*fem*GYN

Date: _____ (Please Print)

NEW PATIENT REGISTRATION

Last Name: _____ First Name: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____ Date of Birth: _____

Occupation: _____ Employer Name: _____

Preferred Telephone #: _____ ☐ Cell ☐ Home ☐ Work
OK to leave voicemail regarding medical care or test results? ☐ Yes ☐ No

Other Telephone #: _____ ☐ Cell ☐ Home ☐ Work
OK to leave voicemail regarding medical care or test results? ☐ Yes ☐ No

E-mail Address: _____
OK to e-mail regarding medical care or test results? ☐ Yes ☐ No

Do you authorize *fem*GYN to discuss your medical care with another individual? ☐ Yes ☐ No
Name: _____ Phone #: _____

Regular Gynecologist: _____ Phone Number: _____
Would you like us to send a copy of your lab results to your Gynecologist? ☐ Yes ☐ No

Emergency Contact Name: _____

Emergency Contact Phone #: _____ Relationship: _____

How did you learn of our practice? _____

PREFERRED PHARMACY

Pharmacy Name: _____ Telephone #: _____

Pharmacy Address: _____

INSURANCE INFORMATION ☐ None

Name of Primary Insurance Company: _____

Insurance Identification #: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent Child ☐Other

I certify that the information provided above is complete and accurate to the best of my knowledge.

_____ _____
Patient Signature Date

PERSONAL HISTORY:

1. Name: _____ Preferred name: _____
2. Age: _____
3. Marital Status: ☐Single ☐Married ☐Long term relationship ☐Divorced ☐Separated ☐Widowed
4. Reason for this visit: _____

MENSTRUAL HISTORY: (complete even if post-menopausal or no longer having periods)

5. Age at first period: _____ years
6. If your menstrual periods are regular; periods start every:_____days
7. If your menstrual periods are irregular; periods start every:_____to___days (e.g.,12 to 60)
8. Number of days that you bleed:_____days
9. Describe the amount of menstrual flow: ☐ Light ☐ Moderate ☐ Heavy ☐ Clots
10. Describe the amount of menstrual discomfort: ☐None ☐Mild ☐Moderate ☐Severe
11. Does bleeding or spotting occur between periods? ☐ Yes ☐ No
12. Does bleeding or spotting occur after intercourse? ☐Yes ☐ No
13. First day of last menstrual period _____
14. Is pain associate with your periods? ☐ Yes ☐ No
15. If you stopped menstruating, at what age did you stop? _____ years
16. Have you had bleeding or spotting since your periods stopped? ☐ Yes ☐ No

PREGNANCY HISTORY: (All pregnancies)

Have never been pregnant ☐

Please record the number of:
Pregnancies: _____ Abortions: _____ Ectopics: _____
Miscarriages: _____ Vaginal/Cesarean births:____/____ Living children:_____
List any complications of pregnancies:

CONTRACEPTIVE/SEXUAL HISTORY: or ☐ None

17. Are you sexually active? ☐No ☐Yes (☐Male ☐Female ☐Both)
18. Do you experience pain or discomfort with sexual activity? ☐No ☐Sometimes ☐Always
19. What birth control method(s) do you currently use? _____
20. Would you like to discuss sexual activity or birth control today? ☐Yes ☐No
21. Birth control methods used in the past:

Method	Length of Use	Reason For Discontinuation

GYNECOLOGYICAL HISTORY: or ☐ None

22. Date of last pap smear: _____ History of abnormal pap smears: ☐ Yes ☐No
23. Date of last mammogram: _____ History of abnormal mammograms: ☐Yes ☐No
24. Date of last colonoscopy: _____

Any personal history of:

☐ Venereal warts	☐ Gonorrhea	☐ Endometriosis	☐ Pelvic inflammatory disease
☐ Genital herpes	☐ Trichomoniasis	☐ Urinary Incontinence	☐ Recurrent vaginal infections
☐ Syphilis	☐ Polycystic ovarian syndrome (PCOS)	☐ Recurrent urinary tract infections (UTIs)	☐ Bacterial (BV) ☐ Yeast
☐ Chlamydia	☐ Fibroids	☐ Ovarian cysts	☐ Other: _____

(Continued on back)

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PAST OBSTETRICAL/GYNECOLOGICAL SURGERIES: Check any that apply: or ☐ None

