- ☐ JOHN MORGAN
- ☐ JACK FREEMAN
- ☐ HEIDI STRAUGHN
- ☐ HEATHER DEISHER
- ☐ MADISON HULKER
- ☐ BRANDY PATTERSON

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

CHART #_____

PLEASE PRINT
PATIENT INFORMATION:

Name _____ SS# _____

Street Address _____

City _____ State _____ ZIP _____ Email Address _____

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

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 _____

SIGNATURE DATE

BROOKWOOD WOMEN'S HEALTH, PC.
Communication Authorization Form

Patient Name: _____

Social Security Number:

_____

Any provider, employee, or representative of Brookwood Women's Health, PC has my permission to verbally discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications, or any other type of protected health information with the following person(s) in order to facilitate and coordinate my care, treatment and payment.

The practice may leave messages and/or text the following number: _____

_____	_____	_____
Name	Relationship	Phone Number(s)
_____	_____	_____
Name	Relationship	Phone Number(s)
_____	_____	_____
Name	Relationship	Phone Number(s)

- ❑ **I do <u>not wish</u> to have test results or other medical information released to anyone other than myself.**

By signing below, I acknowledge the above and give authorization to receive Text and/or Email messages from Brookwood Women's Health, PC.

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Brookwood Women's Health, PC or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals, it may be subject to redisclosure by the individual(s).

Patient Signature: _____ Date: _____

Patient Name: _____CHART#_____

Consent for Treatment – I consent to and authorize necessary medical treatment, exams, labs, injections/drugs, performance of operations, conduction of diagnostic tests, hospital services or other studies that may be used by the attending physician, nurse or staff.

Authorization for Release of Information – I authorize the providers of Brookwood Women's Health, PC to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care or my employer who is providing payment of my medical bills due to injury on the job.

Assignment of Benefits – I hereby authorize payment directly to Brookwood Women's Health, PC of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but do not exceed the charges for these services. I understand that I am financially responsible for any charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverage is subject to coordination of benefits.

Medicare – If my insurance is Medicare; I certify that the information given by me in applying for payment under Title XVIII of the Social Security Administration Act is correct. I certify that I am the patient or am duly authorized by the patient's general agent to execute this document and accept its terms.

Guarantee of Account – For services furnished by Brookwood Women's Health, PC I hereby authorize the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama.

No Show Fee – We understand that situations arise in which you must cancel your appointment. It is therefore requested that you provide a 24 hour notice. Appointments which are not canceled may be subject to a $50.00 fee, per occurrence, that is not covered by insurance.

Financial Agreement – I fully understand that I am ultimately responsible for any and all of the charges associated with my account. I understand that I will be responsible for any and all charges incurred in the collection of any balance due including reasonable interest, reasonable attorney's fees and reasonable collection agency fees not to exceed 33 1/3%. Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any services and any collectors of my accounts, through various means such as 1) any cell, landline or text number I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages and other forms of communication. It is understood that failure to pay for services rendered may result in a dismissal from this practice.

Patient Signature_____ **Date**_____

Responsible Party Signature_____ **Date**_____

Brookwood
Women's Health, P.C.

ACCT# _____
BP: _____
HT: _____
Wt: _____

Please circle the provider you are here to see:
DEISHER FREEMAN HULKER MORGAN PATTERSON STRAUGHN

LAST NAME _____ FIRST NAME_____ DOB _____

Pharmacy Name & Address: _____

Circle the purpose of your visit: ANNUAL PROBLEM POSTPARTUM POSTOP OTHER

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

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

Surgical History: (list any surgery and the date they were performed) _____
_____
_ _____

Last Pap/Annual: _____ Last Mammogram: _____ Last colonoscopy: _____ Last Bone Scan: _____

Who is your primary care provider? _____

Are you allergic to any medications? Yes____ No____ If so, list name and reaction: _____

Please list all of the medications you are currently using, prescription & over the counter:
_____
_
_____

Family History:_____

Relationship	Breast, Ovarian, Uterine, or Colon Cancer	Blood Clots	Diabetes	Heart Disease/ Heart Attack	Hypertension	Other
Mother						
Father						
Brother						
Sister						
Other						

Have you ever received a dose of the Covid-19 vaccine? ☐ Yes ☐ No
Have you ever received a dose of the HPV vaccine? ☐ Yes ☐ No

Social History:

Do you smoke? If yes, how much per day? _____

Do you drink alcohol? If yes, how much? _____

Do you use recreational drugs? _____

Do you exercise? If yes, how frequently? _____

What is your marital status?

Single Engaged Married Common Law Divorced Separated Widow

What is your occupation? _____

GYN History:

Age of onset of first period? _____

Are your periods regular? ☐ Yes ☐ No

Would you consider them heavy? ☐ Yes ☐ No

Do you have pain with your periods? ☐ Yes ☐ No

If yes, how severe is your pain? ☐ Mild ☐ Moderate ☐ Severe

Have you been diagnosed with endometriosis? ☐ Yes ☐ No If yes, when?_____

Have you had an abnormal pap smear? ☐ Yes ☐ No

Have you had a sexually transmitted infection? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No

Sexual preference? _____

What are you using for contraception?

Birth Control Pills The Patch The Ring Depo-Provera Nexplanon IUD Condoms Pullout

Natural Family Planning Tubal Vasectomy Nothing

Pregnancy History: (any pregnancies <u>you</u> have had)

Date of Delivery	How many weeks?	Birth Weight	Male or female?	Vaginal or cesarean delivery?	Reason for cesarean?	Epidural?	Place of Delivery	Complications/Comments? (ex. Preterm labor, diabetes or hypertension)

Any miscarriages/abortions? ☐ Yes ☐ No If yes, how many? _____

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

Patient Signature: _____ Date: _____

Review of Systems

Please indicate if any of the following apply to you:

CONSTITUTIONAL

Fatigue	Yes	No
Headaches	Yes	No
Night sweats	Yes	No
Weight loss	Yes	No
Weight gain	Yes	No

BREAST

Breast mass	Yes	No
Breast skin changes	Yes	No
Nipple discharge	Yes	No
Pain in breast	Yes	No

GASTROINTESTINAL

Bloating	Yes	No
Bloody stool	Yes	No
Constipation	Yes	No
Diarrhea, frequent	Yes	No
Nausea or vomiting	Yes	No

GYNECOLOGIC

Bleeding after intercourse	Yes	No
Hot flashes	Yes	No
Pain with intercourse	Yes	No
Vaginal burning	Yes	No
Vaginal discharge	Yes	No
Vaginal itching	Yes	No
Vaginal odor	Yes	No
Vaginal pain	Yes	No

GENITOURINARY

Blood in urine	Yes	No
Frequency of urination	Yes	No
Incomplete emptying	Yes	No
Involuntary loss of urine	Yes	No
Pain with urination	Yes	No
Urgency of urination	Yes	No

PSYCHIATRIC

Anxiety	Yes	No
Depressed mood, sadness	Yes	No
Feeling helpless, worthless	Yes	No