Patients Name
Address
City, State, Zip

Provider
Appt Date, Time

Women's Healthcare
Medical-Surgical Specialty Group
135 Newton Sparta Road Suite 201
Newton, New Jersey

PATIENT INFORMATION

Patient Name ______________________________ SS# ______-______-______
Address ______________________________ Date of Birth ____________
Address ______________________________ Age _______
City, State, Zip ______________________________ First Day of Your Last Period
Email ____________________
Home Phone ______________________ Cell Phone ______________________
Work Phone ______________________ Ext ________
Martial Status (circle one) Widowed Married Single Divorce

SIGNIGICANT OTHER/ EMERGENCY CONTACT PERSON

Name ______________________________ Phone __________________
Address ________________________ Relation to Patient ______________
________________________ Date of Birth __________________

INSURANCE INFORMATION

Primary Insurance ____
Policy # __________________________ Group # ___________________
Subscriber's Name ____
Subscriber's SS # ____
Subscriber's Date of Birth ______________ SS# _____________________
Subscriber's Address ____
Relationship to Patient Self Spouse Child

Secondary Insurance ____
Policy # __________________________ Group # _________________
Subscriber's Name ____
Subscriber's SS # ____
Subscriber's Date of Birth ________________ SS# ___________________
Subscriber's Address ____
Relationship to Patient Self Spouse Child

OUTSIDE LABS

Outside labs maybe used for testing the following procedures: lab work, cultures and pap smears. If we participate with your insurance carrier we will send it to the lab they direct us to, otherwise we will send the specimens to labs which we use for the quality of service. Please specify if there is a lab your carrier has an agreement with:

Lab (circle one) Quest Labcorp LabOne Newton Memorial Hospital

Pharmacy ___________________ Pharmacy Phone _________________________

Primary Care Physicain ______________________ Phone Number ______________

Name: ______________________________ Date: ____________________

PAST MEDICAL HISTORY

Please check if you have had any of the following conditions or diseases, indicating date and treatment.

Yes	No	Condition/ Disease	Date	Treatment
___	___	Anemia	______	____________________
___	___	Asthma	______	____________________
___	___	Blood Transfusion	______	____________________
___	___	Blood in Urine or Stool	______	____________________
___	___	Cancer	______	____________________
___	___	Diabetes	______	____________________
___	___	Emotional Disorder	______	____________________
___	___	German Measles (Rubella)	______	____________________
___	___	Heart Problems	______	____________________
___	___	High Blood Pressure	______	____________________
___	___	Infertility	______	____________________
___	___	Kidney/Bladder Problems	______	____________________
___	___	Liver Problems/Hepatitis	______	____________________
___	___	Lung Disease	______	____________________
___	___	Migraine Headaches	______	____________________
___	___	Phlebitis/Blood clots	______	____________________
___	___	Psychiatric Condition	______	____________________
___	___	Rheumatic Fever	______	____________________
___	___	Seizures	______	____________________
___	___	Syphilis/Gonorrhea(STD)	______	____________________
___	___	Thyroid disease	______	____________________
___	___	Tuberculosis	______	____________________
___	___	Other	______	____________________

Do you Smoke? Yes No If Yes, How many cigarettes per day? ____________________

Do you Drink? Yes No If Yes, How many drinks per Day? ____________________

What MEDICATION are you taking? Please list ______________________________

____

____

Do you have ALLERGIES? ______________________________

____

____

Please list any OPERATION / SURGERIES you have had

	DATE	HOSPITAL
1) ______________________________	__________	______________
2) ______________________________	__________	______________
3) ______________________________	__________	______________
4) ______________________________	__________	______________

GYNECOLOGICAL HISTORY:

Last normal menstrual period (first day) _______________ Menarche (age when your period began) ________
Interval between periods ____________________________ Duration of flow__________________________

Abnormal Bleeding? Yes No Describe____

Bleeding after intercourse Yes No Describe ____

Painful intercourse Yes No Describe ____

Infection in Vagina Yes No Describe ____

Date of last Pap Smear _______________ Results ___________________ Where__________________

