Lifeline Medical Associates
Transforming Women's Healthcare
www.LMA-LLC.com

Patient Name: ____________
MRN# ____________
Date: ____________

Patient Registration Form

Stefanie Marshall, D.O. *Gregory W. Demeo, D.O.* *Alexander Kirifides, D.O.* *Sarah Eaton, C.N.M.*
(Circle Provider)

Last Name: ____________ First Name: ____________ Middle Name: ____________

Date of Birth: ____________ SSN: ____________ Maiden Name: ____________

Street Address: ____________ City: ____________ State: ____________ Zip Code: ____________
(Include Apartment #, if applicable)

Home PH: ____________ Work PH: ____________ Cell PH: ____________ Primary: Home/Work/Cell (circle one)

Email Address: ____________ Preferred Method of Communication: Mail / Home PH / Cell Ph / Work PH (circle one)

Race: (circle one)
American Indian/Alaska Native
Asian
Black/African American
Native Hawaiian/Pacific Islander
White
Other Race
Decline to Answer

Ethnicity: (circle one)
Hispanic or Latino
Not Hispanic or Latino
Decline to Answer

Marital Status: (circle one)
Divorced
Domestic Partner
Married
Separated
Single
Widowed

Primary Language:
English
Spanish
Other: ____________

Preferred Local Pharmacy: ____________
(Include pharmacy location)

Preferred Mail Order Pharmacy: ____________
(Include address/city/state if available)

Employer Name: ____________ Occupation: ____________

Family Physician: ____________ Family Physician Phone: ____________

EMERGENCY CONTACT:

Contact Name:	Address:	Phone:	Relationship to Patient:

If the patient is NOT the primary/secondary insurance holder, please provide the following information:

Primary/Secondary Insured's Name:	Relationship to Patient: (circle one)
Date of Birth: (MM/DD/YYYY)	SS#
Home Address:	City / State / Zip
Employer:	Employer's Address:

INSURANCE:

PRIMARY Insurance Company Name:	Coverage Under: (circle one) Patient / Self – Spouse – Parent / Step-Parent – Legal Guardian
SECONDARY Insurance Company Name: (if applicable)	Coverage Under: (circle one) Patient / Self – Spouse – Parent / Step-Parent – Legal Guardian

Medical History Form

Today's Date: ______________ Name: __________________________________ Date of Birth: ___________________

Do You Think of Yourself as (circle): Heterosexual Homosexual Bisexual Something Else Unsure

Last Menstrual Period: ____________________ Any Irregular Bleeding: Yes No

Has Your Uterus Been Remove: Yes No If Yes, For What Reason: _______________________________

Do You Still Have Ovaries: Yes No Are You On Hormone Replacement Therapy: Yes No

Allergies to Medications, Environment, or Dyes (Please Include the Reaction to All Allergies):

____

Medications:

__________________________ ____________________________ ____________________________

What Are You Using For Birth Control: ____

Did You Receive Gardasil (HPV vaccination): Yes No

__Medical History:__ *(Please Circle Any That Apply to YOUR Health):*

Alcoholism	Arthritis	Asthma	Blood Clot/DVT/PE	Cancer
Chlamydia	Depression	DES Exposure	Diabetes	Drug Addiction
Eating Disorder	Genital Warts	Gonorrhea	Headaches/Migraines	Heart Disease
Hepatitis	Herpes	High Blood Pressure		High Cholesterol
HIV	Kidney Disease	Lupus	Mental Health Conditions	
Osteoporosis	Seizures	Syphilis	Stroke	Thyroid Disease

If You Circled **YES** To Any Of The Above, Please Explain:

____

____

__Surgical History:__ *(Please Indicate Type and Date):*

__________________________ ____________________________ ____________________________

__Family History:__ *(Please Note The Family Member & Maternal (M) OR Paternal (P) When Appropriate):*

Breast Cancer: ________________________________ Colon Cancer: ________________________________

Diabetes: ________________________________ Genetic Disorders: ________________________________

Heart Disease: ________________________________ High Blood Pressure: ________________________________

Kidney Disease: ________________________________ Lung Cancer: ________________________________

Osteoporosis: ________________________________ Other Cancer: ________________________________

