New

- ☐ JOHN M. MORGAN
- ☐ JACK B. FREEMAN
- ☐ HEIDI K. STRAUGHN
- ☐ JAMIE M. ROUTMAN

BROOKWOOD WOMEN'S HEALTH, P.C.
PATIENT REGISTRATION

CHART # _____

PLEASE PRINT
PATIENT INFORMATION:

Name _____ SS# _____

Street Address _____

City _____ State _____ ZIP _____ Email Add _____

Home # (_____) _____ Cell # (_____) _____ Marital Status M S D W

Date of Birth _____ / _____ / _____ Age _____ Race _____ Primary Language Spoken _____

Religion _____ Referred by _____

Patient's Employer _____ Position _____

Employer Address _____ Phone # _____

PHARMACY NAME: _____ **ADDRESS:** _____

SPOUSE/GUARANTOR INFORMATION:

Name _____ Relationship _____

Employer _____ SS# _____

Employer Address _____ Work # _____

EMERGENCY CONTACT PERSON

Name _____

Relationship to Patient _____ Phone # _____

INSURANCE INFORMATION

Name of **Primary** Insurance _____

Policyholder's name _____ Date of Birth _____

Policyholder's employer _____

Name of **Secondary** Insurance (if applicable) _____

Policyholder's name _____ Date of Birth _____

Poiicyholder's employer _____

Authorization to release information: I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment to my insurance company.

I hereby assign to and authorize directly to the above physician, all benefits payable under the terms of any insurance policy listed above. I realize the insurance benefit may not pay the entire bill. I agree to pay the difference of the entire bill if necessary. I also agree to pay costs of collection, including attorney's fee and waive my exemption under the constitution and laws of the State of Alabama.

_____

SIGNATURE DATE

Brookwood
Women's Health, P.C.

WT: _____

BP: _____

OFFICE USE ONLY

TODAY'S DATE _____

PLEASE CIRCLE THE DOCTOR YOU ARE HERE TO SEE: **FREEMAN** **MORGAN** **ROUTMAN** **STRAUGHN**

LAST NAME _____ **FIRST NAME** _____

DOB _____ **Pharmacy Name & Address:** _____

CIRCLE THE PURPOSE OF YOUR VISIT: Annual Exam Annual Exam & Other Reason Office Visit Post-Partum/Post OP

What problems or issues would you like to discuss today? _____

_____

When was the first day of your last menstrual cycle? _____

Do you Smoke? Yes/How many_____ No Do you drink Alcohol? Yes/How much _____ NO

Do you Exercise? Yes/Frequency _____ No Sexually Active? Yes No

PLEASE LIST ALL OF YOUR MEDICATIONS YOU ARE CURRENTLY TAKING—PRESCRIPTION & OVER THE COUNTER:

_____

_____

_____

What Contraceptive or Hormone Replacement Therapy are you using?

_____

ARE YOU ALLERGIC TO ANY DRUGS? YES/IF SO WHAT? _____ No

Do you have a Primary Care Doctor? Yes/Name _____ No

Last Mammogram? _____ Last Colonoscopy? _____ Last Bone Scan? _____

MEDICAL HISTORY: Please list any NEW medical problems since your last Annual:

_____

SURGICAL HISTORY: Please list any NEW surgeries/hospitalizations and dates performed since last Annual:

_____

FAMILY HISTORY: Please list any NEW OR ANY CHANGES to your family history since last Annual:

_____

_____

OVER

REVIEW OF SYSTEMS

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU:

CONSITITUTIONAL
Weight Loss ☐
Weight Gain ☐
Fever ☐
Fatigue ☐

EYES
Vision changes ☐
Wear glasses or contacts ☐

ENT
Headaches ☐
Sinus Problems ☐

CARDIOVASCULAR
Chest pain ☐
Difficult breathing on exertion ☐
Swelling of legs ☐
Palpitations ☐

RESPIRATORY
Wheezing ☐
Spitting up blood ☐
Shortness of breath ☐
Cough ☐

GASTROINTESTINAL
Diarrhea, frequent ☐
Bloody Stool ☐
Nausea or vomiting ☐
Constipation ☐

GENITOURINARY
Blood in urine ☐
Pain with urination ☐
Involuntary loss of urine ☐
Frequency of urination ☐
Incomplete emptying ☐

MUSCULOSKELETAL
Muscle weakness ☐

BREAST
Pain in breast ☐
Nipple discharge ☐
Breast Lumps ☐

SKIN INTEGUMENTARY
Rash or ulcers ☐

NEUROLOGICAL
Dizziness ☐
Seizures ☐
Numbness ☐
Trouble walking ☐

PSYCHIATRIC
Depressed mood, sadness ☐
Inability to concentrate ☐
Problems sleeping ☐
Anxiety ☐
Change in appetite ☐
Feeling helpless, worthless ☐

ENDOCRINE
Dry skin ☐
Abnormal thirst ☐
Hot flashes ☐

HEMATOLOGIC/LYMPHATIC
Bruises, frequent ☐
Cuts do not stop bleeding ☐
Enlarged lymph nodes ☐

INSURANCE

Do you have any Insurance changes? NO _____ YES _____ PLEASE LIST NEW INFORMATION BELOW:

Insurance Company: _____ Contract#: _____ Group#: _____

Policyholder's Name: _____ DOB: _____ Relationship to Patient: _____

SIGNATURE: _____ DATE: _____

BROOKWOOD WOMEN'S HEALTH, P.C.

