurred. In addition, I understand that CPS OB/GYN Associates uses third party laboratories for all diagnostic lab work, and I will be held responsible for any fees incurred by third party laboratories.

______________________________________ ______________________________________

Patient (Your) Signature **Today's Date**

PATIENT SELF GYNECOLOGICAL HISTORY

Last Name:	First Name:
Today's Date:	Birth Date: / / Age:
Preferred phone number for our office to call you for lab results / follow ups: ( )	
Marital Status: ☐ Single ☐ Living with Partner ☐ Married ☐ Divorced ☐ Widowed	
Sexual orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual	
Number of Living Children:	Number of people in Household:
School Completed: ☐ High School ☐ Some College ☐ College ☐ Graduate Degree ☐ Other	
Occupation:	Employer:

Ancestry & Clinical History

☐	Caucasian	☐	Mediterranean	☐	Black	☐	French Canadian
☐	Ashkenazi Jewish	☐	Hispanic	☐	Asia	☐	Other

Gynecological History

	Yes	No		Yes	No
First day of your last period:			Have you ever had an ovarian cyst?		
Age periods began			Are you currently sexually active?		
Are your periods regular?			Have you ever had sex?		
Length of periods (Total number of days of bleeding):			Length of time with current partner?		
Number of days in between periods:			Number of sexual partners (lifetime)?		
Any recent changes in your periods?			Present method of birth control:		
Do you have heavy vaginal bleeding or clots?			Have you ever used birth control pills?		
Do you have very painful periods?			Have you ever used an IUD?		
Do you experience premenstrual symptoms?			Are you interested in a new form of birth control?		
Do you experience hot flashes?			Have you ever had a sexually transmitted infection?		
Have you gone through menopause?			Which one?		
Have you ever taken hormone replacement therapy or alternative therapies?			Do you lose urine when coughing or lifting?		
When was your last Pap smear?			Do you experience a strong urgency to urinate?		
Do you have a history of fibroids?			Do you ever incompletely empty your bladder?		
Have you ever had an abnormal Pap smear?			Do you have any unintended urine loss?		
Have you ever had a procedure called a colposcopy, cryosurgery, or cone biopsy?			Do you have pain with urination?		
When was your last mammogram?			Have you ever had blood in your urine?		
What was the result?			Do you urinate frequently?		
Do you do regular breast self-examination?			Do you urinate more than one time over night?		

Obstetric History

Total Pregnancies		Abortions		Miscarriages	
Live Births		Premature births		Living Children	

#	**Birth Date**	**Birth weight**	**Male / Female**	**Weeks Pregnant**	**Type of Delivery (Vaginal, cesarian, etc.)**
1					
2					
3					
4					

Personal Past History of Illness

Major Illness	Yes	No	Major Illness	Yes	No
High blood pressure	☐	☐	Depression / anxiety	☐	☐
Diabetes	☐	☐	Collagen vascular disease (lupus)	☐	☐
Heat Attack / Heart Problems	☐	☐	Rheumatic fever	☐	☐
Asthma	☐	☐	Reflux / hiatal hernia / ulcer	☐	☐
Pneumonia / Lung Disease	☐	☐	Bowel problems	☐	☐
Blood Clots in lungs or legs	☐	☐	Gallbladder disease	☐	☐
Stroke	☐	☐	Hepatitis / Jaundice / Liver Disease	☐	☐
Kidney infections / stones	☐	☐	Glaucoma / Cataracts	☐	☐
Thyroid Disease	☐	☐	Tuberculosis	☐	☐
Anemia	☐	☐	HIV / AIDS	☐	☐
Blood Transfusions	☐	☐	Cancer	☐	☐
Arthritis / joint pain / back problems	☐	☐	Chicken Pox	☐	☐
Seizures / convulsions / epilepsy	☐	☐	Other		

Operations and Hospitalizations

Reason	Date	Hospital

Current Medications

(including hormones, vitamins herbs, non-prescription medications)

Drug Name	Dosage	Prescriber

Drug Allergies

Drug Name	Reaction

Social History

Do you or have you ever smoked cigarettes			☐ Yes	☐ No
Packs per day	Years:	Quit:	☐ Yes	☐ No
Alcohol Drinks Per Day:	Per Week:		☐ Yes	☐ No
Recreational Drug Use			☐ Yes	☐ No
Regular exercise:	How long / often?		☐ Yes	☐ No
Have you ever been sexually abused, threatened, or hurt by anyone?			☐ Yes	☐ No

