

Return

- 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 _____

Policyholder'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:

REVIEW OF SYSTEMS

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

CONSTITUTIONAL

- 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