Vicksburg Women's Care

Patient Registration Information

First Name:_____ Middle Name:_____ Last Name:_____ Sex: M F

Birth Date:_____ Social Security #:_____ Drivers License #:_____

Address:_____ City/State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Marital Status:_____ Referring Physician:_____

Patient's Employer:_____

Address:_____ City/State:_____ Zip:_____

Occupation:_____ Work Phone:_____

How did you hear about us? _____

Spouse/Guardian Information

Name:_____ Birth Date:_____ Sex: M F

Social Security #:_____ Cell Phone:_____ Home Phone:_____

Address:_____ City/State:_____ Zip:_____

Employer:_____ Work Phone:_____

Emergency Contact Information

Name:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____

Primary Insurance Information

Company Name:_____ Member Name:_____

ID#:_____ Group #:_____ Phone Number:_____

Secondary Insurance Information

Company Name:_____ Member Name:_____

ID#:_____ Group #:_____ Phone Number:_____

I hereby grant permission to **Vicksburg Women's Care** to employ such medical, surgical, and x-ray procedures as my doctor may consider necessary in my diagnosis and treatment. I authorize the holder of medical or other information to release to my insurance carrier, governmental agency, or its intermediary, any information needed for this or a related insurance claim. I agree to pay any charges incurred by me to **Vicksburg Women's Care.**

_____ _____

Signature of Patient (Parent must sign if patient is a minor) Date

Vicksburg Women's Care

Financial Policies

Copayment and deductible payments as determined by your agreement with your insurance carrier are **due at the time of service.** We will file your insurance claim if you agree to have your insurance company pay the doctor directly for services provided. Not all insurance plans cover all services; in the event your insurances plan determines a service to be "not covered", you will be responsible for the payment. Payment is due upon receipt of a statement from our office.

If you have no health insurance, payment will be due at the time of service. There will be a $25 fee for returned checks.

In fairness to other patients and the physicians, we request 24 hours notice to cancel an appointment. You may be charged $25 for a missed appointment. Missing more than two appointments without providing notice are grounds for discharge from the practice.

I agree to the above financial policy. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release information necessary to secure the payment of benefits from my insurance company.

Referral Requirement

I am seeking treatment from a certain practice/physician and understand the if my medical insurance company requires a referral to see a specialist, I am responsible for ensuring that the referral has taken place. If I have not obtained a required referral at the time of my appointment, I understand that I am financially responsible for any charges incurred during that office visit, if not covered by my insurance company.

Notice of Privacy Practices

I understand that, under the **Health Insurance Portability & Accountability Act of 1996 ("HIPPA"),** I have certain rights to privacy regarding my protected health information. I further understand that this information can and may be used for any of the following:

1. To conduct, plan and direct my care and follow-up with the multiple healthcare providers who may be directly or indirectly involved with the treatments.
2. To obtain payment from third party payers (insurance).
3. To conduct normal and required healthcare operations such as quality assessments and physician certifications.

I have been informed by my physician of their **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I have had the opportunity to review the entire **Notice of Privacy Practices** prior to signing this consent.

I have read and agreed to the above policies:

_____ _____

Signature (parent must sign if patient is a minor) Date

OB/GYN Health History Questionnaire

Your answers on this form will help your health care provider better understand you medical concerns and conditions. If you are uncomfortable with any questions, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. All questions contained on this questionnaire are optional and will be kept confidential.

Main reason for today's visit:_____
Other concerns:_____

Allergies

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affect you.

1._____
2._____
3._____

Preferred Pharmacy

Name:_____ Phone Number:_____
Address:_____ City/State:_____ Zip:_____

Medications

Please list all medications that you are taking and the frequency in which you take them. Include prescribed drugs and over-the-counter drugs (such as vitamins and inhalers).

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Immunization Records

Check received immunizations and the most recent date received.

◯ Chickenpox date:_____
◯ Flu Shot date:_____
◯ Gardasil/ HPV date:_____
◯ Hepatitis A date:_____
◯ Hepatitis B date:_____
◯ Meningococcus date:_____
◯ MMR (Measels, Mumps, Rubella) date:_____
◯ Pneumonia date:_____
◯ Tdap (Tetanus and pertussis) date:_____
◯ Tetanus date:_____
◯ Zostavax (Shingles) date:_____

Obstetric and Gynecology History

When was your last PAP Smear? _____ Was it abnormal? Yes or No
When was your last mammogram? _____ Was it abnormal? Yes or No
Age of first menstrual period? _____
Date of last menstrual period or age of menopause? _____
Number of pregnancies? _____ Number of births? _____
Number of miscarriages? _____ Number of abortions? _____
Bleeding between periods? _____
Heavy periods? _____
Extreme menstrual pain? _____
Vaginal itching, burning, or discharge? _____
Wake in the night to go to the bathroom? _____
Hot flashes? _____
Breast lump or nipple discharge? _____
Painful intercourse? _____
Are you sexually active? _____
Do you use a condom? _____
What other birth control methods do you use? _____
Is your current sexual partner a male or female? _____
Are you interested in being screened for STD's? _____

Past Medical History

Please check all that apply.

