The Healthcare Group for Women

Margaret A. Rempe, MD Laurie Klabi, MD Ann Marie Rockamann, MD

3023 North Ballas Rd
Suite 600, Bldg D
St. Louis, MO 63131

Tel: 314-567-7018
Fax: 314-567-7048
Exchange: 314-222-7311

Welcome Patient!

Thank you for choosing The Healthcare Group for Women. Please complete the enclosed forms and bring them with you to your appointment, along with your current insurance cards, photo ID and any applicable co-payment. Without insurance cards, co-pays and referral letters, if applicable, insurance mandates that we reschedule your appointment. Please provide your pharmacy phone number for new prescriptions and refills.

You have an appointment on ________________ at ____________am/pm in our office on the Missouri Baptist campus. If for any reason you will be unable to keep your scheduled appointment, please notify our office at your earliest convenience. Please arrive 30 minutes prior to your appointment time. Please contact our office 24 hours prior to your appointment for cancellations to avoid a cancellation fee of $25.00.

We look forward to being your healthcare provider.

Sincerely,

The Healthcare Group for Women
Laurie Klabi, M.D.
Margaret Rempe, M.C.
Ann Marie Rockamann, M.D.
Erica Banes, WHNP-BC
Kimberly Coleman, WHNP-BC

Directions to Missouri Baptist Medical Center Office:
From HWY 40/64- go south on Ballas Rd to the Missouri Baptist Campus. Follow signs to Building D (North Entry) parking.

REGISTRATION/UPDATE INFORMATION FORM

____ Laurie Klabi, M.D. | ____ Margaret Rempe, M.D. | ____ Ann Marie Rockamann, M.D.

PLEASE PRINT

PATIENT: ____
Last Name First Name Middle Initial

Street Address: ____

City: ______________________ State: ____________ Zip Code: ____________

Home Phone #: (________)______________ Cell Phone #: (________)______________ Single ☐ | Married ☐

Email Address: ____

Age: __________ Date of Birth: ______________ Soc. Sec. # ______________

Patient Employed By: ______________________ Business Address: ______________________

Business Phone #: (________)______________

Primary Care Physician (PCP): ______________________ PCP Address: ______________________

PCP Phone #: (________)______________ PCP Fax #: (________)______________

Spouse/Parent/Guardian (Circle One): ______________________ Date of Birth: ____________

Soc. Sec. # ____________ Phone Number: (_____)__________ | Employer: ______________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: ____

Insurance ID #: ______________________ Group ID #: ______________________

Guarantor (Covered Employee): ______________________ Date of Birth: ____________

Soc. Sec. #: ______________ Place of Employment: ______________________

SECONDARY INSURANCE COMPANY: ____

Insurance ID #: ______________________ Group ID #: ______________________

Guarantor (Covered Employee): ______________________ Date of Birth: ____________

Soc. Sec. #: ______________ Place of Employment: ______________________

_____ NO Insurance (Charges due at date of service by patient or responsible party)

PLEASE NOTE: THIS SECTION MUST BE COMPLETED

In case of emergency, who should we notify? ______________________ Phone #: (________)______________

What number may we use to contact you with confidential information? ______________________

If the patient is under 18 years of age, with whom may we speak? ______________________

PLEASE READ AND SIGN BELOW

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including private insurance, Medicare, and other health plans to: Signature Health Services, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges incurred. I hereby authorize said assignee to release all information necessary to secure payment.

A finance charge will be made on all charges that are at least 120 days old. Our monthly finance charge is 1.5% ($0.50 minimum). Our annual percentage rate is 18%. The amounts subject to finance charge are al balances at least 60 days old after applicable payments have been deducted.

In the event of non-payment, you will be responsible for any legal and collection fees. The collection fee is 21% of the total balance turned over to an outside agency.

SIGNATURE: ______________________________ DATE: ______________

Patient History
The Heathcare Group for Women

Name ______________________ D.O.B __________ Age: ______ Date ____________

Questions	Yes	No	N/A	Comments
What was the first day of you last menstrual period?				
When was your last Pap test? Was it normal?				
Have you ever had an abnormal Pap test?				
When was your last Mammogram? Was it normal?				
When was your last Bone Density? Was it normal?				
When was your last Colonoscopy? Was it normal?				
Are you sexually active?				
Do you and your partner use contraception/birth control? If yes, which types?				
Do you have any questions regarding your sex life?				
Do you smoke? If yes, how many per day?				
Do you drink alcohol? If yes, how much per week?				
Do you exercise? How many times per week?				
Any unusual weight gain or loss?				
Do you currently take any medications or vitamins? Please list:				
Do you have any allergies to medications?				
Operations, injuries, or illnesses requiring hospitalization?				