SURGERY	YEAR	SURGERY	YEAR	SURGERY	YEAR
☐ D&C		☐ Ovarian cysts removed ☐L ☐R		☐ Hysterectomy	
☐ Hysteroscopy		☐ Ovary removed ☐L ☐R		☐ Myomectomy	
☐ Tubal ligation		☐ Cesarean section		☐ Other (specify):	
☐ Laparoscopy		☐ Vaginal or bladder repair for prolapse or incontinence		_____	

CURRENT MEDICATIONS: or ☐ None

Medication	Dose	Frequency

Any known allergies? ☐ Yes ☐ No If yes, please list: _____

PAST MEDICAL HISTORY: Check if you or a blood relative have any that apply: or ☐ None

	Myself	Family		Myself	Family		Myself	Family
Anemia	☐	☐	Anxiety	☐	☐	Thyroid problems	☐	☐
High blood pressure	☐	☐	Eating disorder	☐	☐	Heart disease	☐	☐
Diabetes	☐	☐	Epilepsy/Seizures	☐	☐	Gall bladder disease	☐	☐
Asthma	☐	☐	Migraine headaches	☐	☐	Breast cancer	☐	☐
Blood clot in veins/lungs	☐	☐	Liver disease/ Hepatitis	☐	☐	Uterine cancer	☐	☐
Kidney disease	☐	☐	Blood transfusion	☐	☐	Ovarian cancer	☐	☐
Depression	☐	☐	Stroke	☐	☐	Colon cancer	☐	☐

Other medical problems (list all):

PERSONAL/SOCIAL HISTORY:

25. Smoke: ☐ No ☐ Yes How many packs per day? _____
26. Use alcohol: ☐ No ☐ Yes How many drinks per day? _____
27. Use illicit drugs ☐ No ☐Yes Which drugs? _____
28. Exercise: Type: _____ How often: _____
29. Have you ever been tested for HIV? ☐ No ☐ Yes Year and result: _____
30. Have you ever been physically or sexually abused? ☐ Yes ☐ No

OTHER SYMPTOMS:

Have you had recent:

☐ Weight change	☐ Breast problems	☐ Vaginal itching
☐ Hair growth/ loss	☐ Anxiety/ Panic	☐ Change in vaginal odor
☐ Change in energy	☐ Depression	☐ Problems with urination
☐ Night sweats/ hot flashes	☐ Abnormal bleeding	☐ Other:

Do you have any particular concerns, special needs, or comments?

_____ _____

Patient Signature Date

*fem*GYN

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please read it carefully.

From time to time, *fem*GYN uses and discloses confidential personal health information about patients. We know this information is private. We call this information "protected health information" (PHI). We are required to protect the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. This notice describes how we may use and disclose your PHI and certain rights you have with respect to your PHI.

Uses and Disclosures for Treatment, Payment and Health Care Operations

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) privacy rules permits us to use or disclose your PHI for the purposes of treatment, payment and healthcare operations, described in more detail below, without obtaining a specific written permission from you, known as an "authorization."

FOR TREATMENT: We may use or disclose information (PHI) about you to coordinate your healthcare. We may consult with other health care providers who are involved in your healthcare. For example, information may be shared to create and carry out a plan for your treatment.

FOR PAYMENT: We may use or disclose information to get payment for the healthcare services you receive. For example, we may provide PHI to bill your health plan for services provided to you.

FOR HEALTHCARE OPERATIONS: We may use or disclose information in performing business activities, which are called healthcare operations. Healthcare operations allow us to improve the quality of care we provide.

APPOINTMENTS AND OTHER HEALTH INFORMATION: We may send you reminders for medical services. We may send you information about health services that may be of interest to you.

Other uses and disclosures for which authorization is not required.

In addition to using and disclosing PHI for treatment, payment and healthcare operations, the HIPAA Privacy Rule permits (or requires) us to use and disclose PHI without your written authorization under the circumstances described below:

AS REQUIRED BY LAW AND FOR LAW ENFORCEMENT: We will use and disclose information when required or permitted by federal or state law or by a court order. If federal or state law creates higher standards of privacy, we will follow the higher standard.

FOR ABUSE REPORTS AND INVESTIGATIONS: If we reasonably believe a patient has been a victim of abuse or neglect, we may disclose PHI as required by law.

FOR GOVERNMENT PROGRAMS: We may use and disclose information for public benefits under other government programs. For example, we may disclose information for the determination of Supplemental Security Income (SSI) benefits.