- ◯ Anemia or Blood Disorder
- ◯ Birth Defects or Inherited Diseases
- ◯ Breast Cancer
- ◯ Breast problems
- ◯ Cancer – other
- ◯ Thyroid Problems
- ◯ Depression
- ◯ Diabetes
- ◯ Ear Problems
- ◯ Eye Problems
- ◯ GI Problems
- ◯ HIV
- ◯ Heart Condition
- ◯ Hepatitis
- ◯ High Blood Pressure
- ◯ Jaundice
- ◯ Kidney or Bladder Problems
- ◯ Lung Disorder or Asthma
- ◯ Nose or Throat Problems
- ◯ Ovarian Cancer
- ◯ Thyroid Problems
- ◯ Variscositis
- ◯ Convulsions or Fainting

Social History

Do you drink caffeinated drinks? _____ If so, how many do you drink a day? _____
Do you drink alcohol? _____ If so, how much do you drink a day? _____
Do you use/or have ever used Tobacco? _____ How many times a day do/did you use tobacco? _____
If so, what type of tobacco do/did you use? _____ How long have you used tobacco products? _____
Do you use recreational or street drugs? _____ If so, what kinds? _____

Past Surgical History

Please list any past surgeries, why you had the surgeries, when, and where.

1._____

_____

2._____

_____

3._____

_____

Family Health History

For each member of the family listed please state whether they are still alive or deceased, their current age or the age they passed away at, and then circle any significant health problems that applied to them.

Grandmother (maternal): Alive?_____ Age?_____

Alcoholism Arthritis Depression Cancer Diabetes Genetic disease
Heart Disease Hypertension Osteoporosis Stroke

Grandfather (maternal): Alive?_____ Age?_____

Alcoholism Arthritis Depression Cancer Diabetes Genetic disease
Heart Disease Hypertension Osteoporosis Stroke

Grandmother (paternal): Alive?_____ Age?_____

Alcoholism Arthritis Depression Cancer Diabetes Genetic disease
Heart Disease Hypertension Osteoporosis Stroke

Grandfather (paternal): Alive?_____ Age?_____

Alcoholism Arthritis Depression Cancer Diabetes Genetic disease
Heart Disease Hypertension Osteoporosis Stroke

Mother: Alive?_____ Age?_____

Alcoholism Arthritis Depression Cancer Diabetes Genetic disease
Heart Disease Hypertension Osteoporosis Stroke

Father: Alive?_____ Age?_____

Alcoholism Arthritis Depression Cancer Diabetes Genetic disease
Heart Disease Hypertension Osteoporosis Stroke

Brother/Sister: Alive?_____ Age?_____

Alcoholism Arthritis Depression Cancer Diabetes Genetic disease
Heart Disease Hypertension Osteoporosis Stroke

Brother/Sister: Alive?_____ Age?_____

Alcoholism Arthritis Depression Cancer Diabetes Genetic disease
Heart Disease Hypertension Osteoporosis Stroke

Current Symptoms

Please circle all that apply to you currently.

Allergies:	Frequent Sneezing Hives Itching Runny Nose Sinus Pressure
Cardiovascular:	Arm Pain or Exertion Chest Pain or Exertion Chest Heaviness Irregular Heart Beats Known Heart Murmur Swelling Light-headed on standing Shortness of Breath
Constitutional:	Exercise intolerance Fatigue Fever Weight Gain Weight Loss
Eyes:	Dry Eyes Irritation Vision Change
Ear/Nose/Throat/Mouth:	Bleeding Gums Difficulty Hearing Dizziness Dry Mouth Ear Pain Frequents Infections Frequent Nosebleeds Hoarseness Mouth Breathing Mouth Ulcers Nose/Sinus Problems Ringing in Ears
Endocrine:	Fatigue Increased Thirst/Hunger/Urination
Gastrointestinal:	Abdominal Pain Black or Tarry Stool Blood in Stool Change in Appetite Frequent Indigestion Hemorrhoids Trouble Swallowing Vomiting Vomiting Blood
Genitourinary:	Blood in Urine Difficulty Urinating Incomplete Emptying Increased Urinary Frequency Urinary Loss of Control
Hematologic/Lymphatic:	Easy Bruising/Bleeding Swollen Glands
Integumentary (skin):	Changes in Moles Dry Skin Eczema Growth/Lesion Itching Jaundice(yellow skin or eyes) Rash
Musculoskeletal:	Back Pain Joint Pain Muscle Aches Muscle Weakness
Neurological:	Dizziness Fainting Headaches Memory Loss Migraines Numbness Restless Legs Seizures Weakness
Psychiatric:	Alcohol Overuse Anxiety/Stress Depression Mania Sleep Problems Do Not Feel Safe In Relationship
Respiratory:	Cough Coughing Up Blood Shortness Of Breath Sleep Apnea Snoring Wheezing

Please add any other information about your health that you would like your provider to know about:

_____

_____

_____

_____

_____

Please sign verifying that you have completed all of the medical questionnaire to the best of your knowledge.

_____ _____

Patient Signature (parent must sign if the patient is a minor) Date