

## Patient Registration

### Patient Information:

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Sec. #: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Email address: \_\_\_\_\_ May we contact you by Email: Yes / No

### Work information:

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Occupation: \_\_\_\_\_

### Spouse Information:

Spouse's Name \_\_\_\_\_ Spouse's Cell: \_\_\_\_\_

Spouse's Date of Birth: \_\_\_\_\_ Spouse's SS: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Spouse's Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Occupation: \_\_\_\_\_

### General Information

Who may we thank for your referral to us? \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_

Who is responsible for payment of this account? \_\_\_\_\_

Emergency contact (other than spouse) \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## Patient Registration

### Primary Insurance

Patient's Relationship to insured: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Insurance Company's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Group #: \_\_\_\_\_ ID#: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### Secondary Insurance

Patient's Relationship to insured: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Insurance Company's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Group #: \_\_\_\_\_ ID#: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

# Health Questionnaire

## General Information:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Referred by: \_\_\_\_\_

Reason for today's visit: Annual exam \_\_\_\_\_ or/ Problem \_\_\_\_\_

If Problem visit (a brief description) \_\_\_\_\_

\_\_\_\_\_

**Gynecologic History:** Last Period \_\_\_\_\_ Age at onset \_\_\_\_\_ Frequency \_\_\_\_\_

Length \_\_\_\_\_ Last Pap Smear \_\_\_\_\_ Contraception \_\_\_\_\_ Past Methods \_\_\_\_\_

Last Mammogram (if over 40) \_\_\_\_\_ Total Pregnancies \_\_\_\_\_ Miscarriages \_\_\_\_\_

Current Symptoms (check if present): discharge \_\_\_\_\_ Odor \_\_\_\_\_ Hot flashes \_\_\_\_\_

Mood swings \_\_\_\_\_ Urinary Frequency \_\_\_\_\_ Painful periods \_\_\_\_\_ Heavy period \_\_\_\_\_

**Past Medical History (Self: S or Family: F)**

- |                                  |       |                                   |       |
|----------------------------------|-------|-----------------------------------|-------|
| 1. Wt Loss/ Gain                 | _____ | 13. Anemia/ Blood Diseases        | _____ |
| 2. Headaches/ Migraines          | _____ | 14. Blood transfusion             | _____ |
| 3. Heart Disease                 | _____ | 15. Varicose veins/ phlebitis     | _____ |
| 4. Hypertension                  | _____ | 16. Thyroid Disease               | _____ |
| 5. Respiratory Disease           | _____ | 17. Diabetes                      | _____ |
| 6. Breast Disease                | _____ | 18. Cancer                        | _____ |
| 7. Jaundice/ Hepatitis           | _____ | 19. Epilepsy/ Neurologic diseases | _____ |
| 8. Gall Bladder Disease          | _____ | 20. Arthritis/ Osteoporosis       | _____ |
| 9. Peptic Ulcer/ hernia          | _____ | 21. Skin Diseases                 | _____ |
| 10. Kidney Disease               | _____ | 22. Anxiety/ Depression           | _____ |
| 11. Bowel Disorders              | _____ | 23. Sleep Disturbances            | _____ |
| 12. Ur. Incontinence/ Infections | _____ |                                   |       |

**Past Surgical History**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Allergies**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Medications**

1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  4. \_\_\_\_\_
  5. \_\_\_\_\_
-

## Consent for Treatment

I authorize and consent to the rendering of medical care, including diagnostic procedures and medical treatment by authorized members of Accent Women's Health and Dr. Hal Bradford MD as many in their professional judgment may be necessary for the below named patient. I acknowledge that no guarantees have been made as to the effect of such examinations and treatment.

