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

Health History Form

Name: _____ **DOB**: _____ **Age**: _____

Marital Status:_____ **Occupation:** _____

Highest Grade Finished: _____ **Ethnicity (please circle)**: African American Caucasian Hispanic Asian American Native American Ashkenazi Jewish Other: _____

Religion (please circle): Christian Baptist Latter-day Saints Catholic Lutheran Mormonism Judaism Islam Buddism Hinduism Muslim Non-Religious Atheist

Do you exercise? Yes No If yes, what type of exercise? _____

Have you ever been sexually active? Yes No **Are you currently sexually active?** Yes No

Partners: Male Female Both **Do you practice safe sex?** Yes No

What type of contraception do you use:_____

Do you smoke? Yes No **Do you drink alcohol?** Yes No

Have you ever used any type of illegal drugs? Yes No Type:_____

Do you wear your seatbelt: Yes No **Do you feel safe at home:** Yes No

Do you have Advance Directives: Yes No **Do you want information about Advance Directives:** Yes No

Have you recently had the following vaccines: HPV/Gardasil Flu Pneumonia Shingles Tetanus

Your Personal History (please check all that pertain):

Asthma/Lung Disease		Diabetes		Fracture		Sexual Issues	
Bleeding Disorders		Gallstones		Kidney Disease		Thyroid Disease	
Breast Cancer		Genital Herpes		Liver Disease		Urinary Issues	
Cervical Cancer		Heart Disease		Lupus/Autoimmune		Uterine Cancer	
Colon Cancer		Hematological Disease		Ovarian Cancer			
Depression/Mental Disease		High Blood Pressure		Pelvic Infection/STD			

Family History (list family member):

Alcohol/Drug Abuse_____; Bleeding/Blood Clots_____;
Breast Cancer_____; BRCA Mutation; Cancer Syndrome_____;
Colon Cancer_____; Diabetes_____;
Heart Disease_____; Ovarian Cancer_____;
Other_____

Menstrual History:

Menstrual History: Age of first period _____ Regular? Yes No Cycle length _____
# of bleeding days_____
First day of last menstrual period_____
# of Pregnancies Total _____ # Live Births _____ # Miscarriages _____
Date of last pap smear _____ History of abnormal pap smear: Yes No
Treatment for abnormal pap smear:_____
Date of last mammogram:_____

WOMEN'S MEDICAL CENTER

Name:_____ **Date:**_____

Name of Pharmacy:_____

Allergies

Medication Allery & Reaction	Food Allergy & Reaction	Environmental Allergy & Reaction

Prescription Medications (including Medical Marijuana)

Medication Name	Dose	Frequency	How long have you taken?	Prescriber

Over-The-Counter Medications (include all pills, liquids, topical creams, etc)

Medication	How often	Used for?

Surgical History

Date	Type

WE CARE FOR ALL WOMEN AT ALL TIMES
WOMEN'S MEDICAL CENTER

OBSTETRICS | GYNECOLOGY | GYNECOLOGIC SURGERY

2000 W. 21st St., Suite A-1, Clovis, NM 88101 | 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: _____

hecking 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:_____

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 _____

WOMEN'S MEDICAL CENTER

"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.