Consent for Treatment
I authorize and consent to the rendering of medical care, including diagnostic procedures and medical treatment by authorized members of Plaza Gynecologic-Oncology as may in their professional judgment be necessary for the below named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment.

Assignment of Insurance Benefits
Patient-Physician Agreement: I, the undersigned, authorize Plaza Gynecologic-Oncology to release any information acquired in the course of my examination or treatment to my insurance company(s) or another physician. I, recognizing that the medical insurance I possess may not completely cover the fee(s) for the professional services rendered me; hereby agree that I am responsible for said fee(s). I authorize payment directly to me for their services. A photocopy hereof shall be valid as the original. I am aware that I may inquire of my physician the fee(s) for any professional services required and/or rendered.

Authorization to Release Information
I authorize Plaza Gynecologic-Oncology to release any information requested by the insurance company necessary to collect benefits under any policy we make claim against for services on this or a related date of service.

Guarantee of Payment
I understand that office visits are to be paid for at the time of service unless other arrangements have been made. I understand that I am responsible for the balance not covered by insurance. I understand that Plaza Gynecologic-Oncology does not accept any insurance policy assignment as a guarantee of full payment.

Patient Signature

(Patient or Parent/Guardian if under 18 years of age)

Relationship of Guardian

Date
Patient Information – Please print

Social Sec #: __________ - ________
Name: ____________________________________________
   Last      First      Mid Initial
Address: __________________________________________
City: _____________________________________________
State: ___________ Zip Code: ____________
Sex: [ ] Male [ ] Female [ ] Other
Marital Status: [ ] Married [ ] Single [ ] Divorced
   [ ] Partner [ ] Widowed [ ] Separated
Primary Care Physician: ____________________________

Referral
Who referred you to our clinic? (Please check box)
[ ] Washington Regional Medical Center [ ] Community or company Health Fair
[ ] Referred by a Physician: __________________________
[ ] Newspaper or Magazine [ ] Treated by Physician in hospital [ ] Employer
[ ] Recommended by a friend or family member
[ ] Internet [ ] Insurance Plan Directory [ ] Drove by Location of Clinic
[ ] Phone Directory (Yellow Pages)
[ ] Return Patient / Not Applicable [ ] Other: ______________________________

Spouse/Parent Information

Spouse/Parent Name: ________________________________
Employer: _______________________________________
Work Address: _____________________________________
City: ______________ State: ____ Zip: _____________
Occupation: _______________________________________

Cell: __________________________ Ext: ___________
Work: ______________ Ext: ___________
Spouse/Parent Sex: [ ] Male [ ] Female
Spouse/Parent DOB: ___/___/____
Social Sec #: ___________ - ________

Emergency Contact Information

Emergency contact: _________________________________
Address: _________________________________________
City: ______________ State: ____ Zip: _____________
Cell: __________________________
Home: ___________________________
Relationship to Patient: _________________
Primary Insurance

Patient's Relationship to Main Policy Holder: ☐ Myself ☐ Spouse ☐ Child ☐ Other: _______________________

Name of Insurance Company: ________________________________

Insurance company Address: ________________________________

City: ___________________________ State: ____________________ Zip: _______________

ID#: ___________________________ Group#: ______________________

Insurance company's Phone Number: __________________________

Main Holder's Name: ___________________________ Main Holder's DOB: ____/____/____
Main Holder's Address: ___________________________
Main Holder's Soc Sec#: _____-____-____

City: ___________________________ State: ____________________ Zip: _______________

Secondary Insurance

Patient's Relationship to Main Policy Holder: ☐ Myself ☐ Spouse ☐ Child ☐ Other: _______________________

Name of Insurance Company: ________________________________

Insurance company Address: ________________________________

City: ___________________________ State: ____________________ Zip: _______________

ID#: ___________________________ Group#: ______________________

Insurance company's Phone Number: __________________________

Main Holder's Name: ___________________________ Main Holder's DOB: ____/____/____
Main Holder's Address: ___________________________
Main Holder's Soc Sec#: _____-____-____

City: ___________________________ State: ____________________ Zip: _______________
General Information

Who is responsible for payment? □ Myself □ Other: __________________________ (Fill out below)
Responsible Party Name: __________________________ Responsible Party DOB: ______/_____/_____
Relationship to Patient: □ Self □ Spouse □ Child □ Other Social Sec#: ______-____-_________
Address: __________________________________________ Phone#: __________________________

Have you ever been seen as a patient at one of our Washington Regional Medical System Clinics?
□ Yes □ No
If Yes, When? ______/_____/_______ Where?______________________________

Release of Information (spouse, children, parents, etc)

