Gynecologic Oncology
Washington Regional

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 #: _____-____-_____

MRN #: _____

Name: _____

Last First Mid Initial

Home Phone: _____

Address:_____

Work Phone: _____

City: _____

Cell Phone: _____

State: _____ Zip Code: _____

DOB: ___/___/____ Age:___yrs

Sex: ☐ Male ☐ Female ☐ Other

Employer:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Partner ☐ Widowed ☐ Separated

E-mail: _____@_____

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: _____

Cell: _____

Employer: _____

Work: _____ Ext: _____

Work Address: _____

Spouse/Parent Sex: ☐ Male ☐ Female

City: _____ State: ____ Zip: _____

Spouse/Parent DOB: ____/____/_____

Occupation: _____

Social Sec #: _____-_____-_____

Emergency Contact Information

Emergency contact: _____

Cell: _____

Address: _____

Home: _____

City: _____ State: _____ Zip: _____

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 messaged 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 _____ Date: _____/_____/_____

Signature (Patient or Parent/Guardian if minor)

PLEASE FILL OUT AND BRING TO YOUR APPOINTMENT

MRN#_____

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:_____

Name:_____

GLANDS

Diabetes Thyroid disease

Other, specify:_____

BONES AND JOINTS

Osteoarthritis Osteoporosis Limited range of motion Rheumatoid Arthritis

Other, specify:_____

EYES- EARS-NOSE-THROAT

Hearing loss Glaucoma Drainage Seasonal allergies

Other, specify:_____

OTHER HEALTH PROBLEMS

Cancer Lupus

HIV

Other, specify:_____

PAST SURGICAL HISTORY

Date	Surgery

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

Name:_____

SOCIAL HISTORY (please circle)

Married Divorced Single Widowed

Smoke (if yes, how much) Alcohol Street drugs

ALLERGIES TO MEDICATIONS

Name of med	Reaction

ALLERGIES TO: LATEX DYE ADHESIVE

CURRENT MEDICATIONS (Prescriptions, Non-Prescriptions, Supplements)

Medication	Strength	How often do you take it?

St John's Wort	Y / N	Aspirin	Y / N
Gensing	Y / N	Anti-coagulants	Y / N
Ginko Bilboa	Y / N	Diet pills	Y / N