Have you ever been pregnant? Please list below:

Year	Type of Delivery (c/s, vaginal, miscarriage, abortion)	Sex	Birth weight	Anesthesia	Complications

Patient Name (please print):______________________________

DOB:_______________ Date:_______________

Pharmacy information:

Pharmacy Name:______________________________

Pharmacy Address:______________________________

Pharmacy Phone:______________________________

The following information is requested to satisfy the government's requirements for "meaningful use" of an electronic record. Thank you for your help.

______I decline to give this information

Language (please check one)

______Arabic
______Bosnian
______Central Khmer
______Chinese
______English
______French
______German
______Haitian; Haitian Creole
______Hebrew
______Hindi
______Vietnamese
______Italian
______Korean
______Polish
______Portuguese
______Russian
______Somali
______Spanish;Castilian
______Swahili
______Thai
______Urdu

RACE (please check one)

______ Alaskan Native
______Asian
______Black or African American
______Greek
______Hispanic or Latino (All Races)
______Indian
______Multiracial (more than one race)
______Native American Indian
______Native Hawaiian
______Pacific Islander
______Unknown/Not reported
______White (not Hispanic/Latino)

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I,____,
give permission for you to discuss my medical condition with my family members specified below.

Spouse/Partner:____

Parent(s):____

____

Children:____

____

____

Other Parties (please specify):_________________________________

____

Please initial next to the following permissions you wish to grant our office.

_____ I do not want my medical condition discussed with anyone other than myself.

_____I give permission for you to leave a message on my answering machine at home.
Phone number ______________________

_____I give permission for you to leave a message on the voicemail of my mobile phone.
Phone number ______________________

Signature:____

Print Name: ____

Date:______________________
Month/Day/Year

SIGNATURE MEDICAL GROUP, INC

Acknowledgment of Receipt of Notice of Privacy Practices

I, ______________________________________, have received a copy of Signature Medical Group, Inc.'s updated Notice of Privacy Practices.

____
Signature of patient or parent/legal guardian/legally responsible person

____
Description of relationship to the patient

____
Date

For Office Use Only

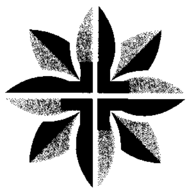
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual/Representative refused to sign the form
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please Specify)

____

____

____



Missouri Baptist
MEDICAL CENTER
BJC HealthCare

Missouri Baptist Medical Center

3009, 3015, 3023 N. Ballas Road • St. Louis, Missouri 63131
314-996-5000 • **missouribaptist.org**

MAP KEY

- Building C, C Garage
- Doctors Buildings A, B
- Main Garage
- North Entry/Bldg. D, North Garage
- Elevator
- Escalator
- Pedestrian Walkway
- Valet

64 40
26
Exit 26 from ramp loops back to enter Ballas Rd.
N
270
Exit 12 from 270 to 64/40 East
12
JESS G. HARMON DR.
North Entry
North Garage Entry
C E COPELAND DR
BLDG. C
C Entry
C Garage
West Entry
Main Tower
Cancer and Infusion Center and ER ONLY
East Entry
EMERGENCY
Cancer Infusion Center
Night Entry
9 p.m. - 5 a.m.
N BALLAS ROAD
West Pavilion
East Pavilion
Main Garage
Clinical Learning Institute
Goldfarb School of Nursing (Level 4)
BLDG. B
BLDG. A
A/B Entry
Hospital Main Entry
Admitting / Lab Registration
METROBUS

Please use our **Free Valet Parking** (*tips not accepted*). Valet kiosks are located at the **Main Entry**, **North Entry** (BLDG. D) and entry to **Doctors Buildings A and B**. Self-parking is available in the Main Garage, C Garage, D Garage located under the North Entry (BLDG. D), and on surface parking lots.
PLEASE NOTE: use the East Entry (Emergency Entrance) for access from 9 p.m. to 5 a.m.

From Interstate 270

- Take I-270 to exit 12 onto I-64/US Highway 40 east.
- Quickly and safely move to the far right lane (exit 26, Ballas Road).
- Turn left (south) on Ballas Road, then turn right into the campus.

From Interstate 64/US Highway 40

- Take I-64/US Highway 40 to exit 26, Ballas Road.
- Turn south on Ballas Road, then turn right into the campus.

MBMC15-1122 5/27/15