Family History

Mother: ☐ Living ☐ Deceased/ Cause: | Father: ☐ Living ☐ Deceased/ Cause:

Your Sibling Living: ________ Number Deceased ________ | Your Children Living: ________ Number Deceased ________

Illness	Yes	No	Which Relative(s)	Illness	Yes	No	Which Relative (s)
Diabetes				High Cholesterol			
Stroke				Osteoporosis			
Heart Disease				Uterine Cancer			
Blood Clots				Breast Cancer			
High Blood Pressure				Colon Cancer			
Asthma				Ovarian Cancer			
Mental illness				Other Cancer			

________________________ ________________________ ____________________ ______________

Patient (Your) Name **Patient (Your) Signature** **Provider Signature** **Today's Date**

CENTRAL PARK SOUTH OBSTETRICS AND GYNECOLOGY ASSOCIATES

SAMUEL RAFALIN, M.D., F.A.C.O.G.   ANGELA FERIN, C.N.M

210 Central Park South, New York, NY 10019

Tel: 212-319-5535   Fax: 212-319-8095

Office Policy on NO-SHOW and Payment Collections

Dear Patient,

Please be advised that we require no less than 24 HOURS notice whenever an appointment is cancelled. Patients are billed **$100.00** for **NO-SHOW appointments**. Insurance companies are not responsible for payment of these bills. In the event that you realize you won't be able to make an appointment during the weekend you should leave a message canceling your appointment. Again **24 HOURS notice is required for cancellations**. If you cancel an appointment with receptionists in our office, you should note their name.

Also, all payments and co-payments are **DUE AT TIME OF SERVICE** to avoid a **$5.00 surcharge fee.**
We thank you in advance for your cooperation.

Preventative Visits

If you are here today for your annual preventive visit, please note that this visit is Prevention focused, not problem focused. If you have new health problems or other diagnoses that need to be addressed during your preventive visit, an additional office visit may be billed. Your insurance carrier may apply the portion of your visit related to the treatment of your diagnosis, to your copay, deductible, or coinsurance. Because we value the time of all of our patients, if you wish to schedule a different appointment for either of the above, the front desk will be happy to assist you.

Diagnostic Benefits

Please be aware that Sonograms are processed under a Diagnostic Benefit by your insurance company and therefore, may be subject to a deductible and/or coinsurance. Please call your carrier if you have questions about your diagnostic benefit.

I have read and understand the above:

____   ____________________________________

Patient (Your) Signature   **Today's Date**

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Notice of Privacy Acknowledgement

Z&E Medical Management LLP

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessment and physician certifications.

I have received, read, and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions but if you agree you are bound to abide by such restrictions.

Patient Name: ____

Relationship to Patient: ____

Signature: ____

Date: ___________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: __________________________________ Initials: _________________________

Reason: ____

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Informed Consent to use Patient Portal

Central Park South Ob/Gyn Associates is offering this secure, HIPAA compliant communication tool as a courtesy to our patients. It is an optional service, and we reserve the right to suspend or terminate it at any time. We will alert you to any changes as promptly as possible. This form is intended to inform you of the facts and risks surrounding the use of the web portal. By signing below, you confirm that you have read, understand, and agree to comply with our procedures and guidelines for using the Patient Portal. You also agree not to hold Central Park South Ob/Gyn Associates or any of their staff liable for network infractions beyond their control.

Privacy and Security

The web portal or webpage has a secure tunnel connection with our clinic that uses encryption to keep unauthorized persons from being able to access and read your health information or your communications to us. To help ensure that the tunnel remains secure, we need to have your current (private) email address and be informed if it ever changes. Keep your portal user ID and password secure so that only you, or someone authorized by you, can gain access to patient information. If you think someone has learned your password, immediately go to the portal site and change it.

Your email address is confidential and protected information. With our best effort we will protect this information as we do your medical and personal information. We will never purposefully share this information with any third party.

All access to our internal network and electronic medical records (EMR) is password protected. Our staff is instructed to logoff their workstations when not physically present. Additionally, in compliance with HIPAA guidelines, our EMR automatically logs the user out after a period of inactivity.
Similar to phone communications, messages may be read and addressed by different Central Park South Ob/Gyn Associates staff.

