CAPITAL HEALTH OBGYN

Name:_____ DOB:_____

Reason for appointment:_____

Referring Physician:_____ Primary Care Physician:_____

Have you seen an OBGYN before? Y / N If so, who?_____

Allergies (medications, foods, latex, iodine etc. Please write allergy and the problem):

Medications and herbal supplements (include dosage and frequency):

Vaccines/Immunizations:

Did you receive the Gardasil Vaccine for HPV? [ ] Yes [ ] No If yes, did you receive all 3 doses? [ ] Yes [ ] No
Did you receive a Flu Vaccine? [ ] Yes [ ] No If yes, when? _____
Have you had a Tdap Vaccine? [ ] Yes [ ] No If yes, when? _____

Problems/Medical History:

(Check off if you currently have or have had any of these medical problems in the past)

	Abuse/Domestic Violence		Cardiac problem		Kidney Disease or Bladder problem
	Acid Reflux/ GERD		Depression		Lung Disease/ Respiratory Illness
	Acne		Dermatology problem/Eczema		Neurologic Disease
	ADD/ADHD		Diabetes- Medication controlled		Osteopenia/Osteoporosis
	Anemia		Diabetes- Diet controlled		Polyps
	Anesthesia Complications		Diabetes- Gestational/Pregnancy		Pre-Eclampsia
	Anxiety Disorder		Eating Disorder		Psychiatric Illness
	Arthritis/Fibromyalgia		Endocrine problem		Stroke
	Asthma		GI problem		Thyroid Disease
	Autoimmune/Rheumatology problem		Headaches/ Migraines		Vascular Disease
	Birth Defects/Inherited Disease		Heart Disease		Varicosities/Vein Problem
	Bleeding Disorder		Hepatitis		Weight Gain
	Blood Transfusion		High Cholesterol		Weight Loss
	Cancer: _____		Hypertension		Other:_____

Gynecological Problem History:

(Check off if you currently have or have had any of these medical problems in the past)

	Fibroids		Infertility		Genital Herpes
	Gonorrhea		Ovarian Cancer		HIV
	Endometriosis		Breast Cancer		Chlamydia
	Ovarian Cysts		Cervical Cancer		Pelvic Inflammatory Disease (PID)
	Syphilis		Uterine Cancer		Genital Warts

Gynecologic/Menstrual History:

Date of your last menstrual period? _____

How often do you get your menstrual cycle? Every _____ days, lasting for _____ days

Is your menstrual flow: [ ] Light [ ] Moderate [ ] Heavy Are your cycles? [ ] Regular [ ] Irregular

Age at first period: _____ If menopausal, age of menopause: _____

Have you had a Pap smear? [ ] Yes [ ] No If yes, when:_____ [ ] Normal [ ] Abnormal

Have you had abnormal pap? [ ] Yes [ ] No If yes, when:_____

Have you ever had a colposcopy? [ ] Yes [ ] No If yes, when:_____ [ ] Normal [ ] Abnormal

Are you sexually active? [ ] Never [ ] Not currently [ ] Yes

Is your partner: [ ] Male [ ] Female [ ] Both

Have you ever had a mammogram? [ ] Yes [ ] No If yes, when:_____ [ ] Normal [ ] Abnormal

Have you ever had a colonoscopy? [ ] Yes [ ] No If yes, when:_____ [ ] Normal [ ] Abnormal

Have you ever had a DEXA/Density Scan? [ ] Yes [ ] No If yes, when:_____ [ ] Normal [ ] Abnormal

Method of Contraception/Birth Control:

(Check all that apply)

[ ] Pregnant	[ ] Rhythm Method	[ ] Essure
[ ] Nuva Ring	[ ] Depo Provera	[ ] Seeking Pregnancy
[ ] Withdrawal	[ ] Implant	[ ] Vasectomy
[ ] Condoms	[ ] IUD	[ ] Pill
[ ] Patch	[ ] Tubal Ligation	[ ] None

Obstetric/Pregnancy History:

Total number of: Pregnancies:_____ Full Term Births:_____ Pre-Term Births:_____

Living Children:_____ Abortions Induced:_____ Miscarriages:_____

Age at first Live Birth:_____

No.	Birth Date	# Weeks at Delivery	Sex	Birth Weight	Delivery Type	Complications	Location of Delivery
1							
2							
3							
4							
5							
6							
7							
8							

Family Medical History:

Please indicate below significant medical problems of family members. Indicate which family member by checking the appropriate column and the AGE OF ONSET: [ ] No Family History [ ] Adopted

	None	Mother	Father	Brother	Sister	Grand Mother (Maternal)	Grand Father (Maternal)	Grand Mother (Paternal)	Grand Father (Paternal)	Aunt (Maternal)	Uncle (Maternal)	Aunt (Paternal)	Uncle (Paternal)
Blood Clots													
Breast Cancer													
Cervical Cancer													
Colon Cancer													
Diabetes													
Ovarian Cancer													
Hypertension													
Stroke													
Uterine Cancer													
Other Cancer not mentioned													
Other Disease not mentioned													

