Advanced Women's Center

OB/GYN

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PATIENT CONSENT FORM

The Department of Health and Human Services has established the Health Insurance Portability and accountability Act of 1996 (HIPAA). This privacy rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of their Private Health Information which may also include any information regarding any accident/work injury. Please understand that this information can be used:

- Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers/insurance carriers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose Personal Health Information for purposes of treatment, payment, or health care operations.

You may refuse to consent to the use or disclosure of your Personal Health Information, but this must be done in writing. Under this law, you may restrict how your private information is used or disclosed to carry out treatment, payment, or other healthcare operations. Under this law, we also have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). I HAVE READ AND UNDERSTAND THIS CONSENT. I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME.

Patient Name:_____ Date:_____

Signature:_____ Relationship to patient:_____

HIPAA Compliance Patient Consent Form

Our notice of Privacy Practices Provides information about how we may use or disclose protected health information.

The notice contains a patient's right section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

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New Patient History

Patient Information

Patient First Name	Middle Name	Last Name	sex
Marital Status	Date of birth (age)	Social Security #	Patient Address
City	State	Zip	Home phone #
Email address	Referred By	Primary Care Physician	Primary Care Physician #

OB History

Total # of Pregnancies ____ # Of Miscarriages ____ # Of Abortions ____
Of Premature Births ____ # of Term Births ____ # Of Living Children ____
Birth Date Type Of Delivery Weeks Pregnant Birth Weight Sex

_____
_____
_____
_____

Pregnancy Complications ☐ Diabetes ☐ High Blood Pressure ☐ Other _____
History of depression before or after pregnancy? ☐ Yes ☐ No _____

GYN History

How old were you when you had your first period? _____
Are your cycles regular/monthly? ☐ Yes ☐ No
How many days does your period last? _____
If in menopause, at what age did it occur? _____
Are you currently sexually active? ☐ Yes ☐ No
If not, have you ever been sexually active? ☐ Yes ☐ No
When was your last pap smear? _____
Have you had any abnormal pap smears? Yes No When? _____
Have you had any treatments for abnormal pap smears? Yes No
Have you ever been treated for any sexually transmitted diseases/infections? Yes No if yes, what year(s)?
When was your last mammogram? _____
Have you had any abnormal mammogram? Yes No
Have you had any breast biopsies? Yes No
Do you do breast self-examination? Yes No

Medical History

Cancer Yes No
Diabetes Yes No
Hypertension Yes No
Kidney Disease Yes No
Psychiatric disorder Yes No
Seizures/ Epilepsy Yes No
Thyroid Disease Yes No
Other_____

Surgical History

List any surgeries you have had and the approximate date.
Example: tonsillectomy, appendectomy, gallbladder, tubal ligation, breast surgery/ biopsy, laparoscopy

_____
_____
_____

Would you accept a blood transfusion if it was medically necessary? Yes No

Family History List any MEDICAL CONDITIONS of your relatives
Mother/ Father Living/ Deceased _____
Siblings_____
Diabetes Yes No
Hypertensions Yes No
Thyroid disease Yes No
Cancer Yes No
Psychiatric illness Yes No
Other Yes No_____

Social History

Occupation
Marital status Single Married Separated Divorced Widowed
Tobacco Yes No
Alcohol Yes No
Drugs Yes No
Exercise

Medications (including over the counter medications and supplements)

List any medications or foods that you are ALLERGIC to (and the reaction)

Food Medication

_____ _____
_____ _____
_____ _____
_____ _____