Keller OBGYN

Rozalyn Love, MD, FACOG **Wendy Orr, CRNP**
P: 256-383-3372 F: 256-386-7109

PATIENT INFORMATION

Full Name: _____ Preferred Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone Number: (____)_____ Cell Phone Number: (____)_____

SS#: _____ Gender: M / F DOB: _____ Age: _____

Email Address: _____ **Marital Status (circle one):** **S M W D**

Race (circle one): White Hispanic American Indian Pacific Islander African American Asian Native Hawaiian Decline

Occupation: _____ □ Disabled □ Retired □ Unemployed

Employer: _____ Work Phone Number: (_____)_____

Spouse's Name: _____ DOB: _____ SS#: _____

Cell Phone Number: (_____)_____ Email Address: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Financially Responsible Party/Guarantor *(Please complete the following if the patient is under 18)*:

Name: _____ Relationship:_____ DOB:_____

Street Address:_____ Phone Number:_____

City: _____ State: _____ Zip Code: _____ County: _____

Primary Insurance:_____ **Secondary Insurance:** _____

*** I authorize HH System Clinics to leave the following messages on my answering machine/voicemail:*

☐ Appointment reminders ☐ Lab and/or Test results ☐ Leave a message to return your call ONLY ☐ Do not leave a message

HIPAA/PROTECTED HEALTH INFORMATION DISCLOSURE □ **None Authorized**

I understand that the information in my health record may include information relating to sexually transmitted diseases, AIDS or HIV. It may also include information about behavioral or mental health, and treatment for alcohol and drug abuse. I authorize the use, release and disclosure of my protected health information including: diagnosis, records, and examinations to the individuals listed below. **I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing to the medical record department. This authorization will remain in effect until terminated or changed by me in writing.**

NAME	DOB	RELATIONSHIP	PHONE NUMBER

Signature: _____ **Date:** _____

Keller OBGYN

Patient: _____
DOB: _____

NOTICE OF PRIVACY PRACTICES

HH SYSTEM CLINICS ADVANCE DIRECTIVE POLICY
In our practices we have decided that we will initiate resuscitative measures anytime they are needed.

FINANCIAL FEES AND ASSISTANCE
FINANCIAL ASSISTANCE: I understand that financial assistance may be available for individual patients who are uninsured or who otherwise meet financial aid criteria. The hospital's overall ability to remain financially stable and provide essential health care services to all members of our community is dependent upon financial resources available to cover services provided to patients. My assistance in providing such information is necessary to determine possible financial aid available to me. If I am uninsured and need financial assistance, I may contact a Financial Counselor and make a request to see if I qualify at 256-265-9438.

AUTHORIZATION OF TREATMENT
I hereby consent and authorize my physician and/or Allied Health professional to render usual and customary medical/emergency treatment that they deem advisable and necessary. I also authorize HH System Clinics to electronically request my medication history if my pharmacy participates in electronic prescribing in order to assist the provider in prescribing necessary medication therapy.

ASSIGNMENT OF BENEFITS, AGREEMENT AND GUARANTY
I authorize HH System Clinics to release any information regarding services rendered to me to third party payers in consideration of payment for my care or to other healthcare providers involved in my care. I understand payment of all insurance benefits, basic and major medical for this period of service must be made directly to HH System Clinics. If the check must be made out to me, I understand the check must be sent to this address: PN Billing P.O. Box 2705 Huntsville, AL 35804. I understand the HH System Clinics must collect for all charges not covered by insurance payments. Payment for all collection costs, securing, or attempting to collect and secure including reasonable attorney fees or Collection Agency fees, whether suit be necessary or otherwise is the financial responsibility of the patient and guardian. Patients who are considered a legal adult are financially responsible for all services rendered.

HH HEALTH SYSTEM NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT
I acknowledge that a copy of the Notice of Privacy Practices for HH Health System has been made available to me. In connection with the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents. I understand that the most current version of the Notice will be posted with the Health System and on www.huntsvillehospital.org.