Do you or have you smoked tobacco? (cigarette/cigar/etc)	No Yes (currently) Yes (former)	[ ] Every day, _____ per day/# of years_____ [ ] Some days, describe:_____ [ ] Former, Quit:_____ years ago
Have you ever used smokeless tobacco (vape/e-cig/chewing tobacco)?	No Yes (currently) Yes (former)	[ ] Every day, _____ per day/# of years_____ [ ] Some days, describe:_____ [ ] Former, Quit:_____ years ago
Do you drink alcohol?	No Yes	[ ] Social [ ] Daily How many drinks per week? _____
Have you ever used illicit drugs?	No Yes	If yes, when and what kind:

OBGYN Surgical History:

(Please write date of surgery below)

√	Surgery/Year	√	Surgery/Year	√	Surgery/Year
	D&C		Hysterectomy (abdominal)		Left Ovary removed
	Hysteroscopy		Myomectomy		Right Ovary removed
	Infertility surgery		Biopsy		Vaginal Prolapse
	Tuboplasty		Ovarian surgery		Bladder Repair/Incontinence
	Tubal Ligation		Left Ovarian Cyst removal		Colposcopy
	Laparoscopy		Right Ovarian Cyst removal		LEEP
	Hysterectomy (vaginal)		Cesarean Section		Other:_____

Non-OBGYN Surgical History:
(Please list any other surgeries with dates)

Surgery	Date	Complications?

Do you have any cultural/religious practices that may affect your treatment? [ ] Yes [ ] No

If so, what:_____

What is your present occupation?_____

Capital Health

General & Financial Consent: Inpatient, Outpatient, Emergency Department

Financial Agreement: I agree whether I sign as a representative of the patient or as the patient, that in consideration of the services to be rendered to me, I obligate myself to pay the account of the hospital in accordance with the regular rates and terms of the hospital. I intend to be legally bound, assume full responsibility for, and agree to pay Capital Health upon presentation of the bill, all expenses, and charges for such services and care. Should the account be referred to an attorney for collection, I shall reimburse Capital Health reasonable attorney's fees and collection expense.

Medicare Authorization for Information and Payment Request Release: I agree the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers or to the Professional Review Organization any information needed in order to process payment for this visit or a related Medicare claim. I request that payment or authorized benefits be made on my behalf, if I am a member of a Medicare Risk Contracting Health Maintenance Organization.

Release of Information: I assign benefits payable for hospital and physicians' services to the physician or provider furnishing the service and authorize such physician or provider to submit a claim containing information related to my treatment, to Medicare, Medicaid or other Insurance Carrier for payment. I understand that if under Medicare Program Guidelines, as necessary, Capital Health is required by various governmental agencies to review and release patient information. Capital Health also cooperates with various agencies by providing statistics and medical information for research purposes. I understand and agree that Capital Health is authorized to review and release such information.

I understand that these records will contain information pertaining to psychiatric, alcohol or drug abuse and HIV counseling or testing. Any specimens taken from my body during my treatment may be retained, preserved, used for teaching purposes, or disposed by Capital Health.

Consent to Release Medical Records: I authorize the release of my medical records and information for the purpose of coordinating care and discharge planning and for the purpose of my follow-up care, this includes the designated Caregiver, if elected. I understand that the information disclosed may include Specially Protected Health Information such as records of psychiatric treatment, counseling or testing, substance abuse counseling or treatment, and or HIV, AIDS diagnosis, treatment, or testing. I may revoke this authorization as it relates to Specially Protected Health Information by providing written notice to Capital Health, Health Information Management Department.

Consent for Blood Test: In the event a physician, hospital employee, worker, student, or other person is accidentally stuck with a needle or otherwise directly exposed to my blood or body fluids in connection with my treatment at Capital Health or during the discharge process, I consent to having my blood drawn and tested for Human Immunodeficiency Virus (HIV, the virus that causes Acquired Immune Deficiency Syndrome, AIDS), Hepatitis B virus, and Hepatitis C virus. Such testing will allow any necessary treatment of the physician, hospital employee, worker, student, or other person to begin without delay. I further understand that if such testing is required I will receive appropriate counseling. The results of the test will be released only to those involved with the medical treatment of the exposed physician, hospital employee, worker, student, or other person as required by law or as agreed to by me.

Information about Doctors at Capital Health: Some physicians and other health care providers who participate in your care, including but not limited to, for example, surgeons, radiologists, anesthesiologists, pathologists, pediatricians, and consultants are private practitioners and not employees or agents of Capital Health. Physicians who practice at Capital Health must meet certain educational and experience requirements; however, Capital Health is not responsible for specific care provided to you by that physician. If you wish to change your physician, ask to speak with a nurse manager.

