NEW RIVER WOMEN'S HEALTH P.C.
Patient Registration Form

PATIENT INFORMATION

Patient Name: _____ _____ _____
(First) (Middle) (Last)

Sex: • Female • Male Marital Status: • Married • Divorced • Single • Separated • Domestic Partner • Widowed

Date of Birth: _____/_____/_____ Social Security Number: _____- _____ -_____

Mobile Number: (_____) _____- _____ Email Address: _____

Home Number: (_____) _____- _____ Work Number: (_____) _____- _____

Home Address: _____

City: _____ State: _____ Zip _____

How did you hear about New River Women's Health: _____

ETHNICITY : • Hispanic or Latino • Not Hispanic or Latino • Patient declines to specify

RACE : • American Indian or Alaska Native • Asian • Black or African American • Native Hawaiian or Other Pacific Islander • White or Caucasian • Patient declines to specify

RESPONSIBLE PARTY (if other than patient)

Guarantor's Name: _____ Phone Number: (_____) _____- _____

Address: _____ City: _____ State: _____ Zip _____
(If different from Above)

Patient Relation to Guarantor: _____ Guarantor's Employer: _____

Employer Address: _____

City: _____ State: _____ Zip _____

Guarantor Social Security #: ____ ____ ____- ____ ____ - ____ ____ ____ Guarantor D.O.B _____/_____/_____

Insurance Information (you may leave blank if you can present your card to the receptionist)

PRIMARY

Name of Insurance Company _____ Policy Holder: _____

ID Number: _____Group Number: _____

SECONDARY

Name of Insurance Company _____ Policy Holder: _____

ID Number: _____Group Number: _____

Emergency Contact:

Name: _____ Relationship to patient: _____

Phone: _____

I hereby authorize New River Women's Health P.C., to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to New River Women's Health P.C of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Patient's signature (or responsible party) _____ Date: _____

PATIENT ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I hereby authorize New River Women's Health P.C., to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to New River Women's Health P.C of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

_____ Date: _____
Patient's signature (or responsible party)

_____ _____
Printed Name of Patient or Personal Representative Relationship to Patient

SPECIFIC INFORMATION RELEASE (If applicable)

I request and authorize New River Women's Health P.C. to disclose protected health care information to the individual(s) listed below.

Name _____ Contact # _____

Name _____ Contact # _____

Name _____ Contact # _____

NOTICE OF PRIVACY PRACTICES (HIPAA)

I acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

_____ Date: _____
Patient's signature (or responsible party)

_____ _____
Printed Name of Patient or Personal Representative Relationship to Patient

CONSENT FOR USE OR DISCLOSURE OF PATIENT INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCRE OPERATIONS

I hereby consent to New River Women's Health P.C. using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to New River Women's Health P.C. using or disclosing my protected health information for treatment activities provided by another provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operation including quality assessment and reviewing the competence of health care professionals.

_____ Date: _____
Patient's signature (or responsible party)

_____ _____
Printed Name of Patient or Personal Representative Relationship to Patient

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received from the Group a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth this Group's privacy practices and my rights regarding privacy of my protected health information.

_____ _____

Patient Signature Or Personal Representative Date

New River Women's Health Cancellation / No Show Policy

1. Cancellation / No Show for Scheduled Appointment:
   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a Thirty Five Dollar ($35) fee; this will not be covered by your insurance company. This appointment will also be marked as a No Show since adequate cancellation notice was not given. We will limit the number of No Shows or late cancellations allowed per patient. If you are a No Show three (3) times, we will no longer schedule appointments for you at our practice.

2. Late Arrival for Scheduled Appointments:
   We understand that delays can happen; however we must try to keep the other patients and doctors on time. If a patient arrives 15 minutes past their scheduled time we will have to reschedule the appointment.

_____
Printed Name

_____
Patient/Guardian Signature

____/____/_____
Date

January 2017

Clinical Profile

Patient Name: _____ DOB: _____/_____/_____

(Circle One) Single Married Widowed Divorced Domestic Partner Separated

Your Employment / Profession: _____

Spouse / Partner's Name: _____

Primary Care Doctor Or Nurse Practitioner: _____

****

Date if Last Menstrual Period:

_____

Medication Allergies:

_____

List all Current Medications (including over the counter):

_____

_____

_____

_____

Tobacco Use: •Yes •No If YES, now long and how much:

_____

Alcohol Use: •Yes •No If YES, how often:

_____

Illegal Drug Use: •Yes •No If yes, what and how often: _____

****

Date of last Women's Health Exam / Pap Smear:

_____

Do you have a history of an abnormal pap? •Yes •No If so when?:

_____

Date of last mammogram: _____

Date of last colonoscopy: _____

Date of last bone density: _____

****

Pregnancy History: please check all that apply and how many of each:

Pregnancies: _____ Vaginal Births: _____

Cesarean Sections: _____ Miscarriages: _____

Fetal Demise: _____ Elective Abortion: _____

Past Medical History: Please check all that apply

- Hypertension
- Heart Disease
- High Cholesterol
- Thyroid Disorder
- Asthma
- Osteopenia
- Depression
- Chronic Kidney Disease
- Gastrointestinal Disorders
- Cancer
- Diabetes
- Stroke
- Migraines
- Seasonal Allergies
- Seizure Disorder
- Osteoporosis
- Anxiety
- Anemia
- Other: Details: _____ _____

****

Past Surgical History: Please check all that apply

Procedure	Date if Known	Procedure	Date if Known
Appendix		Tonsillectomy	
Gall Bladder		D&C	
Hysterectomy		Endometrial Ablation	
C-Section		Hernia	
Incontinence Procedure		Right of Left Ovary Removal	
Sterilization • Tubal •Essure • Partner Vasectomy			

Other surgeries:

_____

_____

—

Family History: Please check all that apply

- Diabetes
- Heart Disease
- Stroke
- High Blood Pressure
- Asthma
- High Cholesterol
- Mental Health Disorder
- Breast Cancer Family Member: _____ Age Diagnosed: _____
- Ovarian Cancer Family Member: _____ Age Diagnosed: _____
- Uterine Cancer Family Member: _____ Age Diagnosed: _____
- Colon Cancer Family Member: _____ Age Diagnosed: _____
- Melanoma Family Member: _____ Age Diagnosed: _____
- Osteoporosis
- Other: Details:

  _____