

PATIENT REGISTRATION



JENNY FREDRICKSON, DNP, FNP
DEBORAH VERUCCHI, MSN, CNP

Today's Date:

Last Name		First Name	
Date of Birth	Mailing Address		
SSN	Mailing City	Mailing State	Mailing Zip
Occupation	Employer		
Contact Telephone	Patient Email		
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Marital Status	Spouse Name	Spouse Phone	
Emergency Contact	Emergency Contact Phone	Relationship to Patient	
Insurance Company	Group Number	Policy Number	
Policy Holder Name	Policy Holder Date of Birth	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (Specify) Relation to Policy Holder	
Policy Holder SSN	Policy Holder Phone		
Policy Holder Address	City	State	Zip
Responsible Party Name <input type="checkbox"/> Same as Insurance Policy Holder	Responsible Party Date of Birth	Responsible Party Phone	
Responsible Party Address	City	State	Zip
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other (Specify) Relationship to Patient			
<input type="checkbox"/> Google <input type="checkbox"/> Facebook <input type="checkbox"/> Yelp <input type="checkbox"/> Already a Patient <input type="checkbox"/> Another Patient (Specify) <input type="checkbox"/> Doctor (Specify) <input type="checkbox"/> Other (Specify) How Did You Hear About Our Clinic?			
Pharmacy Name	Pharmacy Phone		
Pharmacy Address	City	State	Zip
Privacy Management - Protected Health Information and Communications: I hereby authorize release of my health information (PHI), including account status, test results, scheduled appointments, and information regarding my treatment, to persons I have listed below. Any person who is not listed will not be able to obtain protected health information. It is not necessary to list other treating physicians or insurance companies.			
1. Name of Authorized Person	Relationship	Phone	
2. Name of Authorized Person	Relationship	Phone	
3. Name of Authorized Person	Relationship	Phone	

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Authorization for Use and Disclosure of Protected Health Information	
Patient Name	Date of Birth
May we leave a message on your phone? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do we have consent to text your cell? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do we have consent to email you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
May we leave normal lab results on any of your contact numbers or email addresses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Preferred number to call with lab results or appointments:	
I acknowledge and agree to adhere to the Notice of Privacy Practices as required by federal and state guidelines. I have been provided a copy of the Notice of Privacy Practice and understand that I may request and review a copy of these Practices at any time from the office staff. I permit the release of any information, including my medical records that may be requested by my insurance company to process any claims.	
Patient Signature	Date

CONSENT TO TREAT

- I hereby give my permission to The Women’s Clinic At The Grove for medical treatment including but not limited to examination, injections, blood tests, diagnostic testing, or medical procedures deemed necessary and appropriate for diagnosis and treatment.

PAYMENT POLICY

- I understand I am financially responsible for payment of all charges at the time services are rendered including any charges in excess of my insurance as reasonable and customary, whether or not covered by Medicare or other insurance. I understand that I am responsible for verifying my insurance coverage and verifying my benefits with my insurance company.
- It is policy for The Women’s Clinic At The Grove to collect all patient balances, co-pays, and deposits due from patients at time of service.
- If you are being seen for certain surgical or medical procedures, our office may contact your insurance carrier to verify insurance coverage and benefits. Your financial responsibility will be determined according to contractual agreement between The Women’s Clinic At The Grove and your insurance company for these services.
- If your insurance claim is denied due to incorrect personal information or insurance information that you have provided, you will be billed for any unpaid claims for your services and payment in full will be due immediately.
- Your health insurance may not provide coverage for all medical services, tests, and/or procedures that our providers may offer or recommend for your treatment. It is your responsibility to know and understand the services covered by your insurance, and if your insurance does not cover these services, you will be responsible for payment.
- If you do not have medical coverage with an insurance for which The Women’s Clinic participates or if you are a new patient and cannot supply your new insurance card or for which coverage cannot be determined, you must pay in full at time of service.
- Certain labs collected in this office may be sent to an outside lab for testing. As such, you may be billed by that reference lab for these.

RETURNED CHECK CHARGE

- The Women’s Clinic At The Grove will charge the patient account \$25.00 for any returned checks to cover The Women’s Clinic’s cost for any related bank charges.

WELLNESS/ANNUAL VISITS WITH OTHER PROBLEMS

- If during your annual/wellness exam, you have or need treatment for a problem and the problem is addressed during the visit in lieu of scheduling a separate appointment, in addition to the preventive exam it may be necessary that a problem/E&M visit be billed along with other labs, testing, and/or procedures, which may be subject to copays and/or deductibles.

MISSED APPOINTMENTS

- Please provide a 24 hour notice if you need to cancel or reschedule your appointment.
- Appointments missed without a notice may incur a missed appointment fee of \$25.

PRACTICE GUIDELINES

- Routine medication refills are called in only during office hours. We do not refill prescriptions after hours on weekends.
- Requests for narcotic prescriptions will not be granted over the phone. An appointment is required.
- If you have questions for the nurse or provider, leave a message on your provider’s nurse’s voice mail. We will return your call as soon as possible, giving priority to scheduled patients in office.
- If you call after 3:00 pm, your message may not be returned until the following business day.
- Physician excuses for days missed from work or school are written only for the days you are seen in our office and additional days needed for recovery. We are unable to write excuses for illnesses not evaluated in our office. We will not back date excuses.