☐ **By checking this box, I confirm that I have read, understand, and accept the above terms, and I agree to be bound to those terms. The act of checking this box shall have the same effect as signing my name.**

Consent for Contact by Telephone, Cellular, and/or Electronic Communications: By signing this form you consent to the terms in this section. Capital Health conducts patient care quality reviews to ensure the continued highest quality of services. Patients may participate or be invited to participate in the surveys through the use of text messaging, phone call, automatic telephone dialing system, artificial, prerecorded voice messaging, or electronic mail. These communications may come from Capital Health or a third party vendor to the phone number or email address that the patients have provided. Patients are not required to provide a phone number or email address as a condition of receiving treatment and/or other healthcare service from Capital Health. Should you choose to opt out of receiving contact from Capital Health or its third party vendor, you understand that it is your responsibility to contact Capital Health Patient Experience Department at 1-609-394-6336 (RMC) or 1-609-303-4280 (Hopewell) with this information. Message and data rates may apply.

☐ **By checking this box, I confirm that I have read, understand, and accept the above terms, and I agree to be bound to those terms. The act of checking this box shall have the same effect as signing my name.**

Consent for Treatment: I consent to be treated by/admitted to Capital Health under the care of my physician, and their associates, partners, assistants, and designees. I consent to any hospital care, which encompasses routine laboratory, diagnostic, or medical/surgical treatment advisable during treatment and or hospitalization. I agree to allow medical students, interns, and residents, under the supervision and direction of a physician to observe my treatment and review my medical record. I understand that no guarantees have been made to me about the outcome of this care. I acknowledge that Capital Health has the authority to dispose of specimens taken for laboratory and pathology examinations.

☐ **By checking this box, I confirm that I have read, understand, and accept the above terms, and I agree to be bound to those terms. The act of checking this box shall have the same effect as signing my name.**

Consent for Interoperability – Admission, Discharge and Transfer Notifications

In accordance with the Interoperability and Patient Access final rule (CMS-9115-F) Capital Health is required to make Conditions of Participation (CoPs) for hospitals. CoPs require Capital Health sends electronic patient event notifications of patient's Admission, Discharge, and/or Transfer to another healthcare facility, or to another community provider or practitioner. Government regulations require Capital Health to notify your primary care physician, referring physician, or other community provider in the event that you are admitted, discharged, or transferred to another facility.

☐ **By checking this box, I confirm that I have read, understand, and accept the above terms, and I agree to be bound to those terms. The act of checking this box shall have the same effect as signing my name.**

Acknowledgement of Privacy Notice: I acknowledge receipt of Capital Health Notice of Privacy Policy:

☐ **By checking this box, I confirm that I have received the Capital Health Notice of Privacy Practices. The act of checking this box shall have the same effect as signing my name.**

By signing below, I agree to be subject to all of the terms in this General and Financial Consent. I agree that any checked boxes shall have the effect of my written signature.

X _____ Relationship to Patient: _____ Date: _____Time: _____
(Signature of patient or patient representative)

Witness: _____ Date: _____ Time: _____

Patient Name: _____ DOB: _____ Date: _____

Living Will:

Do you have a Living Will and Durable Power of Attorney? **YES** **NO**

If **YES**, please furnish us with a copy for your medical chart or allow us to make a copy to attach to your chart. Thank you.

If **NO**, would you like more information regarding this subject? **YES** **NO**

I. When we need to contact you regarding test results, prescription refills, rescheduling appointments, etc., Please indicate where we can leave a message:

CIRCLE YES OR NO

HOME NUMBER ~ YES / NO _____

CELL NUMBER ~ YES / NO _____

II. I AUTHORIZE THE FOLLWING INDIVIDUALS TO RECEIVE INFORMATION PERTAINING TO MY MEDICAL CARE.

NAME	RELATIONSHIP	CONTACT NUMBERS

I agree _____ to the above. Date Signed: _____
(Patient Signature)

Signing this form verifies all information is correct and /or has been updated.

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Medication History & Medication Benefits Consent

I give permission for Capital Health to obtain my current Medications and Medication History from the Surescripts Pharmacy Clearinghouse.

I understand that this information will be stored in my Electronic Health Record and may be used in the normal course of my treatment at Capital Health.

Patient Signature: _____ Date: _____

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MEDICAL GROUP

Missed Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment

In order to be respectful of the medical needs of other patients, please be courteous and call our office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least **24 hours** in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment

To cancel appointments, please call your office. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

Late Cancellations: A late cancellation is considered when a patient fails to cancel their scheduled appointment with a **24 hour** advance notice.

No Show Policy: A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your appointment history as a "no-show".

Missed Appointment Fees

- Patients who fail to keep an appointment will be rescheduled once upon request: **No Charge**
- After a second and subsequent missed appointment: **$25 fee billed to your account**
- Third missed appointment: **Possible discharge from our practice**

Patient Name: _____

Patient's Signature: _____ Date: _____