## PATIENT REGISTRATION

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 | | |
| ☐ Single ☐ Married ☐ Divorced ☐ Widowed<br>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 | ☐ Self ☐ Spouse ☐ Child ☐ Other (Specify)<br>Relation to Policy Holder | |
| Policy Holder SSN | Policy Holder Phone | | |
| Policy Holder Address | City | State | Zip |
| Responsible Party Name ☐ Same as Insurance Policy Holder | Responsible Party Date of Birth | Responsible Party Phone | |
| Responsible Party Address | City | State | Zip |
| ☐ Self ☐ Spouse ☐ Parent ☐ Other (Specify)<br>Relationship to Patient | | | |
| ☐ Google ☐ Facebook ☐ Yelp ☐ Already a Patient ☐ Another Patient (Specify) ☐ Doctor (Specify) ☐ Other (Specify)<br>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 |

5740 Getwell Road • Building 1, Suite B • Southaven, Mississippi 38672
Phone 662.470.7969 • Fax 844.830.7467 • info@wcgrove.com

| Authorization for Use and Disclosure or Protected Health Information | |
|---|---|
| Patient Name | Date of Birth |
| May we leave a message on your phone? ☐ Yes ☐ No | |
| Do we have consent to text your cell? ☐ Yes ☐ No | |
| Do we have consent to email you? ☐ Yes ☐ No | |
| May we leave normal lab results on any of your contact numbers or email addresses? ☐ Yes ☐ 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

Today's Date:

Appointment Date:

| Last Name | First Name | |
|---|---|---|
| Date of Birth | Age | Phone |

Reason for Today's Visit: ☐ Routine Checkup ☐ Problem Visit ☐ 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: |
|---|---|---|
| ☐ Penicillins | ☐ NSAIDS (Like Naproxen) | |
| ☐ Sulfa (Sulfonomides) | ☐ Opioid Analgesics | |
| ☐ Tetracyclines | ☐ Iodine (Including Shellfish) | |
| ☐ Fluoroquinolones (Like Cipro) | ☐ Seasonal | |
| ☐ 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: | ☐ Term ☐ Preterm | ☐ Vag ☐ C/S | ☐ Girl ☐ Boy | Birth Weight: |
| Date: | ☐ Term ☐ Preterm | ☐ Vag ☐ C/S | ☐ Girl ☐ Boy | Birth Weight: |
| Date: | ☐ Term ☐ Preterm | ☐ Vag ☐ C/S | ☐ Girl ☐ 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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## Authorization for Release of Records TO The Women's Clinic At The Grove, LLC

**Name** _____ **DOB** _____ **Date** _____

I, _____ , do hereby authorize the following facilities _____

_____

_____

to release to **The Women's Clinic At The Grove, LLC** the medical records prepared by personnel of the clinic, hospitals, staff physicians/providers or other health care providers between the dates of _____ and _____ relating to my care in said facility for the purpose of continuity of care.

**The information released shall include the following types of treatment:**

☐ **Entire Medical Record**

☐ Radiology Reports ☐ Lab Results ☐ Operative Reports

☐ Other _____

_____

I **DO NOT** want the following information released: _____

**Expiration Date:**

- This will expire **six (6) months** after the date recorded below.
- This authorization covers only treatment prior to the date recorded below.
- I understand I may revoke this authorization at any time with a written request to the Health Information Management Department of the facility listed above. The request to revoke authorization must contain the signature of the patient.
- Revocation of this authorization is allowable only to the extent that the release of the information has not already occurred and/or only if facility has not taken action in reliance thereon.
- I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization.
- I further understand that any disclosure of records concerning diagnosis and/or treatment for alcohol or drug abuse is covered by Title 42 of the Code of Federal Regulations, and if there is any such information, I hereby authorize the release of the information.
- This authorization also includes any information related to diagnosis and/or treatment of any genetic condition, psychiatric or mental illness and/or any state of infection with the HIV (AIDS) virus.
- This authorization covers materials considered "hospital records" reasonably capable of being reduced to printed form.

**The Women's Clinic at the Grove and its affiliates** are hereby released from all legal liability that may arise from the release of the information requested. Please note that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under the applicable federal law.

Signature _____ Date _____

Relationship of Signed by Other Than Patient _____ Social Security _____

Street Address _____

City _____ State _____ Zip _____

Phone _____