EXPRESS PERMISSION TO CONTACT PATIENT BY CELL PHONE
I agree in order for HH System Clinic to service my account or to collect monies I owe, HH System Clinics and/or our agents may contact me by any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. HH System Clinics may also contact me by sending text messages or emails, using any email address I provided. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

I have read this disclosure and agree that HH System Clinics, its employees, and/or agents may contact me as described.

Patient Signature: _____

Date: _____

OR

Authorized Rep. (Print): _____

Relationship to patient: _____

Authorized Rep. (Signature): _____

Date: _____

Keller OBGYN

Patient: _____
DOB: _____

MEDICAL HISTORY

GYN HISTORY/PROBLEMS

□ **No previous GYN problems**

Please check if you have or ever have ever been diagnosed with any of the following problems:

□ Abnormal Pap Smear
□ Bartholin Cyst
□ Bleeding Between Periods
□ Breast Cancer
□ Breast Lump
□ Cervical Cancer
□ Cervical Dysplasia
□ Chronic Vaginal Infections
□ Chronic Pelvic Pain
□ Endometrial Hyperplasia
□ Endometriosis
□ Fibrocystic Breast
□ Habitual Aborter (>3 Miscarriages)
□ Heavy Periods
□ Infertility
□ Lichen Sclerosis
□ Ovarian Cancer
□ Ovarian Cyst
□ Pelvic Inflammatory Disease
□ Prolapse
□ Severe Cramps
□ Sexually Transmitted Disease
□ Chlamydia □ Syphilis
□ Gonorrhea □ HIV
□ Herpes □ Trichomonas
□ Urinary Incontinence
□ Uterine Cancer
□ Uterine Fibroids
□ Vaginal Burning
□ Vaginal Itching
□ Other _____

GYN PERIOD HISTORY

Age at first period _____
Length of Period _____
Frequency of period _____
Menstrual Flow □ light □ medium □ heavy
HPV vaccine □ YES □ NO
Self-breast exams □ YES □ NO
Hormone Replacement Therapy if menopausal □ YES □ NO

SURGICAL HISTORY

□ **No previous surgeries**

Check all of the following surgeries/procedures you have had & indicate your age &/or year:

	AGE	YEAR		AGE	YEAR
□ Arthroscopy:			□ Sinus Surgery		
□ Appendectomy/Appendix			□ Tonsillectomy		
□ Cataract			□ Tonsillectomy/Adenoid		
□ Cardiac Surgery			□ Tubes in Ears		
□ Cystoscopy			□ Wisdom Tooth Extraction		
□ Gallbladder Removal			□ Other:		
□ Hip Replacement: R or L			□ Other:		
□ Knee Replacement: R or L			□ Other:		

□ Breast Augmentation / Lift	AGE	YEAR	□ D&C	AGE	YEAR
□ Breast Biopsy			□ Endometrial Biopsy		
□ Breast Reduction			□ Tubal Ligation		
□ Cesarean Section			□ Hysterectomy Abd / Vag		
Cervical Procedure(s)			□ Laparoscopy		
□ Cone Biopsy			□ Laparotomy		
□ Cryo			□ Mastectomy: R or L		
□ Laser			□ Ovaries Removed: R / L / B		
□ LEEP			□ Other:		
□ Colposcopy			□ Other:		

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Patient: _____
DOB: _____

MEDICAL HISTORY CONTINUED

SCREENINGS & RESULT	YEAR		YEAR
□ **Breast Mammogram** □ Abnormal		□ **PAP Smear** □ Abnormal	
□ **DEXA scan / Bone Density** □ Abnormal		□ **Colonoscopy** □ Abnormal	

MEDICAL HISTORY □ **Not Applicable**

Please check if you have or have ever been diagnosed with any of the following conditions:

