



## New Patient Gynecology

(Please Fill Out Completely)

Patient's Last Name				First Name			MI
Social Security Number	Date of Birth	Age	Cell Phone		E-mail Address		
Address (Street, Route, Apt. No., etc.)				City	State	Zip Code	
Home Phone	Marital Status		Driver's License Number		Employed By		
Business Phone	Is it okay to call you at work? <input type="radio"/> YES <input type="radio"/> NO	Employer's Address		City	State	Zip Code	

### Guarantor Information

Name	Address	City	State	Zip Code	
Home Phone	Social Security Number	Date of Birth	Relationship to Patient		
Employed by		Business Phone			
Employer's Address		City	State	Zip Code	
Emergency Contact (Friend or relative not at Patient's address who can get a message to you.)			Daytime Phone		
Referring Physician		Pharmacy	Pharmacy Phone		
How did you hear about us?					

### Insurance Information

Primary Health Insurance Company \_\_\_\_\_  
 Ins ID# \_\_\_\_\_ Policy # \_\_\_\_\_  
 Insured Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_ Rel \_\_\_\_\_

Secondary Health Insurance Company \_\_\_\_\_  
 Ins# ID \_\_\_\_\_ Policy # \_\_\_\_\_  
 Insured Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_ Rel \_\_\_\_\_

### List Any Persons to Whom You Will Allow Access Of Your Medical Records

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

*\*\*The doctor's service is provided directly to you and not to an insurance company. Therefore, we cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment. As a courtesy, we will file any and all claims as authorized by you and will assist in making collections from the insurance company and then will credit all such collections to your account. By signing below, I hereby authorize SJMG, LLC to furnish information concerning my present medical care to the insurance company that is listed above.*

*I direct the insurer to Pj without equivocation, directly to SJMG, LLC, all benefits due them as a result of the claim. Although covered by insurance, I am aware that I am personally responsible for all charges. A photostatic copy of this authorization will be as valid as the original.\*\**

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_  
*\*\*I acknowledge that I have been given access to the 'Notice of Privacy Practices' for SJMG, LLC, .\*\**

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_



Name

Birth Date

Today's Date

## New Patient History - Gynecology

Your age at first Period: \_\_\_\_\_ Date of your last period: \_\_\_\_\_ Date of previous period: \_\_\_\_\_  
 How long does your period last: \_\_\_\_\_ How many pads/tampons on worst day: \_\_\_\_\_  
 Are your periods regular: \_\_\_\_\_ Do you bleed or spot between periods: \_\_\_\_\_  
 Do you have pain with your periods: \_\_\_\_\_ Do you miss work because of your periods: \_\_\_\_\_  
 Are you menopausal: \_\_\_\_\_ If so, have you had any bleeding since menopause: \_\_\_\_\_  
 Have you taken hormones: \_\_\_\_\_ Do you have hot flashes or other symptoms: \_\_\_\_\_  
 Current method of birth control: \_\_\_\_\_  
 Have you ever used:  
 \_\_\_ Pills \_\_\_ IUD \_\_\_ Diaphragm \_\_\_ Condoms \_\_\_ Vasectomy/tubal ligation \_\_\_ Ring \_\_\_ Shot  
 Have you ever had:  
 \_\_\_ Herpes \_\_\_ Gonorrhea \_\_\_ Chlamydia \_\_\_ PID \_\_\_ Venereal warts/HPV \_\_\_ HIV  
 Are you sexually active: \_\_\_ Does your partner have Herpes, HIV, or HPV? \_\_\_  
 List your total number of pregnancies: \_\_\_ Number of vaginal deliveries: \_\_\_  
 Number of caesarean sections: \_\_\_ Number of miscarriages or abortions: \_\_\_ Number of living children: \_\_\_  
 Your age at first intercourse: \_\_\_ Number of lifetime partners: \_\_\_ none \_\_\_ 1-4 \_\_\_ 5 or more  
 Have you ever had an abnormal Pap smear: \_\_\_ Do you examine your breasts monthly: \_\_\_  
 Date of last Pap smear: \_\_\_\_\_ (Normal or Abnormal)  
 Date of last mammogram: \_\_\_\_\_ (Normal or Abnormal)  
 Date of last colon screening: \_\_\_\_\_ (Normal or Abnormal)  
 Date of last bone density: \_\_\_\_\_ (Normal or Abnormal)