Who may we discuss your information with? For example: Medical issues/care, results, billing, etc
Name: __________________________ Relationship with Patient: __________________________
Name: __________________________ Relationship with Patient: __________________________
Name: __________________________ Relationship with Patient: __________________________

Preferred Language: □ English □ Spanish □ Mashallese □ Arabic □ Decline □ Other: __________________________

Race: □ African American □ Asian □ Hispanic □ Native American Indian/Alaskan
□ Native Hawaiian/Other Pacific Islander □ White □ Unknown □ Decline

Ethnicity (Origin): □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown □ Decline

Preferred Communication Method: □ Print □ Decline

Contact Preference: □ Phone □ Email □ Both Phone & Email

Preferred Pharmacy: __________________________ Location: __________________________

I authorize release of any medical information necessary to process my claim to all my insurance companies. I authorize direct payment of medical benefits to the provider. I permit a copy of this authorization to be used in the place of the original. I consent for my photo to be taken, I understand that I am responsible for any amount not covered by insurance. I permit the faxing and electronic transmission of medical information to other health care providers, attorneys, or insurance companies involved in my care. I give my permission for messages to be left on my answering machine or sent by email. I, the undersigned, authorize and consent to the rendering of medical care, including diagnostic procedures, and medical treatment by authorized members of Washington Regional Medical System or their designees, as may in their professional judgement be necessary for the above named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment. I have received a copy of the Notice of Privacy Practices of the clinic. I permit this facility to obtain my medication history electronically.

X __________________________
Signature (Patient or Parent/Guardian if minor)

Date: ______/_____/______
PLEASE FILL OUT AND BRING TO YOUR APPOINTMENT

Randall Hightower, M.D.
HerHealth Gynecologic Oncology

Name: ___________________ DOB: ___________ Date: ___________

Which medical conditions do you have or have you had? (Circle all that apply)

**HEART**
- Coronary artery disease
- Congestive heart failure
- Heart murmur
- Pacemaker
- High cholesterol
- High blood pressure
- Irreg heart beats
- Defibrillator
- Mitral valve prolapse
- Other, specify: __________________________

**LUNGS**
- Shortness of breath
- Coughing
- Asthma
- Wheezing
- CPAP

- COPD/Emphysema
- Other, specify: __________________________

**GASTROINTESTINAL**
- Hepatitis
- Heartburn
- Irritable bowel syndrome
- Diarrhea
- Constipation
- Blood in stool
- Other, specify: __________________________

**KIDNEY**
- Urinary incontinence
- Frequent urination
- Blood in urine
- Frequent infections
- Other, specify: __________________________

**GYNECOLOGY**

Number of Pregnancies: _________ Number of Deliveries: _________ Miscarriages: _________

Menses onset: ___________ Last PAP: ___________ Results: __________________

Age of menopause: __________________

**NERVOUS SYSTEM**
- Headaches
- Numbness
- Other, specify: __________________________

**PSYCHIATRIC**
- Depression
- Anxiety
- Bipolar

Other, specify: __________________________
GLANDS

Diabetes

Other, specify:

Thyroid disease

BONES AND JOINTS

Osteoarthritis

Limitied range of motion

Rheumatoid Arthritis

Osteoporosis

Other, specify:

EYES- EARS-NOSE-THROAT

Hearing loss

Glucoma

Drainage

Seasonal allergies

Other, specify:

OTHER HEALTH PROBLEMS

Cancer

Lupus

HIV

OTHER, specify:

PAST SURGICAL HISTORY

<table>
<thead>
<tr>
<th>Date</th>
<th>Surgery</th>
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Blood transfusion:

FAMILY HISTORY OF BREAST, COLON OR GYN CANCER (please circle and specify type of cancer)

Mother

Maternal Grandmother

Maternal Grandfather

Father

Paternal Grandmother

Paternal Grandfather
SOCIAL HISTORY (please circle)
Married    Divorced    Single    Widowed
Smoke (if yes, how much)    Alcohol    Street drugs

ALLERGIES TO MEDICATIONS

<table>
<thead>
<tr>
<th>Name of med</th>
<th>Reaction</th>
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<tbody>
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ALLERGIES TO:    LATEX    DYE    ADHESIVE

CURRENT MEDICATIONS (Prescriptions, Non-Prescriptions, Supplements)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Strength</th>
<th>How often do you take it?</th>
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</thead>
<tbody>
<tr>
<td>St John’s Wort</td>
<td>Y / N</td>
<td>Aspirin</td>
</tr>
<tr>
<td>Ginsing</td>
<td>Y / N</td>
<td>Anti-coagulants</td>
</tr>
<tr>
<td>Ginko Bilboa</td>
<td>Y / N</td>
<td>Diet pills</td>
</tr>
</tbody>
</table>