Brookwood Women's Health, P.C.

New GYN Patient Form

ACCT # _____
BP _____
Height _____
Weight _____

Provider you are here to see:

❍ Deisher ❍ Falkenstrom ❍ Freeman ❍ Hulker ❍ Johnson ❍ Morgan ❍ Patterson ❍ Straughn

Last Name: _____ First Name: _____

Date of Birth _____ Marital Status: ❍ S ❍ M ❍ D ❍ W ❍ Other

Patient's Employer: _____ Position: _____

Pharmacy Name & Address: _____

Who is your Primary Care Provider? _____

What is the purpose of your visit? ❍ Annual Exam ❍ Problem ❍ Postpartum ❍ PostOp ❍ Other

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

_____

Are you allergic to any medications? ❍ Yes ❍ No If yes, list and name reaction: _____

_____

Please list all the medications and dosages you are currently taking, including prescription & over the counter: _____

_____

_____

GYNECOLOGY HISTORY

When was the FIRST day of your last menstrual cycle? _____ Are you sexually active? ❍ Yes ❍ No

Sexual partner preference? _____ Have you had a sexually transmitted infection? ❍ Yes ❍ No

What are you using for contraception? ❍ Birth Control Pills ❍ The Patch ❍ The Ring ❍ Depo-Provera ❍ IUD
❍ Natural Family Planning ❍ Nexplanon ❍ Condoms ❍ Pullout ❍ Tubal ❍ Vasectomy ❍ Nothing

Have you had an abnormal pap smear? ❍ Yes ❍ No 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 ever been diagnosed with endometriosis? ❍ Yes ❍ No

If you are postmenopausal, are you on hormone replacement therapy? ❍ Yes ❍ No

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

Have you ever received a dose of the HPV vaccine? ❍ Yes ❍ No

Patient Signature: _____ Date _____ NGYN

New GYN Patient Form

PREGNANCY HISTORY

Please list any pregnancies you 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

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

FAMILY HISTORY

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

SOCIAL HISTORY

Do you exercise? ❍ Yes ❍ No If yes, how frequently? _____

Do you smoke? ❍ Yes ❍ No If yes, how much per day? _____

Do you drink alcohol? ❍ Yes ❍ No If yes, how much? _____

Do you use recreational drugs? ❍ Yes ❍ No _____

SURGICAL HISTORY

Please list any surgeries and the dates they were performed: _____

_____

MEDICAL HISTORY

Please list any medical problems such as diabetes, asthma, migraines, hypertension, depression, etc.:

_____

_____

Patient Signature:_____ Date _____ NGYN

Brookwood Women's Health, P.C.

Patient Registration Form

CHART #_____

Provider you are here to see:

❍ Deisher ❍ Falkenstrom ❍ Freeman ❍ Hulker ❍ Johnson ❍ Morgan ❍ Patterson ❍ Straughn

PATIENT INFORMATION (PLEASE PRINT)

Name _____ SS# _____

Street Address _____

City _____ State _____ ZIP _____

Email Address _____ Marital Status: ❍ S ❍ M ❍ D ❍ W ❍ Other

Home Phone (_____) _____ Cell Phone (_____) _____

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 to Patient _____

Employer _____ SS# _____

Employer Address _____ Phone (_____) _____

EMERGENCY CONTACT PERSON

Name _____ Relationship to Patient _____

Home Phone (_____) _____ Cell 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 _____

Patient Signature: _____ Date _____

Brookwood Women's Health, P.C.

Communication Authorization Form

Patient Name (Please print) _____

Social Security Number _____

Any provider, employee, or representative of Brookwood Women's Health, P.C. 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(s):**

Name _____ Relationship to Patient _____

Home Phone (_____) _____ Cell Phone (_____) _____

Name _____ Relationship to Patient _____

Home Phone (_____) _____ Cell Phone (_____) _____

Name _____ Relationship to Patient _____

Home Phone (_____) _____ Cell Phone (_____) _____

❍ **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, P.C.

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, P.C. 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 _____

Brookwood Women's Health, P.C.

Patient Consent Form

Patient Name _____ Chart Number _____

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 _____