# WOMEN'S MEDICAL CENTER PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY

**DATE:** _____

**Patient Legal Name** _____

**If Minor, Parent or Legal Guardian Name** _____

**Mailing Address** _____ **City** _____ **State** _____ **Zip** _____

**Street Address** _____ **City** _____ **State** _____ **Zip** _____

**Home Phone** _____ **Birth Date** _____

**Cellular Phone** _____ **Social Security #** _____

**Message Phone** _____ **Referred by** _____

**Patient employed by** _____ **Occupation** _____

**Business Phone** _____ **Are calls allowed?** ☐ **Yes** ☐ **No**

**Emergency Contact** (not at same number) _____ **Phone** _____

**Marital Status** ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated**

**Race** ☐ **American Indian** ☐ **Asian** ☐ **Black or African American** ☐ **Native Hawaiian** ☐ **White** ☐ **Other**

**Ethnicity** ☐ **Hispanic or Latino** ☐ **Non Hispanic or Latino** **Primary language** _____

## INSURANCE INFORMATION

**PRIMARY INSURANCE:** **Name of Insurance Company:** _____

**Address of Insurance Company** _____

**Insurance Number** _____ **Group #** _____

**Name of Policy Holder AND relationship to you** _____

**Home Phone** _____ **Birth Date** _____ **Social Security #** _____

**Employed by:** _____ **Business Phone** _____

**SECONDARY INSURANCE** **Name of Insurance Company:** _____

**Address of Insurance Company** _____

**Insurance Number** _____ **Group #** _____

**Name of Policy Holder AND relationship to you** _____

**Home Phone** _____ **Birth Date** _____ **Social Security #** _____

**Employed by:** _____ **Business Phone** _____

## DO YOU HAVE AN ADVANCE DIRECTIVE? ☐ Yes ☐ No

**If no, would you like information on it?** ☐ **Yes** ☐ **No**

## AUTHORIZATION OF CARE

Authorization is given to Women's Medical Center, its providers and employees to provide services and administer provider orders. Certain procedures require a separate consent form.

_____ _____

**Patient signature AND legal guardian signature** (if patient is a minor) **Date**

## ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to the physician/provider for services. Failure to pay any balance due by the undersigned may involve a collection agency or attorney. It is understood and agreed that reasonable attorney fees are payable by the undersigned. To the extent not expressly prohibited by applicable law, the undersigned, agrees to pay all charges not paid in full to Women's Medical Center by a third-party payer.

_____ _____

**Patient signature AND legal guardian signature** (if patient is a minor) **Date**

WOMEN'S MEDICAL CENTER, L.L.P.
OBSTETRICS | GYNECOLOGY | GYNECOLOGIC SURGERY
2000 W. 21st St., Suite A-1, Clovis | 575-762-8055 | www.womensmedicalofclovis.com

Date: _____

Name:_____ DOB: _____

How may we contact you?
(Please check and fill out your contact information for all that apply)

- ○ HOME PHONE:_____
- ○ CELL PHONE: _____
- ○ VOICE MAIL/ANSWERING MACHINE
- ○ EMAIL: _____

Checking the above information gives Women's Medical Center, LLP permission to call you and/or leave a message. This also gives the doctor or representative permission to give you results via phone; we will not leave test results on a voice mail or answering machine without further permission.

Patient Signature:_____

# PATIENT INITIATED HISTORY

**Name:** _____

Current health problems/concerns: Mark [**C**] for current problems. Mark [**X**] to indicate if you had these problems in the past.

**NECK**
- ___ Goiter
- ___ Lump
- ___ Pain or stiffness

**BREAST**
- ___ Lump
- ___ Discharge
- ___ Pain

**NEUROLOGICAL**
- ___ Frequent headaches
- ___ Convulsions
- ___ Depression or anxiety
- ___ Other _____

**HEART AND LUNGS**
- ___ Chronic cough
- ___ Shortness of breath
- ___ Night sweats
- ___ Chest pain or pressure
- ___ Palpitation or fluttering
- ___ Swollen ankles

**EXTREMITIES**
- ___ Arthritis, joint pain
- ___ Varicose veins
- ___ Cramps in legs
- ___ Blood clots
- ___ Swollen lymph nodes

**INTESTINAL**
- ___ Loss of appetite
- ___ Swelling
- ___ Nausea or vomiting
- ___ Vomiting of blood
- ___ Pain in abdomen
- ___ Gallbladder trouble
- ___ Change in bowel habits
- ___ Constipation
- ___ Diarrhea
- ___ Blood in stools
- ___ Black, tarry stools

**KIDNEY, BLADDER & GENITALS**
- ___ Albumin or sugar in urine
- ___ Blood or pus in urine
- ___ Kidney or bladder infection
- ___ Getting up at night to urinate ( ___ times)
- ___ Vaginal discharge
- ___ Urine leakage

**MENSTRUATION**
- Age of onset of period _____
- Date of last period _____
- Bleeding between periods _____
- Number of pregnancies _____
- Year of menopause _____

