Health Questionnaire

Name:______________________________ Date of Birth: ____________ Age: ______

Reason for Visit: Annual ____ and/or Problem ____ Description of problem(s) ________________

____

Gynecological History: Age @ onset of periods ________

First day of last period ___________ Frequency ________ Length of periods ________

Date of last pap smear ___________ Have you ever had any abnormal pap smear: Y / N

Current contraception ____________________ Past Methods ____________________

Total pregnancies ____ Miscarriages ____ Terminations ____

Date of last mammogram ___________ Location ______________________________

Personal Past Medical History (problems/symptoms/diagnosis): ____________________________

____

Past Surgical History:	**Allergies:**	**Current Medications:**
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

Family Medical History: History of breast, uterine, ovarian, or cervical cancer: Y / N

	Health Problems:
Mother: living / deceased	______________________________
Maternal Grandmother: living / deceased	______________________________
Maternal Grandfather: living / deceased	______________________________
Father: living / deceased	______________________________
Paternal Grandmother: living / deceased	______________________________
Paternal Grandfather: living / deceased	______________________________
Siblings: Sisters: ____	______________________________
Brothers: ____	______________________________

Patient Registration

Name: ______________________________ Home Phone: __________________

Address: ____________________________ Cell Phone: __________________

City: __________________________ State: ______ Zip Code: __________

Date of Birth: __________ Social Security # ________________ Marital Status: ___

Preferred Language: _____________ Race: __________ Ethnicity: __________

Email Address: ________________________ May we contact you by email: Y / N

Employer: ____

Employer Address: _______________________________________

Work Phone: __________________ Ext: ____ Occupation: ________________

Spouse Name: ______________________________ Spouse Cell: ________________

Spouse Date of Birth: __________ Spouse Social Security # ________________

Spouse Employer: _______________________________________

Employer Address: _______________________________________

Spouse Work Phone: ________________ Ext: ___ Occupation: ________________

Whom may we thank for your referral to us? ______________________________

Who is your Primary Care Physician? __________________________

Who is responsible for payment of this account? ______________________________

Alternate contact (other than spouse): ______________________ Relationship: __________

Address: ________________________________ Phone: ________________

Accent Women's Health

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Gynecology/Infertility

Release of Information

You may discuss my **medical** information with:____

You may discuss my **billing** information 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.

Signature (Patient/Parent Guardian) Date

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 of FAX systems.

Signature (Patient/Parent Guardian) Date

Witness

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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 Health 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 do not accept any insurance policy assignment as a guarantee of full payment. I also understand that should I have any account balance turned over to a collection agency, I will be responsible for all costs incurred with collecting my balance owed in full.

____

Patient Name (printed)

____ ____________________

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

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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:

____
Name of Facility or Person

____
Address

____
City, State, Zip

____
Area code + Phone & Fax

Obtain information from:

____
Name of Facility or Person

____
Address

____
City, State, Zip

____
Area code + Phone & Fax

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:

____ Complete Medical Record
____ Discharge Summary
____ Operative Reports
____ History and Physical
____ Consultation
____ Pathology Reports
____ EKG
____ ER Record
____ Radiology Reports
____ Laboratory Tests
____ X-Rays
____ Billing
____ Other (please specify): ____

I understand that I may inspect or request copies of any information disclosed 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 Guardian | Relationship to Patient | Date

______________________________ ______________
Witness | Date

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Summary Notice of Privacy Practices

This summary of our Notice of Privacy Practices informs you of how we may use or disclose your health information. It also explains your rights and duties under current privacy laws.

Our Rights:

We may use and disclose your health information to:

- Provide patient care and treatment
- Process claims to your health plan or insurance company
- Comply with laws that require reporting of your health information.
- Review your records for quality of care
- Remind you of appointments
- Inform you of any health service or benefit that may interest you

Your Rights:

While the records we maintain about you belong to us, you have a number of rights with respect to those records. You have the right to:

- Request a copy of our full privacy notice
- Request a copy of your record
- Request we amend your record if you believe it is not complete or correct
- Request we send information to you in a confidential manner
- Complain to us and/or the US Department of Health and Human Services if you believe we have violated your privacy rights

Our Duties:

We must provide you with our Notice of Privacy Practices and abide by its terms. We may:

- Charge you a fee for copies of your medical records
- Require up to 60 – 90 days to process your request for records
- Deny your request to amend your records for certain reasons if asked, and give you a written reason
- Amend the Notice from time to time, post the revised notice, and make a copy for you upon request.

If you have questions, please contact us at: 479-444-1440

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