### List your current prescription / nonprescription / herbal medications:

---



---



---



---



---



---



---

### List any drug allergies:

---



---



New Patient History Page 2 - GYN

Name \_\_\_\_\_

Birth Date \_\_\_\_\_

Have you ever had the following:

- thyroid disease       diabetes       high blood pressure       cancer
- stroke       heart trouble       seizures       bleeding tendency
- blood clots (legs/lungs)       hereditary defects       other diseases

List previous hospitalizations / surgeries / serious injuries and dates:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list your family's medical history:

	Age	Diseases	If deceased, cause of death and age
Father:	_____	_____	_____
Mother:	_____	_____	_____
Brothers:	_____	_____	_____
Sisters:	_____	_____	_____
Grandmother (mother's):	_____	_____	_____
Grandfather (mother's):	_____	_____	_____
Grandmother (father's):	_____	_____	_____
Grandfather (father's):	_____	_____	_____

Any other history of breast or colon cancer: \_\_\_\_\_

Any family history of bleeding or clotting problems: \_\_\_\_\_

Marital Status:     Single     Married     Divorced     Widowed

Use of Alcohol:     Never     Rarely     Moderately     Daily

Use of Tobacco:     Never     Previously     Currently

Use of Recreational Drugs:     Never     Previously

Excessive exposure at home or work to  fumes     dust     solvents     noise

Have you been sexually, verbally, physically, or emotionally abused or neglected: \_\_\_\_\_

Regular exercise: \_\_\_\_\_ Seat belt use: \_\_\_\_\_ Sun screen use (make-up): \_\_\_\_\_

Recent foreign travel: \_\_\_\_\_

Do you have an advanced directive/living will: \_\_\_\_\_ Are you an organ donor: \_\_\_\_\_

Do you eat daily?

- 3 dairy servings     5 fruit or vegetable servings     any sodas     caffeinated beverages     low fat diet



Name

Birth Date

**Have you had any of the following recently: (please circle)**

Fever, chills, decreased appetite, unintentional weight gain, unintentional weight loss

Vision problems, eye pain

Ear pain, hearing problems, nosebleeds, voice problems, throat problems

Chest pain, heart problems, swelling, palpitations

Lung problems, wheezing, difficulty breathing

Nausea, vomiting, diarrhea, constipation, blood in stool, change in bowel habits, loss of appetite

Frequent urination, burning or painful urination, incontinence or dribbling urine, blood in urine

Vaginal discharge, painful sex, genital sores, hot flashes, night sweats, vaginal dryness

Breast lumps, nipple discharge, breast pain, other breast problems

Muscle pain or cramps, joint pain, back pain

Skin rash, itching, unusual spots, excessive hair

Lightheadedness, dizziness, frequent falls, frequent headaches, difficulty walking, slurred speech

Nervousness, depression, sleep problems, memory loss, considered suicide

Cold intolerance, heat intolerance, excessive thirst, excessive urination, dry skin

Easy bruising or bleeding, ice/dirt/starch eating

Hay fever, food allergies, other allergies



**FINANCIAL PAYMENT POLICY**

We find that communication with our patients regarding our financial policy assists us in providing the best service to you. We have therefore taken the time to answer some of the most commonly asked questions.

**How may I pay?**

We accept payment by cash, check, VISA and Mastercard.

**Do I need a referral?**

If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled.