Non-Covered Services Waiver

As your physicians, we want to provide you with the best care possible. There are services that we feel are necessary for the maintenance of good health and/or treatment of your condition that may not be covered by your health insurance. If they are non-covered, you will be expected to pay for those services. We will order only the tests and/or treatments that we feel are necessary for your treatment and care. If you have questions about whether or not a particular service is covered, our staff will be glad to assist you: however, we do not guarantee payment of your claim. Final determination of payment will be made by your insurance company when they receive our claim.

Bioidentical Hormone Implant:

Routine services-Pre-existing conditions

Mental/Nervous/Anxiety conditions: Labs:

DX screening (DEXA/(Ultrasound): Injections

Contraceptive devices: Weight Management:

Service(s) that may not be covered _____ **Date** _____ **Patient Signature**

Consent for Use or Disclosure of Protected Health Information (PHI) for Payment, Treatment and Health Care Operations

By signing below, you hereby consent for Brookwood Women's Health, P.C. (the "Practice") to use or disclose information about you (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form. You should read the Notice of Privacy Practices for PHI, available at the front desk, before signing this Consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Practice's Privacy Officer for a copy.

You also have the right to request that the Practice restrict how your PHI is used or disclosed in carrying out treatment, payment or health care operations. Please be aware, however, that the Practice is not required to agree to these requested restrictions. Should the Practice agree to your requested restrictions, though, the restrictions are binding.

Information about you is protected under federal law, and you have the right to revoke this consent at any time. This revocation will not apply to action(s) the Practice has already taken in reliance on your consent (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed may be subject to redisclosure by the recipient and may no longer be protected under federal law.

Brookwood Women's Health, P.C. may communicate confidential information, including payment invoices and appointment reminders, to me at the following address and/or phone numbers. I understand that I need not supply either, provided I do not wish to be contacted by the Practice. In such case, I agree to pay for all charges incurred during my visit at the time of service.

PLEASE CHECK ONE OR BOTH:

[ ] The Practice may send correspondence to me at the address listed in my patient information file.

[ ] The Practice may leave messages at the following number(s):

Home_____ **Cell**_____ **Work**_____

I authorize the following persons to communicate on my behalf with the Practice concerning my medical care:

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Name:_____ Relationship: _____

By signing below, I acknowledge the above and give authorization to receive Text and/or Email messages from Brookwood Women's Health, PC. I was also given/offered a copy of Brookwood Women's Health's Notice of Privacy Practices effective 9/23/2013.

My cell phone carrier (for purpose of receiving text messages) is: _____

_____ _____

Signature of Patient or Legal Guardian **Date**

Brookwood Women's Health: Medical History Form (NG)

Name:_____ **Date** _____/_____/_____

Medical History: (list any medical problems: diabetes, asthma, migraines, hypertension, depression, etc.)

_____

_____

Pregnancy History: (any pregnancies you have had)

Date of Delivery	How many weeks?	Birth Weight	Male or Female?	Cesarean, Vaginal	Reason for Cesarean?	Epidural?	Place of Delivery	Complications/Comments?

Any miscarriages / abortions? ____ If yes, how many? _____ Procedure or medication?_____

GYN:

Age at onset of period _____ How many days apart are your periods?_____

How many days does your period last? _____ Would you consider them heavy? _____

Do you have pain with periods? _____ Do you take medication for this? _____ If so, what medication? _____

Have you had: Endometriosis? _____ An abnormal pap smear? _____ Sexually transmitted infection?_____

Are you sexually active? ____

Surgical History: (list any surgeries/hospitalizations and dates they were performed)

_____

_____

Social History:

What is your marital status? Single Engaged Married Common Law Divorced Separated Widowed Other

Do you smoke? ____ If yes, how many packs per day? ____

Do you drink alcohol? _____ How many drinks per week? _____ Any recreational drugs? _____

How frequently do you exercise? _____ What type(s) of exercise? _____

What is your occupation? _____

Family History:

Relationship	Breast, Ovarian, Uterine or Colon Cancer (Specify)	Blood Clots	Diabetes	Heart Disease (Heart attack)	Hypertension	High Cholesterol	Other
Mother							
Father							
Brother							
Sister							
Maternal GF							
Paternal GF							
Maternal GM							
Paternal GM							

(turn over)