

Patient Information – Please print

Social Sec #: _____ - _____ - _____ MRN #: _____
Name: _____ Home Phone: _____
Last First Mid Initial
Address: _____ Work Phone: _____
City: _____ Cell Phone: _____
State: _____ Zip Code: _____ DOB: ___/___/___ Age: ___yrs
Sex: Male Female Other Employer: _____
Marital Status: Married Single Divorced Email: _____@_____
 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 Employer
 Treated by Physician in hospital 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 Marshallese Arabic Decline Other: _____

Race: African American Asian European Hawaiian/Other Pacific Islander Marshallese

Mexican American Indian Middle Eastern or North African Multiracial

Native American Indian/Alaskan Spanish American Indian White Caucasian

Unknown Decline Other

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

Contact Preference: Home Phone Cell Phone (Call) Cell Phone (Text) 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 _____

Date: ____/____/____

Signature (Patient or Parent/Guardian if minor)

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 profession judgement 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 college 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

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 Irregular 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

of Pregnancies:____ # of Deliveries:____ Miscarriages:____ Menses onset:____
Last PAP:_____ Results:_____
Age of Menopause:_____

NERVOUS SYSTEM

Headaches Numbness Other, specify:_____

PSYCHIATRIC

Depression Anxiety Bipolar Other, specify:_____

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