Patient Information

Full Name:____ Maiden/Other:________________________

Date of Birth:_________________ Marital Status:_____________________ SSN:___________________

Address:____

City:_____________________State:_________________________Zip:___________________________

Preferred Phone:______________________________ Circle: Home / Mobile / Work

Secondary Phone:_____________________________ Circle: Home / Mobile / Work

Email Address:____

Employment Status (full/part time, student, retired, etc):______________________________________

Employer:_________________________________ Occupation:_________________________________

Religion:________________________________Language:______________________________________

English fluency? Not at all / Not well / Well / Very well Interpreter needed? Yes / No

Race:_________________________________ Nationality:___________________________________

Ethnicity (Please circle one):

- Are you Hispanic or Latino? Yes / No / Decline to specify / Unknown
- Are you Arab or Chaldean? Yes / No / Decline to specify / Unknown

Emergency Contact Information

Preferred Contact Name:____

Relationship:______________________________ Phone:_______________________________________

Secondary Contact Name (optional):____

Relationship:______________________________ Phone:_______________________________________

Preferred Pharmacy

Name:____

Address:____

Primary Care Physician

Name:____

Location/Phone:____

Patient Medical Information

Name:____ Date of Birth:_______________________________

Whom may we thank for referring you? ____

Why are you seeing the doctor today?

____

Prescription and Over the Counter Medications **(Include strength and frequency)**

Drug Allergies (with reaction): ____

Latex allergy? Yes/No

Gynecological History **(Menopausal patients may skip questions 3-5)**

1. First day of last menstrual period: ____
2. Age of first menstrual period:____
3. Length of cycle (days from start of one period to the next):__________________________________
4. Average period length:____
5. Do you have any menstrual irregularities?____

Have you had or do you currently have any of the following? Please circle Yes or No:

Chlamydia	Y	N	Pelvic Infection	Y	N	Infertility	Y	N
Gonorrhea	Y	N	Trichomonas	Y	N	Herpes	Y	N
AIDS/HIV	Y	N	Syphilis	Y	N	Genital Warts	Y	N
Endometriosis	Y	N	Gyn Cancer	Y	N	Pelvic Pain	Y	N
Fibroid Tumors	Y	N	Vaginitis	Y	N	Abnormal Paps	Y	N

Last pap smear date:____

Last mammogram date:____

Have you ever had an abnormal mammogram?____

Sexual History

Are you sexually active? Yes/No

Are you using any form of birth control currently?____

Have you ever had any problems with birth control?

____

Do you douche? Yes/No   If yes, how often?____

Obstetrical History

Please list all pregnancies, including miscarriages, ectopic and terminations:

Date of delivery or term.	Location of delivery or term.	Duration of Pregnancy	Hrs. of Labor	Type of Delivery	Complications for mother and/or baby	Child		
						Sex M/F	Birth Weight	Present Health

Reason for c-sections, if any: ____

Additional Past Medical History

Have you had or do you currently have problems related to any of the following? Please circle Yes or No:

High Blood Pressure	Y	N	Stomach	Y	N	Bladder	Y	N
Diabetes	Y	N	Seizures	Y	N	Skin Disease	Y	N
TB	Y	N	Lupus/Arthritis	Y	N	Cancer	Y	N
Ears and Eyes	Y	N	Blood Disease	Y	N	Psychological	Y	N
Nose and Throat	Y	N	Breast	Y	N	Kidney	Y	N
Lungs (including Asthma)	Y	N	Musculoskeletal	Y	N	Thyroid	Y	N
Heart	Y	N	Blood Clots/Strokes	Y	N	Liver	Y	N

Please provide brief explanations for any "YES" answers:

____

____

Surgical History

Please provide your surgical history:

Type	Date	Any complications?

Have you ever had any complications related to anesthesia?

____

Family History

Please indicate if any family members have been affected by the conditions listed below:

	Alive? Y/N	Check if past medical history applies					
		High Blood Pressure	Diabetes	Cancer (indicate type)	Clotting Disease	Heart Disease	Other
Mother							
Father							
Siblings							
Children							
Grandparents							

Additional notes for provider:____

Social History

Marital Status:____

With whom do you reside? ____

Do you smoke tobacco? Yes/No Packs per day:____________ How long have you smoked?_________________

Do you drink alcohol? Yes/No How often?_____________________________ How much?___________________

Do you use street drugs? Yes/No What kinds?____

In summation, I have carefully read all of the above questions and the information I have provided is complete and accurate to the best of my knowledge.