**Which plans do you contract with?**

Because this is a new entity, we are in the application process with many of the managed care programs. We are, in fact, currently participating in some of the major plans. Due to the fact that we have multiple physicians in various stages of application process, we suggest that you speak with our front office supervisor and/or our administrator if after checking with your plan we are still not listed in their system. Our policy during this transition period is to make sure that all patients are able to receive care and treatment from their physicians just as they have in the past. In other words, if we were in-network previously, whether we are finalized or not with your the managed care plan, claims and patient balances are to be billed as if we were in network.

**What is my financial responsibility for services?**

Your financial responsibility depends on a variety of factors, explained below.

<b>If you have.....</b>	<b>You are responsible for.....</b>	<b>Our staff will.....</b>
<b>Commercial Insurance</b>	Payment of the patient responsibility for all office visits, injections, office procedures and other charges at the time of office visit.	File an insurance claim as a courtesy to you.
<b>HMO &amp; PPO plans with which we have a contract</b>	If the services you receive are covered by the plan: All applicable co-pays and deductibles are requested at the time of visit. If the services you receive are not covered by the plan: Payment in full is requested at the time of visit.	File an insurance claim as a courtesy to you.
<b>HMO with which we are not contracted and are not applying for.</b>	Payment in full for office visits, injections, office procedures and other charges at the time of visit.	Provide the necessary information for you to complete and file your claim directly with the insurance company.
<b>Point of Service Plan or Out of Network PPO</b>	Payment of the patient responsibility – deductible, co-pay, non-covered services-at the time of the visit.	File an insurance claim on your behalf.



<b>Medicare</b>	<p>If you have Regular Medicare, and have not met your deductible, we ask that it be paid at the time of service.</p> <p>Any fees for services not covered by Medicare are requested at the time of service.</p> <p>If you have Regular Medicare as primary, and also have secondary insurance or Medigap; No payment is necessary at the time of service.</p>	<p>File the claim on your behalf, as well as any claims to your secondary insurance.</p>
<b>Medicare HMO</b>	<p>All applicable co-pays and deductibles at the time of service.</p>	<p>File the claim on your behalf, as well as any claims to your secondary insurance.</p>
<b>Worker's Compensation</b>	<p>If we have verified the claim with your carrier: No payment is necessary at the time of service.</p> <p>If we are not able to verify your claim: Payment in full is requested at the time of service.</p>	<p>If you bring proper documentation: call your carrier to verify the accident date, claim number, primary care physician, employer information, and referral procedures.</p>
<b>Worker's Compensation (Out of State)</b>	<p>Payment in full is requested at the time of service.</p>	<p>Provide you a receipt so you can file the claim with your carrier.</p>
<b>Occupational Injury</b>	<p>Payment in full is requested at the time of service.</p>	<p>Provide you a receipt so you can file the claim with your carrier.</p>
<b>No Insurance</b>	<p>Payment in full is required at the time of service.</p>	<p>Work with you to settle your account and/or plan monthly payments for hardships. Please ask to speak with our front office supervisor or practice administrator for further assistance.</p>

*I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.*

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Printed Name**



## PATIENT REQUEST FOR MEDICAL RECORDS RELEASE

I hereby authorize the release and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I authorize \_\_\_\_\_ (hospital/physician) to release the following information from my medical records to \_\_\_\_\_ (hospital/physician).

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Covering the period of health care from \_\_\_\_\_ (date) to \_\_\_\_\_ (date).

This authorization will stay in effect for 30 days from the date of my signature below.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Information to be released:

\_\_\_\_\_ Complete health record(s)

**OR**

Select from the following (check as many as apply):

\_\_\_\_\_ History & Physical Examination

\_\_\_\_\_ Follow-up Office Visit Reports

\_\_\_\_\_ X-ray reports

\_\_\_\_\_ Photographs, videotapes, digital or other images

\_\_\_\_\_ Consultation Reports

\_\_\_\_\_ Laboratory Tests

\_\_\_\_\_ AIDS or HIV infection

\_\_\_\_\_ Progress Notes

\_\_\_\_\_ Mental health care or services

\_\_\_\_\_ Treatment for alcohol and/or drug abuse

\_\_\_\_\_ Other: \_\_\_\_\_