Confidential email, please print clearly: ____

Patient Name: ____

Date of Birth: ___________________________________

Patient's Signature: ______________________________

Date: _______________________

30 – SECOND QUESTIONNAIRE: COSMETIC MEDICAL TREATMENTS

Please take a few moments to answer the questions below. We are pleased to offer our valued patients the country's most popular non-surgical aesthetic procedures here in our office under a new name Central Park Aesthetique. Let us know if you would like to speak with our clinical consultant for more information on any of these procedures while visiting us today. ***Please return to the front desk after completing. -Dr. Rafalin***

We have TruSculpt 3D! The latest body sculpting and tightening device to reduce pocket areas of fat and tighten the skin in 20-40 minutes non-surgically! Would you be interested? Yes ___ No ___

Do you have problem areas of fat in any of these areas?
Love handles ___ Belly ___ Bra fat ___ Inner or outer thighs ___ Neck ___

Would you be interested in wrinkle removing therapy with Botox or Xeomin? Yes ___ No ___
If yes, which facial areas would you be interested in having treatment?
Forehead ___ Crow's Feet ___ Frown Lines (between the eyebrows) ___ Other _____________

Would you be interested in dermal filler treatments? Yes ___ No ___
If yes, which facial areas would you be interested in having treated?
Smile Lines ___ Vertical Lip Lines ___ Lip Borders ___ Marionette Lines (lines at the corner of mouth) ___ Other _______

Would you be interested in Laser Hair Removal? (*permanent hair reduction treatments are faster, more comfortable, and more affordable than electrolysis and waxing*) Yes ___ No ___
If yes, which areas would you be interested in having treated?
Face ___ Underarms ___ Bikini Line ___ Legs ___ Arms ___ Back ___ Chest ___ Other ___

Would you be interested in receiving a facial rejuvenation treatment or IPL?
(*a series of safe, effective, non-invasive treatments designed to erase or reduce skin imperfections on either the face, neck, chest or other body areas. Safe for all skin types)* Yes ___ No ___
If yes, which conditions are you interested in having treated?
Age Spots ___ Rosacea ___ Sun Damage ___ Spider Veins ___ Broken Capillaries ___ Fine Lines & Wrinkles ___
Enlarged Pores ___ Active Acne ___ Acne Scarring ___

Would you be interested in discussing Vaginal Rejuvenation with the doctor? Yes ___ No ___
(*a safe, highly effective, and easy in-office procedure with mild to no discomfort that addresses vaginal discomfit, dryness and itching, vaginal tone, and flexibility by stimulating collagen and vaginal tissue)*
If yes, do you experience any of the following?
Pain with sex ___ Urinary incontinence ___ Vaginal Dryness ___

☐ **Yes! Please contact me with new information on cosmetic procedures, products, and specials.**

Name ____

Date: ____________________ Phone: ____________________

Email: ____

PATIENT IN – OFFICE SURVEY

Juliet Laser for Vaginal Health

We are evaluating a new treatment for our practice and could appreciate it if you could take a few minutes to answer the following questions so that we can gauge patient interest. Thank you for your time!

POSTPARTUM WOMEN

1. Have you delivered more than one child vaginally? ☐Yes ☐No
2. Do you feel your vagina is looser than it used to be? ☐Yes ☐No
3. Does this looseness impact your sexual satisfaction or sexual confidence? ☐Yes ☐No
4. Do you experience any urine leakage during physical activity or exertion such as when you cough, sneeze, laugh, exercise, etc.? ☐Yes ☐No
5. Would you be interested in a simple painless, in-office non-surgical treatment to tighten your vaginal canal?
   ☐ Yes ☐ No ☐ Maybe

PERIMENOPAUSAL WOMEN

1. Have you started, are you going through menopause, or are you post menopause? ☐ Yes ☐ No ☐ Sometimes
2. As a result of menopause, do you suffer from:
   - Vaginal Dryness ☐ Yes ☐ No ☐ Sometimes
   - Burning or itching ☐ Yes ☐ No ☐ Sometimes
   - Painful Intercourse ☐ Yes ☐ No ☐ Sometimes
3. Do these conditions affect your quality of life? ☐ Yes ☐ No ☐ Sometimes
4. Would you be interested in a simple, painless, in-office, non-surgical laser procedures that can restore vaginal health and treat these conditions? ☐Yes ☐No

WOMEN OF ALL AGES

1. Are you concerned about the appearance of your external genitals?
   ☐ Yes ☐ No ☐ Sometimes
2. Does this concern affect your quality of life or confidence?
   ☐ Yes ☐ No ☐ Sometimes
3. Would you be interested in a simple, painless, in-office, non-surgical treatment to improve the appearance (i.e., color, texture, size, skin laxity) of your vagina or labia area?
   ☐ Yes ☐ No ☐ Maybe

PERSONAL INFORMATION

NAME: ____ AGE: __________