**PAST HISTORY**

Please list with approximate dates

Major illnesses _____

Operations _____

**FAMILY HISTORY OF DISEASE**

(i.e. cancer, high blood pressure, diabetes)

Mother _____

Father _____

Siblings _____

Children _____

**SOCIAL HISTORY**

Please complete the following:

I live with _____

Marital status _____

Occupation _____

Do you smoke? ☐ **YES** ☐ **NO**

Do you drink? ☐ **YES** ☐ **NO**

Do you use drugs? ☐ **YES** ☐ **NO**

**ALLERGIES** _____

_____

_____

**MEDICATIONS** _____

_____

_____

Please place a check mark (✓) in the boxes below for yourself and for each family member who has had cancer diagnosed as indicated.

| | **BREAST CANCER** Before Age 50 | **OVARIAN CANCER** At any age | **COLON CANCER** Before age 50 | **COLON CANCER** After age 50 | **ENDOMETRIAL CANCER** Before age 50 | **ENDOMETRIAL CANCER** After age 50 | **OTHER CANCERS AT ANY AGE** Ovarian, gastric, kidney/urinary tract, gall-bladder, central nervous system, small bowel |
|---|---|---|---|---|---|---|---|
| **FIRST DEGREE RELATIVES** | | | | | | | |
| Yourself | | | | | | | |
| Mother | | | | | | | |
| Sister(s) | | | | | | | |
| Daughter(s) | | | | | | | |
| **MOTHER'S SIDE** | | | | | | | |
| Grandmother | | | | | | | |
| Aunt(s) | | | | | | | |
| Cousin(s) | | | | | | | |
| **FATHER'S SIDE** | | | | | | | |
| Grandmother | | | | | | | |
| Aunt(s) | | | | | | | |
| Cousin(s) | | | | | | | |

**Ask your provider to evaluate your risk for hereditary breast and ovarian cancer if you have**
- Two (2) or more check marks (✓) in the above table **OR**
- One (1) check mark (✓) in the above table and you are of Ashkenazi Jewish descent, **OR**
- Any male relatives with breast cancer at any age.

**Ask your provider to evaluate your risk for HNPCC if you have a personal or family history of:**
- Colon or endometrial cancer diagnosed before age 50 **OR**
- Two (2) first degree relatives with colon or endometrial cancer diagnosed at any age, **OR**
- Two (2) or more tumors in the same individual (two colon cancers or colon and endometrial cancer)

# WOMEN'S MEDICAL CENTER

## "Consent to Use and Disclosure of Protected Health Information"

**Use and Disclosure of Your Protected Health Information**
Your protected health information will be used by Women's Medical Center, LLP or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

**Notice of Privacy Practices**
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

**Requesting a Restriction on the Use or Disclosure of Your Information**
You may request a restriction on the use or disclosure of your protected health information.

**Women's Medical Center, LLP** may or may not agree to restrict the use or disclosure of your protected health information

If Women's Medical Center, LLP agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Revocation of Consent**
You make revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

**Reservation of Right to Change Privacy Practices**
Women's Medical Center, LLP reserves the right to modify the privacy practices outlined in the notice.

**Signature**
I have reviewed this consent form and give my permission to Women's Medical Center, LLP to use and disclose my health information in accordance with it.

_____

**Name of Patient (Print or Type)**

_____

**Signature of Patient**

_____

**Date**

_____

**Signature of Patient Representative**

_____

**Relationship of Patient Representative to Patient**

# "Notice of Privacy Practices"

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW THIS CAREFULLY.**

**Uses and Disclosures**

*Treatment.* Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical records to all health professionals who may provide treatment or who may be consulted by staff members.

*Payment.* Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

*Health care operations.* Your health information may be used as necessary to support the day-to-day activities and management of Women's Medical Center, LLP. For example, information on the services your received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

*Law enforcement.* Your health information may be used to disclose to enforcement agencies, without permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

*Public health reporting.* Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

**Other uses and disclosures requiring your authorization.** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

**Additional Uses of Information**

*Appointment reminders.* Your health information will be used by our staff to send you appointment reminders.

*Information about treatments.* Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

**Individual Rights**

You have certain rights under the federal privacy standards. These include:

The right to request restrictions on the use and disclosure of your protected health information.

The right to receive confidential communications concerning your medical condition and treatment

The right to inspect and copy your protected health information

The right to amend or submit corrections to your protected health information

The right to receive an accounting of how and to whom your protected health information has been disclosed

The right to receive a printed copy of this notice

## Women's Medical Center Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

## Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

## Requests to Inspect Protected Health Information

As permitted by federal regulation, we require the requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Lonnie Ray, Privacy Officer.

## Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concern to:

**Lonnie Ray, Privacy Officer**
**Women's Medical Center, LLP**
**2000 W. 21st St., Suite A-1**
**Clovis, NM 88101**

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against by filing a complaint.

## Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

**Lonnie Ray, Privacy Officer**
**Women's Medical Center, LLP**
**2000 W. 21st St., Suite A-1**
**Clovis, NM 88101**

## Effective Date

This Notice is effective April 14, 2003.