Signature _____ **Date** _____



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PATIENT MEDICAL HISTORY



JENNY FREDRICKSON, DNP, FNP
DEBORAH VERUCCHI, MSN, CNP

Today's Date:

Appointment Date:

Last Name		First Name	
Date of Birth	Age	Phone	
Reason for Today's Visit: <input type="checkbox"/> Routine Checkup <input type="checkbox"/> Problem Visit <input type="checkbox"/> Follow Up			
Describe Your Problem(s): _____			

This section relates to medical conditions you have experienced **BOTH** currently **AND** in the **PAST**.
 If you have ever been treated for any of these conditions, please check **"YES"**

Medical Condition	Yes	No	Medical Condition	Yes	No	Medical Condition	Yes	No
Abnormal Pap Smear			Kidney Infections			Irritable Bowel Syndrome		
Abnormal Uterine Bleeding			Kidney Stones			Celiac or Crohn's Disease		
Fibroid Tumors			Urinary Disease					
Infertility			• Incontinence			Hepatitis/Jaundice		
Chlamydia			• Overactive Bladder			Liver Disease		
Gonorrhea			Urinary Tract Infections					
Herpes Simplex Virus - HSV						Arthritis/Joint Pain		
Human Papilloma - HPV			Anemia			Bone Fractures		
Sexually Transmitted Disease			Blood Transfusions			Osteopenia		
			Heart Disease			Osteoporosis		
Breast Cancer			Heart Murmur					
Cervical Cancer			High Blood Pressure			Anxiety		
Ovarian Cancer			High Cholesterol			Depression		
Uterine Cancer			DVT/Blood Clot			Mood Disorders		
Other Cancer (List)			Stroke			Neurological Disorder		
			Heart Attack			ADD/ADHD		
			Diabetes			Asthma		
			Thyroid Disease			Chronic Lung Disease		
			Other (List):					

Screenings Examinations History			Prior Surgeries, Hospitalizations, & Office Procedures	
Examination Type	Date	Results	Type	Date
Pap Smear				
Mammogram				
Colonoscopy				
Bone Density				
Cholesterol				
Other Labs				

Medications Taken
Include over the counter, herbal and natural remedies, vitamins and supplements

Medication Name	Strength mg, mcg, IU, g, etc.	How often do you take the medication?	Prescriber	Check here if not a prescription

List any additional medications on a separate sheet and bring it with you to your appointment

Allergies

Medication Name	List Others:
<input type="checkbox"/> Penicillins	<input type="checkbox"/> NSAIDS (Like Naproxen)
<input type="checkbox"/> Sulfa (Sulfonamides)	<input type="checkbox"/> Opioid Analgesics
<input type="checkbox"/> Tetracyclines	<input type="checkbox"/> Iodine (Including Shellfish)
<input type="checkbox"/> Fluoroquinolones (Like Cipro)	<input type="checkbox"/> Seasonal
<input type="checkbox"/> Latex	

Gynecological History

First day of your last normal period: _____ I am no longer having periods

Describe your menstrual periods: Regular Irregular Light Medium Heavy Passing Clots

Do you experience cramps? Yes No Describe: Mild Moderate Severe

Are you currently sexually active? Yes No Birth control method: _____

History of abnormal pap smear? Yes No Details: _____

Obstetrical History

Total number of pregnancies: _____ Total number of living children: _____

Full Term: _____ Preterm: _____ Elective Abortions: _____ Miscarriages: _____

List Deliveries:

Date:	<input type="checkbox"/> Term <input type="checkbox"/> Preterm	<input type="checkbox"/> Vag <input type="checkbox"/> C/S	<input type="checkbox"/> Girl <input type="checkbox"/> Boy	Birth Weight:
Date:	<input type="checkbox"/> Term <input type="checkbox"/> Preterm	<input type="checkbox"/> Vag <input type="checkbox"/> C/S	<input type="checkbox"/> Girl <input type="checkbox"/> Boy	Birth Weight:
Date:	<input type="checkbox"/> Term <input type="checkbox"/> Preterm	<input type="checkbox"/> Vag <input type="checkbox"/> C/S	<input type="checkbox"/> Girl <input type="checkbox"/> Boy	Birth Weight:

Family History - Blood Relative Medical History

Condition	Relationship of Relative(s) Diagnosed with Condition								Alive or Deceased	Age at Death
	Mother	Father	Maternal GM	Maternal GF	Paternal GM	Paternal GF	Sibling	Child		
Breast Cancer										
Ovarian Cancer										
Uterine Cancer										
Colon Cancer										
Lung Cancer										
Other Cancer										
Depression/Anxiety										
Dementia										
Diabetes										
Heart Disease										
High Blood Pressure										
Stroke										
Other:										

Social History

Occupation:

Marital Status: Single Married Divorced Widowed Separated Engaged

Who do you live with? Alone Spouse Significant Other Children Parents Other:

Do you smoke or vape? Yes No

Type and amount per day: Want to quit? Yes No

Do you drink alcoholic beverages? Yes No If yes, how many drinks per week?

Do you use any type of illicit drugs or substances? Yes No If yes, what type(s)?

Do you have a history of sexual abuse? Yes No

Do you have a history of physical abuse? Yes No

Are you currently in a situation or relationship that makes you feel uncomfortable or threatened? Yes No

Have you had a new sexual partner in the past year? Yes No



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