Ovarian Cancer: ________________________________ Ovarian Cancer: ________________________________

Stroke/DVT/Clotting/Bleeding Disorder: ____

Thyroid Disease: ________________________________ Uterine Cancer: ________________________________

Other: ____

__Note The Date For The Following Tests, If Applicable:__

Mammogram: ______________________________

Colonoscopy: ______________________________

Bone Density Scan: ______________________________

__Pregnancy History:__ ☐ Check If No Changes

Total Number of Pregnancies: __________

How Many Living Children: __________

Miscarriages: __________

Abortions: __________

Preterm Delivery: Yes No

Any Cesarean Sections: Yes No

Any Complications with Pregnancies: Yes No

__Social History:__

Do You Smoke: Yes No If Yes, Amount: ______________________________

Do You Drink Alcohol: Yes No If Yes, Amount: ______________________________

Any Drug Use: Yes No If Yes, Type & Amount: ______________________________

Do You Have Any History of Abuse: Yes No If Yes, Type, Age, & By Whom: ______________________________

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FIRST STATE WOMEN'S CARE

A DIVISION OF Lifeline Medical Associates, LLC

GREGORY W. DEMEO, D.O.   STEFANIE MARSHALL, D.O.   ALEXANDER KIRIFIDES, D.O.   SARAH EATON, C.N.M.

Phone: 302-454-9800   Fax: 302-454-6446

Patient Name: ______________________________ Today's Date: __________________

Date of Birth: ______________________________

Many of our patients allow family members such as their spouse, parents or others to call and request information including appointment days and times, results of tests and results of procedures. Under the requirements for HIPAA, we are not allowed to give this information to anyone without the patient's written consent. If you wish to have your protected health information released to family members you must review, fill-in, and sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent will remain in force until revoked or requested in writing by you our patient.

I authorize First State Women's Care to release information about my care including appointment days/times, results of tests and procedures and billing information to the following individuals:

1. ____________________________________ Relation to Patient: __________________

2. ____________________________________ Relation to Patient: __________________

3. ____________________________________ Relation to Patient: __________________

DECLINE ANY RELEASE TO INDIVIDUALS: _________ ***(please check)***

****Emergency Contact:*** ________________________ ***Phone:*** ______________________

Signature of Patient/Guardian:

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First State Women's Care-Financial Policy

Thank you for choosing First State Women's Care, where we are dedicated to providing our patients with the best possible care and services. We would like you to take the time to review some of our office policies.

- We accept cash, Visa, or MasterCard. Returned checks are subject to a $30 service charge.
- All payments are due at time of service unless previous arrangements have been made.
- Past due accounts will be sent to a collection agency. You will be responsible for all costs of collection which may include: collection fees, attorney fees, and any miscellaneous fees charged by the collection agency including, but not limited to, a fee for a partial payment made on a past due account.
- *Medicare only covers routine PAP smears every two years.* You will be asked to sign an Advanced Beneficiary Notice or ABN, separate from this form. You will be responsible for any deductible or co-insurance not covered by Medicare.
- We require 24-hour notice of cancellation for your appointment. If proper notice is not given, you may be subject to a $25.00 missed appointment fee.
- We require 7 days' notice if you need to reschedule or cancel your outpatient or inpatient surgical procedure. If notice is not given, you will be subject to a $50.00 fee.
- We will be happy to complete and FMLA/Disability forms. There is a $20.00 administrative fee. Please allow 7-10 days for completion of forms.
- Copies of medical records will be subject to a fee schedule as defined by Delaware law. Please allow 7-10 days for completion of your request.
- It is your responsibility to check with your insurance company which lab/radiology facility you may utilize. Every insurance company has "preferred" providers.
- It is your responsibility to check with your insurance company to determine if you will need a referral or authorization for any service. If you need our office to process an authorization/referral, please allow 48 hours to complete the request.
- It is your responsibility to be able to provide a current copy of your identification and insurance card at *EVERY* visit.

I have read and fully understand the office and financial policies set forth. I agree to the terms of the above policies. I also understand and agree that the terms of the financial policy may be terminated by the practice at any time without prior notification to the patient.

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Patient Signature Date