Patient Information Form

NAME Last: _____ First: _____ MI: _____

Preferred Name: _____ SSN: _____

DOB: _____ Age _____ Married____ Single____ Divorced____ Separated____ Widowed____

Address _____ City _____ ST _____ Zip _____

Home phone: _____ Cell: _____ Email: _____

How do you prefer to be contacted? Home____ Cell____ Email_____
Would you like to receive information via email regarding access to our Patient Portal? Yes____ No____

Employer: _____ Work Ph: _____

Pharmacy: _____ Location _____ Phone: _____

Spouse/Parent: _____ DOB: _____ SSN: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Allergies:

Previous Medical/Surgical History:

Advanced Directives
Do you have an Advanced Directive (DNR)? Y N

For Office Use Only

Date	Problems	Date	Surgeries/Deliveries

Marion Women's Health Center
Insurance Information and Payment Authorization

Patient Name: _____

Primary Coverage Insurance Company: _____

Policy ID# _____ Group # _____

Effective Date: _____ Copay amount* $ _____

Subscriber Name _____

Subscriber SSN: _____ Subscriber Date of Birth: _____

Subscriber Address (if different from patient) _____

Subscriber relationship to patient _____

Subscriber Employer _____

Secondary Coverage Insurance Company (if applicable): _____

Policy ID# _____ Group # _____

Effective Date: _____ Copay amount* $ _____

Subscriber Name _____

Subscriber SSN: _____ Subscriber Date of Birth: _____

Subscriber Address (if different from patient) _____

Subscriber relationship to patient _____

Subscriber Employer _____

PAYMENT AUTHORIZATION

I, _____, hereby authorize Marion Women's Health Center to furnish information concerning my care. I direct the insurer to pay, without equivocation directly to the physician, all benefits due to him as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. A photostatic copy of authorization will be as valid as the original.

Signature of Patient or Guardian: _____ Date: _____

*If your insurance requires a Co-payment, this Co-pay must be paid at each visit for which they are required. If you are unable to make your Co-payment at the time of service, your visit will be rescheduled.

Tony Moodley M.D.

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Marion
Women's
Health
Center

To ensure confidentiality and comply with HIPAA regulations, it is the policy of our office to release information regarding our patients only to the patient. By signing this, you are giving our office staff permission to release information to your referring physician, insurance companies and any necessary treating physicians, therapists or hospitals.

If you wish for others to receive information regarding your care, please list their name, telephone number and relationship to you below. If you are a minor, parents/guardians are not automatically authorized to be given information. You must list each parent/guardian you give permission for our staff to speak to.

I give my permission to Dr. Moodley, Brenda Gatchel, and their staff to speak to the following people regarding my care in addition to those listed in the first paragraph above:

Name	**Telephone Number**	**Relationship.**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALL REQUESTED MEDICAL RECORDS require a release filled out and signed by the patient.

When calling our office, our staff will need to speak with you directly.
When we are trying to reach you by telephone, do we have your permission to leave a message on your answering machine or voice mail?

YES NO (Circle One)

_____
Patient Name (please print)

_____
Patient Signature

_____
Date

Marion Women's Health Center

NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

I acknowledge that I have been offered a copy of Marion Women's Health Center's Notice of Privacy Practices, but decline to take a copy.

_____ _____

Patient or Personal Representative Signature date

I acknowledge that I have received a copy of Marion Women's Health Center's Notice of Privacy Practices.

_____ _____

Patient or Personal Representative Signature date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to patient: _____

MARION WOMEN'S HEALTH CENTER

Name _____ Age_____ Primary Care Physician _____

Reason for today's visit_____

List any drug allergies _____

List any medical problems_____

Current medications (include any OTC and herbal) _____

New medications added since your last visit_____

List any previous surgery _____

Hysterectomy Y N If yes, complete? Y N

What type of birth control do you use? _____ Tubes Tied Y N Partner w/Vasectomy Y N

# of pregnancies _____ # of children _____ Are you currently trying to conceive_____

Date of last pregnancy _____ Date of last menstrual period _____ Length _____ Frequency _____

ANSWER THE FOLLOWING QUESTIONS ONLY IF YOU HAVE MEDICARE:

Did you engage in sexual activity before age 16? _____

Have you had multiple sexual partners? (more than 5 in a lifetime) _____

Do you have a history of a sexually transmitted disease? (including human papillomavirus and/or HIV) _____

Have you had fewer than 3 negative Pap tests within the previous 7 years? _____

Circle any changes in your medical status since your last visit:

Weight loss or gain Changes in appetite Abdominal pain Bowel problems/pain Sexually transmitted disease

Bladder leakage on coughing/sneezing Bladder urgency Bladder frequency

Menstrual cycle changes Vaginal infection/discharge Breast discharge/pain Marital/sexual problems

Other-specify _____

Indicate your consumption of the following:

Alcohol – glasses/week _____ Caffeine(coffee,tea,soda)-glasses/day _____

Cigarettes-packs/day_____ Do you exercise regularly? _____

Date of last pap _____ Normal or Abnormal

Date of last mammogram _____ Normal or Abnormal

Date of last Bone Density scan _____ Normal or Abnormal

Date of last colonoscopy _____ Normal or Abnormal

Do you have a family history of:

Breast cancer Y N Who _____

Cervical cancer Y N Who _____

Ovarian cancer Y N Who _____

Uterine cancer Y N Who _____

Signature _____ Date _____