

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

Name: _____ Date of Birth: _____ Age: _____

Reason for Visit: Annual _____ and/or Problem _____ If problem visit (a brief description) _____

Gynecological History: Age @ onset of periods _____

First day of last period _____ Frequency _____ Length of periods _____

Date of last pap smear _____ Have you ever had an abnormal pap: Y / N

Current Contraception _____ Past Methods _____

Total Pregnancies _____ Miscarriages _____ Terminations _____

Date of last mammogram (if over 40) _____

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

If yes, who was diagnosed & with which type _____

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 _____

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)

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

"Putting the emphasis on you"

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:

- | | | |
|--|--|--|
| <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 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

Hal Bradford MD, FACOG • Board Certified • www.AccentWomensHealth.com

3000 N. Market Ave., Suite E • Fayetteville, AR 72703 • (479) 444-1440 • Fax: (479) 444-1447