DEMOGRAPHIC INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ SEX: _____ SOCIAL SECURITY # _____

RACE: _____ ETHNICITY: _____ LANGUAGE: _____

ADDRESS 1: _____ CITY: _____ STATE: _____ ZIP: _____

MARITAL STATUS: ☐ SINGLE ☐MARRIED ☐PARTNER ☐DIVORCED ☐WIDOWED

☐ PREGNANT (Check if applicable) ☐ NURSING (Check if applicable)

Whom may we thank for referring you to our practice? _____

CONTACT INFORMATION

HOME PHONE: _____ WORK PHONE: _____ EXT: _____

CELL PHONE: _____ EMAIL: _____

EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME: _____ CONTACT LAST NAME: _____

CONTACT HOME PHONE: _____ CONTACT CELL PHONE: _____

RELATIONSHIP TO PATIENT: _____ CONTACT ADDRESS: _____

CITY: _____ STATE: _____ ZIP_____

PRIMARY CARE PHYSICIAN

PHYSICIAN NAME: _____ PRACTICE NAME: _____

PHONE NUMBER: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP_____

PHARMACY NAME: _____ PHONE NUMBER: _____

LOCATION: _____

INSURANCE INFORMATION

1)PRIMARY INSURANCE: _____ MEMEBR ID#_____

RELATIONSHIP TO POLICY HOLDER: _____ GROUP # _____

2)SECONDARY INSURANCE: _____ MEMEBR ID#_____

RELATIONSHIP TO POLICY HOLDER: _____ GROUP # _____

EMPLOYMENT STATUS: ☐ Employed ☐Unemployed ☐Student ☐Retired

LAST DEGREE EARNED: ☐ HIGH SCHOOL ☐COLLEGE ☐GRADUATE SCHOOL

OCCUPATION: _____ BUSINESS PHONE #: _____

CANCELLATION/NO SHOW POLICY

If you are not able to make your appointment, a 24 hour notice must be given. Please call if you know you will not be able to make your appointment and we will work to get you back in as soon as possible. If a notice is not given and you do not show up for your appointment, you will be charged a $25 fee. A courtesy call will be given within 1 week of your missed appointment. After 3 no shows have occurred you will be dismissed from our practice.

By signing below I acknowledge that I am responsible for following the policy listed above and for any charges due to not following the policy properly.

Patient:_____ **Date:**_____
(Print Name)

_____
(Sign Name)

APPOINTMENT REMINDER TEXT/EMAIL CONSENT

Check all forms of communication you would like us to use in order to send you reminders of your upcoming appointments.

☐ Text Message Reminder
Phone Number:

☐ Email Reminder
Email:

Sign: _____ **Date:** _____

MEDICAL RECORDS RELEASE FORM

PATIENT NAME: _____ DATE OF BIRTH: _____

RECORDS REQUESTED FROM:

PHYSICIAN: _____ BUISINESS: _____

FAX NUMBER: _____

RECORDS TO BE DISCLOSED TO:

DR. PATEL DO OB-GYN

901 LEIGHTON AVE SUITE 103 ANNISTON, AL 36207

PHONE:256-405-0161 FAX:256-405-0160

☐ CLINIC NOTES	☐ NURSES NOTES
☐ PROGRESS NOTES	☐ OPERATIVE NOTES
☐ HISTORY AND PHYSICAL	☐ EKG, EEG, EMG
☐ DISCHARGE SUMMARY	☐ EMERGENCY ROOM
☐ RADIOLOGY REPORTS	☐ DOCTOR CONSULTS
☐ LAB REPORTS	☐ PHYSICIAN ORDERS
☐ PATHOLOGIC REPORTS	☐ URGENT CARE

BY SIGNING BELOW I AUTHORIZE THE ABOVE MENTIONED TO RELEASE MY MEDICAL RECORDS TO DR. PATEL AT WOMENS HEALTH PHYSICIANS AND SURGEONS.

SIGN: _____ PRINT: _____

DATE: _____

HIPAA Authorization for Release of Information to Family Members

Patient Name:_____ D.O.B:_____

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will give us permission to release your information to only the person(s) listed below.

I authorize Women's Health Physicians and Surgeons to release my medical/billing information to the following individuals:

1._____ Relationship:_____

2._____ Relationship:_____

3._____ Relationship:_____

4._____ Relationship:_____

5._____ Relationship:_____

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information that is disclosed.

Patients Signature:_____ Date:_____

NAME:_____ DATE OF BIRTH:_____

What is the reason for your visit today:_____

GYN History:

Age of your first period: _____ First day of your last period:_____/_____/_____

Cycle Length _____ days Flow ☐ Heavy ☐ Moderate ☐ Light

Current birth control_____

Date of last Pap Smear:_____/_____/_____ Have you had a abnormal pap smear? ☐ Y ☐ N

Date of last Mammogram:_____/_____/_____ Have you had a abnormal mammo? ☐ Y ☐ N

Have you had any of the following, mark all that apply?

