Emerson GYN Surgical Associates

NAME: ______________________________ DATE OF BIRTH: ____________

ADDRESS: ____

CITY: ______________________ STATE: ________ ZIP CODE: ________

HOME PHONE#: ______________ CELL PHONE#: ______________

PREFERRED CONTACT: HOME /CELL MAY WE LEAVE DETAILED MESSAGES? YES / NO

MARITAL STATUS: S / M / W / DIV PREFERRED LANGUAGE ____________

RACE: ______________ ETHNICITY: ______________

WE ENCOURAGE YOU TO SIGN UP FOR OUR PATIENT PORTAL? YES / NO

EMAIL ADDRESS (Only if signing up for the Portal): ______________

PRIMARY CARE PHYSICIAN: ______________ REFERRING PHYSICIAN: ______________

PHARMACY NAME/TOWN: ______________ MAIL ORDER PHARMACY: ______________

WHOM MAY WE CONTACT IN THE EVENT OF AN EMERGENCY? ______________

RELATIONSHIP TO PATIENT: ______________ PHONE #: ______________

MAY WE DISCUSS YOUR CONDITION WITH ANY MEMBER OF YOUR FAMILY? Yes / No

IF YES, WHO ______________ PHONE NUMBER: ______________

****IF YOUR INSURANCE REQUIRES REFERRALS, YOU ARE RESPONSIBLE FOR OBTAINING THEM PRIOR TO YOUR APPOINTMENT. YOU WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED FOR UNAUTHORIZED CARE.**

PRIMARY INSURANCE COMPANY: ______________

SUBSCRIBER NAME: ______________ POLICY #: ______________

SECONDARY INSURANCE COMPAY: ______________

SUBSCRIBER NAME: ______________ POLICY #: ______________

THIS INFORMATION IS GIVEN FOR THE PURPOSE OF ESTABLISHING AN ACCOUNT AND MEDICAL FILE WITH EMERSON GYN SURGICAL ASSOCIATES. IT IS UNDERSTOOD THAT I SHALL BE RESPONSIBLE FOR ALL CHARGES INCURRED BY ME (OR ANY MINOR CHILD AS NOTED ABOVE). I AUTHORIZE PAYMENT FOR ANY INSURANCE CLAIMS BE MADE DIRECTLY TO EMERSON PRACTICE ASSOCIATES, INC.

______________________________ ______________

SIGNATURE **DATE**

____

PATIENT REPRESENTATIVE SIGNATURE (IF PATIENT IS A MINOR OR UNABLE TO SIGN)

____

RELATIONSHIP / REPRESENTATIVE TO PATIENT

Emerson GYN Surgical Associates

SERVICES PROVIDED WITHOUT REFERRAL AUTHORIZATION

I understand that I have an obligation to obtain a referral from my Primary Care Physician for services.

I acknowledge that if I DO NOT have a referral today that I will be responsible for payment for services received should this be denied by my insurance carrier.

PATIENT NAME ______________________ DOB ______________

PATIENT SIGNATURE ______________________

DATE OF SERVICE ______________ TODAYS DATE ______________

PATIENT REPRESENTATIVE SIGNATURE IF MINOR OR PATEINT IS UNABLE TO SIGN ______________________

RELATIONSHIP / REPRESENTATIVE TO PATIENT ______________________

EMERSON HOSPITAL

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE
AND
CONSENT TO TREAT/ DISCLOSE HEALTH INFORMATION

ACKNOWLEDGMENT OF RECEIPT OF EMERSON'S NOTICE OF PRIVACY PRACTICES:
By my signature below, I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Emerson Hospital, Emerson Practice Associates, Concord Gastroenterology Associates, any health care professional providing services in the Hospital's clinically integrated care setting, any members of our volunteer group that we allow to help you, and all employees, staff and other Emerson Hospital personnel (collectively, "Emerson")."

CONSENT FOR TREATMENT/TO DISCLOSE MY GENERAL HEALTH INFORMATION:
By my signature below, I hereby authorize Emerson Hospital and those physicians, assistants and consultants as may be selected by them to render such care including diagnostic procedures, medical and surgical treatment and emergent blood transfusions, which may be necessary to care for me. I also authorize Emerson Hospital to disclose my medical information so that Emerson may treat me, seek payment from third parties for such treatment, and generally carry on Emerson's health care operations (e.g., quality assurance). I also authorize Emerson to disclose my medical/insurance information to insurers and providers outside of Emerson when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations. I also authorize Emerson to send me information regarding health services at Emerson Hospital.