## Assignment of Insurance Benefits

Patient-Physician Agreement: I, the undersigned, authorize Accent Women's Care and Dr Hal Bradford to release any information required in the course of my examination or treatment to my insurance company(s) or another physician. I, recognizing that medical insurance I possess may not completely cover the fee(s) for professional service rendered me, hereby agree that I am responsible for said fee(s). I authorize payment directly to and to me for their services. A photocopy hereof shall be valid as the original. I am aware that I may inquire of my physician the fee(s) for any professional services required and/or rendered.

## Authorization to Release Information

I authorize Accent Women's Health and Dr Hal Bradford to release any information requested by the insurance company necessary to collect benefits under any policy we make claim against for services rendered on this or a related date of service.

## Guarantee of Payment

I understand that office visits are to be paid for at the time of service unless other arrangements have been made. I understand that I am responsible for the balance not covered by insurance. I understand that Accent Women's Health and Dr Hal Bradford does not accept any insurance policy assignment as a guarantee of full payment.

**Patient:** \_\_\_\_\_ **ID:** \_\_\_\_\_

\_\_\_\_\_ **Date:** \_\_\_\_\_

Signature of Patient (or Parent or Guardian if under 18 years of age)

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## Release of Information

You may discuss information (Medical, Billing, Etc.) with: \_\_\_\_\_

I authorize the release of any medical information necessary to process my claim to all my insurance companies. I authorize direct payment of medical benefits to the provider. I permit a copy of this authorization to be used in place of the original. I understand that I am responsible for any amount not covered by insurance. I permit the faxing of medical information to other health care providers involved in my care. I, the undersigned, authorize and consent to the rendering of medical care, including diagnostic procedures and medical treatment by authorized members of Accent Women's Health or their designees, as may in their professional judgment be necessary for the above named patient. I acknowledge that no guarantees have been made as to the effect of such examinations. I have received a copy of the Notice of Privacy Practices of the clinic.

\_\_\_\_\_ Date: \_\_\_\_\_

Signature (Patient/Parent or Guardian)

## Consent For Electronic Transmission

### Of Medical Records

I understand that my medical records may be transmitted by electronic methods, such as a FAX machine or internet. I hereby give consent, with the knowledge that my records might be received by another party, in error, due to possible connection errors in the phone, computer or FAX systems.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**Accent Women's Health**

**Chart # \_\_\_\_\_**

3000 N. Market Ave., Ste. E

Fayetteville, Arkansas 72703

Phone: (479)444-1440

Fax: (479)444-1447

## **Authorization To Release or Obtain Medical Information**

**Patient Name:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_ **Social Security:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**I hereby authorize Accent Women's Health to:**

**Release information to:**

**Obtain information from:**

\_\_\_\_\_  
**Name of Facility or Person**

\_\_\_\_\_  
**Name of Facility or Person**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**City, State, Zip**

\_\_\_\_\_  
**City, State, Zip**

\_\_\_\_\_  
**Area code+ Telephone**

\_\_\_\_\_  
**Area Code + Telephone**

**Expiration date. This authorization shall automatically expire within 120 days from the date of the signature below or upon written notice.**

**Please Check the Type of Records to be obtained/released:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Complete Medical Record     | <input type="checkbox"/> Consultation      | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Discharge Summary           | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Laboratory Tests  |
| <input type="checkbox"/> Operative Reports           | <input type="checkbox"/> EKG               | <input type="checkbox"/> X-Rays            |
| <input type="checkbox"/> History and Physical        | <input type="checkbox"/> ER Record         | <input type="checkbox"/> Billing           |
| <input type="checkbox"/> Other Please Specify: _____ |  |  |

**I understand that I may inspect or request copies of any information disclosed pursuant to this authorization. I understand that I may revoke this authorization by notifying Accent Women's Health in writing. I acknowledge and understand that once I sign this authorization Accent Women's Health can rely on it until it expires or I revoke it in writing.**

**I agree to pay any and all fees allowable by law that are incurred by Accent Women's Health in complying with this authorization.**

\_\_\_\_\_  
**Signature of Patient or Legal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Date**