□ Anemia
□ Arthritis
□ Asthma
□ Blood Clot (PE, DVT)
□ Blood Transfusion
□ Bowel Problems
□ Chronic Urinary Infection
□ Diabetes (type _____)
□ Elevated Cholesterol
□ Epilepsy
□ Fibromyalgia
□ Heart Problems
□ Angina □ Heart Disease
□ Heartburn/Reflux
□ Hepatitis (type_____)
□ High Blood Pressure
□ Kidney Stones/Disease
□ Lupus
□ Migraines
□ Obesity
□ Osteoporosis
□ Psychiatric Disorder
□ Bipolar Disorder □ Compulsive/Obsessive
□ Depression □ Schizophrenia
□ Stroke
□ Thyroid Disorder
□ Hyperthyroid □ Hypothyroid
□ Goiter □ Graves Disease
□ Other _____
_____
_____

FAMILY MEDICAL HISTORY □ **Unknown** □ **Patient Adopted** □ **None**

Please list the immediate family members (mother, father, sister, brother) that has been diagnosed or treated for the following:

Breast Cancer		Thyroid Disease	
Colon Cancer		Osteoporosis	
Ovarian Cancer		Epilepsy	
Diabetes		Kidney Problems	
Hypertension		Lung Problems	
Stroke		Problems with Anesthesia	
Heart Disease		Other:	

SOCIAL HISTORY

Substance Use	**Type**	**Amount/Day**	**#Years**	**#Years Quit**
Tobacco Use: □ NO □ YES □ FORMER				
Caffeine Use: □ NO □ YES □ FORMER				
Alcohol Use: □ NO □ YES □ FORMER				
Illicit Drug Use: □ NO □ YES □ FORMER				

Sexual Preference: □ Men □ Women □ Both
Sexually Active: □ YES □ NO **Use Condoms:** □ YES □ NO
History of Physical or Sexual Abuse? □ YES □ NO
Accept Blood Transfusion: □ YES □ NO

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Patient: _____
DOB: _____

MEDICATION(S) HISTORY

MEDICATION QUESTIONNAIRE ☐ No Known Medication Allergies

Medication allergies and reactions: _____

_____

Pharmacy: _____ **Location:** _____

MEDICATION LIST ☐ No Home Medications

Please include all over the counter medication and prescription medications.

MEDICATIONS	DOSE/STRENGTH	# OF PILLS/AMT	TIMES/DAY

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DOB: ______________________

OBSTETRICAL HISTORY

OBSTETRICAL SOCIAL HISTORY ☐ **Not Pregnant**

Father of Baby: ______________________________________ **DOB:** ___________ **PHONE:** ______________________________

OBSTETRICAL HISTORY ☐ **No Previous Pregnancy**

Please fill out for each pregnancy even if it was a miscarriage or abortion. *If you have had a tubal ligation, hysterectomy, or are over the age of 60, only date and type of delivery are necessary.*

Preg. #	Delivery Type	DOB	Gestational Age	Birth Weight	Sex	Hospital	Doctor	Complications
	☐ Miscarriage ☐ Vaginal Del. ☐ C-Section ☐ Abortion		☐ Term (>37 wks) ☐ Preterm (<37wks)		☐ M ☐ F			
	☐ Miscarriage ☐ Vaginal Del. ☐ C-Section ☐ Abortion		☐ Term (>37 wks) ☐ Preterm (<37wks)		☐ M ☐ F			
	☐ Miscarriage ☐ Vaginal Del. ☐ C-Section ☐ Abortion		☐ Term (>37 wks) ☐ Preterm (<37wks)		☐ M ☐ F			
	☐ Miscarriage ☐ Vaginal Del. ☐ C-Section ☐ Abortion		☐ Term (>37 wks) ☐ Preterm (<37wks)		☐ M ☐ F			
	☐ Miscarriage ☐ Vaginal Del. ☐ C-Section ☐ Abortion		☐ Term (>37 wks) ☐ Preterm (<37wks)		☐ M ☐ F			
	☐ Miscarriage ☐ Vaginal Del. ☐ C-Section ☐ Abortion		☐ Term (>37 wks) ☐ Preterm (<37wks)		☐ M ☐ F			