☐Herpes	☐Gonorrhea/Chlamydia	☐Genital Warts
☐Pelvic Pain	☐IUD placed in the past	☐Abnormal period
☐Abnormal Bleeding	☐Pain with Intercourse	☐Missed periods without pregnancy

OB History:

Have you ever been pregnant ☐ Yes (continue Below) ☐ No (Skip to next section)

Total # of pregnancies_____

Abortions _____

Miscarriages _____

Still Borns_____

# of Living Children_____

Have you went into spontaneous labor before 37 weeks? ☐Y ☐ N

Year	Single/Twins	Weight	Complications

Personal History

Do you have any medication or latex allergies?

Allergy:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you use tobacco? ☐ YES ☐NO

How Long/How Often? _____

Excessive alcohol use? ☐ YES ☐NO

Have you ever had surgery?

Surgery:	Year:
_____	_____
_____	_____
_____	_____

Please list all Medications/Dose/ How often taken

_____

_____

_____

_____

_____

Medical/Family History

Parents Living:_____ Total # of Siblings_____

Please mark all health problems you have experienced personally or have a family history of below

Medical Problem	Personal History (If marked explain)	Family History (If marked, which family member?)
☐Anxiety		
☐Anemia		
☐Asthma		
☐Arthritis		
☐Back Pain		
☐Birth Defects		
☐Blood Clots		
☐Blood in Urine		
☐Bloody/Dark Stools		
☐Chest Pain		
☐Constipation		
☐Convulsions		
☐Diabetes		
☐Depression		
☐Skin Disease		
☐Frequent Urination		
☐Gallbladder Disease		
☐Glaucoma		
☐Gout		
☐Headaches		
☐Hearing Loss		
☐Hepatitis		
☐High Cholesterol		
☐HIV		
☐Heart Attack		
☐Heartburn		
☐Heart Murmur		
☐High Blood Pressure		
☐Kidney Disease/stones		
☐Osteoporosis		
☐Pnuemonia		
☐Sexual Concerns		
☐Shortness of Breath		
☐Stroke		
☐Thyroid Disease		
☐Ulcers/Digestion		
☐Cancer		

Family history questionnaire

MyRisk®
Hereditary Cancer Test

Personal information

Patient name | Date of birth | Healthcare provider | Today's date

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based on your personal and family history of cancer. The following blood relatives should be considered: **parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family.** ***For cancer sites with a '1st-degree relative' notation, only parents, siblings, and children should be considered.***

Do you have a personal history of breast, ovarian, colon, rectal or pancreatic cancer at any age? ☐ Yes ☐ No

Do you have personal history of uterine cancer at 64 or younger? ☐ Yes ☐ No

Do you have family history of:	Yes (Y) / No (N)	Maternal (M) Paternal (P)	Which relative?	Age at diagnosis?
Breast cancer at 50 or younger	☐ Yes ☐ No	☐ M ☐ P		
Two different breast cancers in one relative at any age	☐ Yes ☐ No	☐ M ☐ P		
Three breast cancers in relatives on the same side of the family at any age	☐ Yes ☐ No	☐ M ☐ P		
Ovarian cancer at any age	☐ Yes ☐ No	☐ M ☐ P		
Male breast cancer at any age	☐ Yes ☐ No	☐ M ☐ P		
Triple negative breast cancer at any age	☐ Yes ☐ No	☐ M ☐ P		
Ashkenazi Jewish ancestry with breast cancer at any age	☐ Yes ☐ No	☐ M ☐ P		
Pancreatic cancer at any age (1st-degree relative)	☐ Yes ☐ No	☐ M ☐ P		
Metastatic or high-risk prostate cancer at any age (1st-degree relative)	☐ Yes ☐ No	☐ M ☐ P		
Colon cancer at 49 or younger (1st-degree relative)	☐ Yes ☐ No	☐ M ☐ P		
Uterine cancer at 49 or younger (1st-degree relative)	☐ Yes ☐ No	☐ M ☐ P		
Three colon and/or uterine cancers on the same side of the family at any age	☐ Yes ☐ No	☐ M ☐ P		
Do you have family history of other cancers?	List them here:			
Have you or anyone in your family had genetic testing for hereditary cancer?	Who?		What gene?	Result?

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE CONTINUE WITH THE FORM BELOW

Height (ft. and in.) | Weight (lbs.) | Age at first menstrual period:

Are you: ☐ Pre-menopausal ☐ Peri-menopausal ☐ Post-menopausal Age at menopause: _____

Have you ever had a live birth? ☐ No ☐ Yes Your age at first child's birth: _____

Have you ever used hormone replacement therapy? ☐ No ☐ Yes If yes, treatment type? ☐ Combined ☐ Estrogen only ☐ Progesterone only

If yes, are you a: ☐ Current user: started _____ years ago, intended use for _____ more years ☐ Past user: stopped _____ years ago

Please indicate if you have had a breast biopsy showing one or more of the following results:

☐ N/A (no biopsy or none of the listed results) ☐ Hyperplasia ☐ Atypical hyperplasia ☐ Lobular carcinoma in situ (LCIS) ☐ Biopsy with unknown or pending results

Information about your female relatives:

Number of daughters: _____ Number of sisters: _____ Number of maternal aunts (mother's sisters): _____ Number of paternal aunts (father's sisters): _____

Cancer risk assessment review (to be completed after discussion with your healthcare provider)

Patient signature | Date

Healthcare provider signature | Date