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	l:					
Name				_SS#		
Street Address						
City	State	ZIP	Email Address	S		
Home # ()		Cell # ()	Marital Status S M D W		
Date of Birth /	/	Age	_ Race Prim	nary Language Spoken		
Religion		Referred by				
Patient's Employer				Position		
Employer Address				_ Phone #		
PHARMACY NAME:			ADDRESS:			
SPOUSE/GUARANTOR I	NFORMATIO	ON:				
Name				Relationship		
Employer				SS#		
Employer Address				Work #		
EMERGENCY CONTACT	PERSON					
Relationship to Patient						
INSURANCE INFORMATI	ON					
Name of Primary Insurance						
Policyholder's name				Date of Birth		
Policyholder's employer						
Policyholder's name				Date of Birth		
Policyholder's employer						

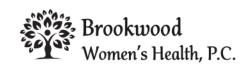
SIGNATURE DATE

BROOKWOOD WOMEN'S HEALTH, PC. Communication Authorization Form

Patient Name:	Social Security N	lumber:
verbally discuss my acc test results, medication	count and medical conditions which	Women's Health, PC has my permission to may include symptoms, treatments, diagnosis, alth information with the following person(s) in ayment.
The practice may leav	ve messages and/or text the follow	ing number:
Name	Relationship	Phone Number(s)
Name	Relationship	Phone Number(s)
Name	Relationship	Phone Number(s)
☐ I do <u>not wish</u> to ha myself.	ive test results or other medical in	formation released to anyone other than
	knowledge the above and give authowood Women's Health, PC.	orization to receive, Call, Text and/or Email
does not affect my acce Brookwood Women's l effect until I change or	ess to treatment. I can refuse to sign Health, PC or completing a new form	to the above individual(s) is voluntary and this form. I can revoke it by writing to m at any time. This authorization will remain in nation is shared with the above individuals, it
Datiant Cianatana		Data

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_____



ACCT#	
BP:	
Ht:	
\/\/t·	

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

LAST NAME	FIRST NAME	DOB	DOB		
Marital Status: S M D W O	:				
Pharmacy Name & Address:					
Circle the purpose of your visit: ANNUAL	PROBLEM POSTPARTUM P	OSTOP OTHER			
What problems or concerns would you li					
Medical History: Please list any NEW med					
Surgical History: Please list any NEW surg	gical procedures/hospitalizations a	nd dates performed s	since your last	 visit:	
Last Pap/Annual:Last Mammog	gram: Last colonoscopy	:Last Bone S	 Scan:		
Who is your primary care provider?					
Are you allergic to any medications? Yes	No If so, list name and react	ion:			
Please list all of the medications and do	osage you are currently taking ind	cluding prescription &	over the co	unter: 	
Family History: Please list any NEW or CHAI	NGES to your family history since yo	our last office visit:			
Have you ever received a dose of the Covid	-19 vaccine? Yes No				
Have you ever received a dose of the HPV v	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?					
Are you sexually active? 🔲 Yes 🗌 No					
Sexual preference?					
What are you using for contraception? Birt Condoms Pullout Natural Family Planning		Ring Depo-Provera	Nexplanon	IUD	
When was the FIRST day of your last menst	rual cycle?				
Patient Signature:					

Review of Systems

Please indicate if any of the following apply to you:

CONSTITUTIONAL			GYNECOLOGIC		
Fatigue	Yes	No	Bleeding after intercourse	Yes	No
Headaches	Yes	No	Hot flashes	Yes	No
Night sweats	Yes	No	Pain with intercourse	Yes	No
Weight loss	Yes	No	Vaginal burning	Yes	No
Weight gain	Yes	No	Vaginal discharge	Yes	No
			Vaginal itching	Yes	No
BREAST			Vaginal odor	Yes	No
Breast mass	Yes	No	Vaginal pain	Yes	No
Breast skin changes	Yes	No			
Nipple discharge	Yes	No	GENITOURINARY		
Pain in breast	Yes	No	Blood in urine	Yes	No
			Frequency of urination	Yes	No
GASTROINTESTINAL			Incomplete emptying	Yes	No
Bloating	Yes	No	Involuntary loss of urine	Yes	No
Bloody stool	Yes	No	Pain with urination	Yes	No
Constipation	Yes	No	Urgency of urination	Yes	No
Diarrhea, frequent	Yes	No			
Nausea or vomiting	Yes	No	PSYCHIATRIC		
			Anxiety	Yes	No
			Depressed mood, sadness	Yes	No
			Feeling helpless, worthless	Yes	No