ASSIGNMENT OF INSURANCE BENEFITS AND RIGHT OF RECOVERY

In consideration of services rendered, I hereby irrevocably assign and transfer to Emerson Hospital, its physicians, assistants and consultants rights, title and interests in the benefits payable for services rendered related to this visit. If I am covered under Medicare, I hereby certify that the information given by me in applying for payment under Title XV11 of the Social Security Act is correct. Said irrevocable assignment and transfer shall be for the recovery on said policy(ies) of insurance, but shall not be construed to be an obligation of Emerson Hospital to pursue any such right of recovery. Provided, however, this assignment and transfer shall not take away my standing to sue or make claim for benefits, individually, should coverage be denied by an insurance carrier(s). I hereby authorize my insurance company(ies) to pay directly to Emerson Hospital and its physicians, assistants, and consultants all benefits due under said policy(ies) by reason of services rendered therein. I will pay Emerson Hospital, its physicians, assistants, and consultants for all charges incurred or alternatively, for all charges in excess of the sums actually paid pursuant to said policy(ies) that my providers are permitted to collect. A photo static copy of this authorization shall be considered as effective and valid as the original.

____ ____________________
Print Name Date

____
Signature of Patient

**If the patient is not an emancipated minor or otherwise incapacitated (physically or mentally), obtain the following signatures:

____
Signature of Personal Representative

____
Description of Authority Date

Emerson GYN Surgical Associates

Health History

NAME: ____ **DATE:** ________________________

AGE: __________ **DATE OF BIRTH:** ________________ **HEIGHT:** ______________ **WEIGHT:** _______________

REFERRING PHYSICIAN: _______________________ **PRIMARY CARE PHYCISIAN:** ___________________________

PHARMACY NAME/TOWN: ____________________________ **MAIL ORDER PHARMACY:** ____________________

CHIEF COMPLAINT (Reason for your visit today): ____

ALLERGIES (Please include: Medications, Latex, IV Contrast, Shellfish, and Foods):

SUBSTANCE: **REACTION**: (ie: Rash, Nausea, Difficulty Breathing, etc.)

_______________________________________ _______________________________________

_______________________________________ _______________________________________

MEDICATIONS (Please list all that you are currently taking; including all Vitamins, Supplements, and Aspirin):

NAME/ DOSAGE/ FREQUENCY **NAME/ DOSAGE/ FREQUENCY**

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

PAST/ CURRENT MEDICAL PROBLEMS (Please indicate the approximate date of your diagnosis):

____

____

____

____

____

PREVIOUS SURGERIES: (Date and Type)

____

____

____

____

____

OBSTETRIC/GYNECOLOGIC HISTORY (Please list approximate dates of pregnancies and their outcome (delivery, miscarriage, etc)

____

____

____

____

____

LMP_________________ HOW FAR APART ARE YOUR PERIODS? (days)__________ AMOUNT OF FLOW?: light - mod - heavy
AGE OF FIRST MENSES______________ PAIN WITH PERIODS?_____________ HOW LONG DOES PERIOD LAST?________
AGE OF MENOPAUSE ______________ ANY USE OF HORMONE REPLACEMENT?________
CURRENTLY SEXUALLY ACTIVE?______________________ WITH: men - women - both?
CURRENT CONTRACEPTION ________________________ ANY PROBLEMS WITH SEX?__________________________

Emerson GYN Surgical Associates

HEALTH SCREENING:

LAST PAP: ___________________ HPV DONE? (y/n)____________ HISTORY ABNORMAL PAP?________________________

LAST MAMMOGRAM: _________________________ LAST BONE DENSITY? _________________________

LAST COLONOSCOPY: _________________________

FAMILY HISTORY: (Fill in any that pertain to an immediate relative(s) (ie: Parents; Grandparents; Aunts; Uncles; Siblings) Please indicate the age of diagnosis, if known.

Breast Cancer: ___________________________________ Ovarian Cancer:____

Endometrial Cancer: ______________________________ Colon Cancer: ____

Osteoporosis: ___________________________________ Heart Disease: ____

Diabetes: _______________________________________ Other: ____

SOCIAL HISTORY:

Marital Status: Single / Married / Divorced / Widowed / Separated

Alcohol Use (What Type/ Amount/ How Often?): ____

Tobacco Use: Never

Quit ___________ (Year) How Much (Packs Daily)? ____________ How Long? ________________________

Current - How Much (Daily)? _____________________________ How Long? ________________________

Drug Use: Yes / No If yes, what type(s) and how often do you use?: ____

Occupation: ____

REVIEW OF SYSTEMS: Have you commonly or recently had any of these symptoms? Please circle all applicable.

Constitutional: Fever / Chills / Dizziness / Night Sweats

Eyes: Double Vision / Other : ____

Ears/ Nose/ Mouth/ Throat: Pain / Pressure / Deafness / Hoarseness

Cardiovascular: Chest Pain / Chest Pressure / Irregular Heart Beat / Shortness of breath / Palpitations

Respiratory: Chronic Cough / Shortness of breath / Sleep Apnea

Gastrointestinal: Abdominal Pain / Vomiting / Heartburn / Change in Bowel Habits / Bloody Stools / Loss of Appetite / Crohn's

Genitourinary: Urinary Tract Infections / Kidney Stones / Waking up at night to urinate / Pain or difficulty urinating

Musculoskeletal: Joint Pain / Swelling / Weakness / Stiffness / Back Pain

Neurological: Weakness / Numbness / Speech Problems / Memory Problems / Headaches

Psychiatric: Depression / Anxiety / Panic Attacks / Insomnia

SIGNATURE: ____ **Date:** ________________________