TO AVOID HARM: We may disclose PHI to law enforcement agencies in order to avoid a serious threat to the health, welfare and safety of a person or the public.

FOR RESEARCH: We may use information for studies and to develop reports.

DISCLOSURES TO FAMILY, FRIENDS, AND OTHERS: We may disclose information to the family or other persons who are involved in the patient's medical care. You have the right to object to the sharing of this information.

Please list the names of the persons who we may disclose the patient's PHI or ☐None

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

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Other uses and disclosures require your written authorization.

For other situations, we will ask for your written authorization before using or disclosing information. You may cancel this authorization at any time in writing. We cannot take back any uses or disclosures already made with your authorization.

YOUR PRIVACY RIGHTS

RIGHT TO INSPECT AND COPY MEDICAL RECORDS: In most cases, you have the right to look at or get copies of your records. You must make the request in writing. You may be charged a fee for the cost of copying your records.

RIGHT TO REQUEST RESTRICTIONS: You have the right to ask us to limit how your information is used or disclosed. You must make the request in writing and tell us what information you want to limit and to whom you want the limits to apply. We are not required to agree to the limit. You can request in writing that the limit be terminated.

RIGHT TO AMEND: You may ask us to change or add missing information to your records if you think there is a mistake. You must make the request in writing, and provide a reason for your request.

RIGHT TO OBTAIN A PAPER COPY: You have the right to ask for a paper copy of this notice at any time.

RIGHT TO FILE A COMPLAINT: You have the right to file a complaint with us at the address listed below and with the Secretary of the United States Department of Health and Human Services if you do not agree about how we have used or disclosed information about you.

RIGHT TO REVOKE PERMISSION: If you are asked to sign an authorization to use or disclose information, you can cancel that authorization at any time. You must make the request in writing. This will not affect information that has already been shared.

RIGHT TO CHOOSE HOW WE COMMUNICATE WITH YOU: You have the right to ask that we share information with you in a certain way or in a certain place. For example, you can ask us to send information to your work address instead of your home address. You must make this request in writing. You do not have to explain the reason for your request.

RIGHT TO RECEIVE NOTICE OF CHANGE TO *fem*GYN PRIVACY STATEMENT: You have the right to receive notice of changes in our privacy statement that affect you on or after the effective date of change. If you have any questions about this notice, the name and phone number of our contact person is listed on this page.

JoAnn Matula, *fem*GYN
175 5th Avenue
Brooklyn, NY 11215
347-987-4414

I hereby acknowledge that I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights I may contact the person listed above. I further understand that the practice will offer me updates to this NOTICE OF PRIVACE PRACTICES should it be amended, modified or changed in any way.

Patient Name	Patient Signature	Date

*fem*GYN

Patient Name: _____ Date of Birth: _____

FINANCIAL POLICY

*fem*GYN participates in select insurance plans. If *fem*GYN does not participate in your insurance plan or you do not have health insurance, you must pay in full for the visit at the time of service.

If you have a health insurance plan that *fem*GYN does not participate in, after you have paid us, you may send the bill to your insurance company. Your insurance may then reimburse you.

If you have a health insurance plan that *fem*GYN does participate in, you may have a co-pay. You must pay your co-pay at the time of service.

All testing done at *fem*GYN will be sent to a laboratory that accepts your insurance (if applicable). This is not a guarantee that lab work done at *fem*GYN will be covered by your insurance. The patient must pay the laboratory any amount not paid by insurance.

_____ _____

Patient Signature Date

PLEASE CHOOSE YOUR PRIVACY OPTIONS

HIPPA PRIVACY INFORMATION

How may we leave messages regarding appointments:

Home Phone (include auto call)	Yes	No
Mobile Phone (include auto call)	Yes	No
Mobile Text (include auto call)	Yes	No
Work Phone (include auto call)	Yes	No
With Another Person	Yes	No
Send via Mail	Yes	No
Send via Email	Yes	No

How may the doctor/nurse practitioner leave medical information:

Home Phone (include auto call)	*Yes*	*No*
Mobile Phone (include auto call)	*Yes*	*No*
Mobile Text (include auto text)	*Yes*	*No*
Work Phone	*Yes*	*No*
With Another Person	*Yes*	*No*
Send via Mail	*Yes*	*No*
Send via Email	*Yes*	*No*

Person(s) Authorized to communicate with: _____

_____