Patient Signature:____ Date:___________________________

Physician Signature:____ Date:__________________________

Barbara Hannah, MD, MS, FACOOG
Leanna Alaiwat, MS, PA-C
Jeanne Gray, RNC, CNP
Mary DeLucia, RNC, CNP

Office Policies

We understand that situations may arise where you cannot keep your scheduled appointment. We do our best to accommodate our patients as much as possible. That being said, we do enforce certain polices to ensure our practice runs smoothly. We appreciate advance notice of appointment cancellations so that other patients may benefit from open time slots. Thank you for your consideration.

No Shows

If you miss your appointment without notifying us in advance, this will be recorded as a no show in your chart. After 2 consecutive no shows, you will be charged a fee of $25. This fee must be paid over the phone or in person before any further appointments can be scheduled.

Late Arrivals

We allow a 15-minute grace period for your convenience. If you arrive later than 15 minutes after your appointment time, you may be asked to reschedule at the discretion of the doctor and clinical staff. It is always best to call us as soon as you know you will be late so that we can let you know before you arrive whether you will be accommodated or rescheduled.

By signing below, I attest that I have read and will abide by the office policies listed above.

Print Name:_______________________________ Date of Birth:_______________

Signature:__________________________________ Date:____________________

	Barbara Hannah, MD, MS, FACOOG **Leanna Alaiwat, MS, PA-C** **Jeanne Gray, RNC, CNP** **Mary DeLucia, RNC, CNP**

General Consent for Treatment

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that your consent for treatment is continuing in nature and that it remains in effect until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your health care provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

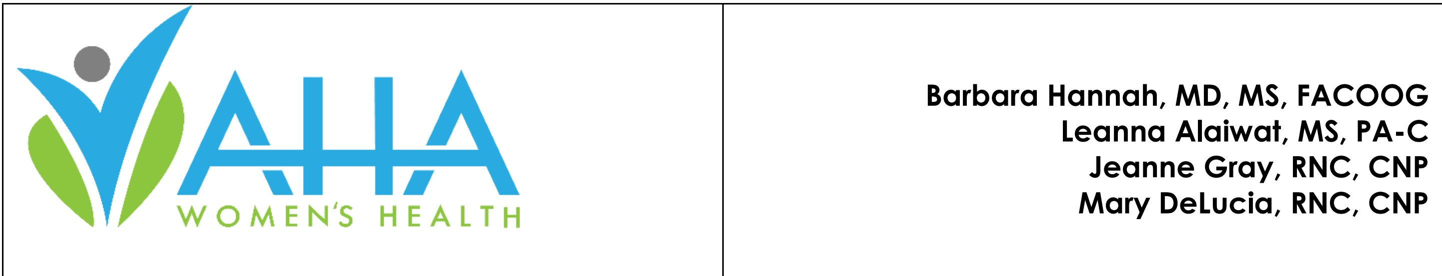
This consent acknowledges that you voluntarily request a physician and/or mid-level provider (Nurse Practitioner or Physician Assistant) and other health care providers to perform the reasonable and necessary medical examination, testing and treatment for the condition which has brought you to seek care at this practice. You understand that if additional testing, invasive, or interventional procedures are recommended, you will be asked to read and sign additional consent forms prior to the test(s) or procedures(s).

This consent also allows Advanced Healthcare Associates to bill your insurance company for services provided to you. By signing, you agree to pay for any services that are not covered by your insurance, including, but not limited to any co-payment, co-insurance, and or deductible.

I certify that I have read and fully understand the above information and consent fully and voluntarily to the contents.

Signature of Patient or Personal Representative:	Date:

Printed Name of Patient or Personal Representative:	Relationship to Patient:



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Acknowledgement of Receipt of Privacy Practice Notice

Date: ______________________

Name: ____

DOB: ______________________

I acknowledge that Advanced Healthcare Associates offered me a copy of the HIPAA Notice of Privacy Practice.

____

Signature of patient or authorized representative*

____

Printed name of authorized representative (if applicable)

*Authorized representatives include (documentation may be necessary):

- Parent of minor
- Legal Guardian
- Personal Representative
- Person under a durable medical Power of Attorney (POA)