Date of Last Mammogram ____________ Results ___________________ Where __________________

OBSTETRICAL HISTORY

Total number of pregnancies _______________ Number of abortions __________________
Number of living children _________________ Number of stillborns ______________________
Number of Miscarriages __________________ Date of last Pregnancy ___________________

Are you presently using any method of contraception? Yes No Method ______________________

In the Past, have you used any of the following contraceptive methods:

Method	Date Started	Length of Use	Problem
____ Birth Control Pills	__________	__________	__________________________
____ Condom	__________	__________	__________________________
____ Diaphragm	__________	__________	__________________________
____ Foam	__________	__________	__________________________
____ IUD	__________	__________	__________________________
____ Natural Family Planning	__________	__________	__________________________
____ Other	__________	__________	__________________________

FAMILY HISTORY:

Has any member of your immediate family had cancer, heart disease, diabetes, or a genetic disease?
Yes No If, Yes Explain: ____
____
____

Are there any other health problems which you may not have covered on this form? Yes No
If, Yes Explain: ____
____
____

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I understand that payment of authorized benefits from Medicare. Medicaid, and/or any Insurance Carrier listed, may be made to me or on my behalf to the provider listed on this form, for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release it to the Division of Family Services, the Health Care Financing Administration, listed insurer and or agents of the company and or the listed responsible person(s), any information needed to determine these benefits or the benefit for the related services.

- I acknowledge that I have received information regarding my rights to privacy of information under HIPPA regulations
- I further acknowledge that if I want my protected health information disclosed, I must make that request to the staff and sign a disclosure release.

Print Name ____

Signature: ____ Date: ___________________

GUARANTEE OF PAYMENT: In consideration of services rendered to the patient named herein, I agree to be financially responsible and to pay charges for all services ordered by the physician (s). I understand that any balance due as a result of being uninsured or under-insured is payable immediately. I further understand that if I fail to maintain any payment, my account may be forwarded to their collection agent and /or attorney.
PRE-CERT[illegible]FICATION/REFERRALS: I understand that if my insurance h[illegible] a pre-certification or authorization requirement, it is my responsibility to notify the carrier of services to be rendered according to the plans provisions. I understand that if my insurance requires referrals it is my responsibility to produce one as needed prior to seeing the physician. Failure to do so will result in reduction or denial of benefit payment and I will be respo[illegible] for all balances.

SIG[illegible]D: ________________________________ **RELATIONSH[illegible]** ____________________

WITNESS: ___________________________________ **DATE:** ________________________

CONSENT FOR TREATMENT

Upon my admission t[illegible]e Northwest NJ Medical Surgical Specialty Alliance, I do volu[illegible]ly CONSENT to the rendering of [illegible] care a[illegible] the physicians and personnel, in their judgment, deem [illegible] necessary for my health and well being [illegible]g my admission to said department.

This consent shall include medical examination and diagnostic testing as well as minor surgical procedures (including sutur[illegible]ng), cast application/removals and shall also include the carrying out of the orders of my treating physician by office personnel. I acknowledge that neither the physician nor the office personnel has made any guarantee or assurance as to the results that may be obtained.

I authorize the practice to discuss my health care with the following person(s) Please circle.

No One Husband Wife Mother Father Child Other

Name and Relationship must be written in order for us to comply with NPP.(Notice of Privacy Practices)

____________________ ____

I authorize Medical Surgical Specialty Group to leave health care information on my:

Please Circle One: Cell Phone Home Phone Neither.

I HAVE READ AND UNDERSTAND THIS CONSENT.

____ __________

Patient's Signature (To be signed by parent or legal guardian if p[illegible]ient (Relationship)
is a minor under the age of 18, or a mentally incompetent patient).

______________________________ Date: __________ Time: ________AM/PM

Witness Signature

Medication List – List all medications you are presently taking (including vitamins, over the counter medications, herbal supplements, birth control, hormone replacements, creams and lotions)

Medications	Dosage	How Often?	Ordering Doctor

Patient Name ______________________________ Date ______________________

Date Birth ______________________________