PT ID Number
Last Verified

Patient Information

Last Name _____ First Name _____ M.I. _____ Maiden _____

Street Address _____ Apt. _____ P.O. Box _____

City _____ State _____ Zip _____ DOB _____ Last Four Digits of SS # _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐ Other (1) Home phone: _____

(2) Work phone: _____ Ext _____ (3) Cell Phone: _____ Indicate primary contact #: _____

E-Mail Address _____ Pharmacy : _____

Patient's Employer Information

Employer Name _____ Employer Phone # _____

Employer Address _____
Street City State Zip

Occupation: _____ If Student ☐ Full time ☐ Part time School _____

Insurance Information - Primary / Secondary / Other

Do you have health insurance? ☐ Yes ☐ No

Primary Insurance _____ Copy of Card? ☐ Yes ☐ No

Subscriber _____ DOB _____ Relationship _____

Secondary Insurance _____ Copy of Card? ☐ Yes ☐ No

Subscriber _____ DOB _____ Relationship _____

Spouse's Information

Name _____ Birth Date _____ Last 4 digits of SS# _____

Occupation _____ Employer _____ Employer's Phone # (_____) _____

Employer Address _____

Emergency Information: MUST BE COMPLETED

In case of an emergency / urgent matter, we may contact:

NAME: _____ (_____) _____ Telephone No. _____ Relationship to Patient

Other

Primary Care Physician: _____ Primary Physician in This Office: _____ Referring Physician: _____

Authorization for Treatment, Payment & Healthcare Operations

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. Additionally, I authorize and assign any payment of medical benefits to the Women's Health Professionals, LLP, its successors and assigns, or any individual it may designate for services provided.

As part of this authorization, Women's Health Professionals, LLP will release HIV, Drug and Alcohol, and Mental Health/Psychiatric information as required by law unless otherwise indicated. I understand that I have the right to request that services for which I have paid out-of-pocket, not be disclosed to my health plan.

I agree to pay interest at the prevailing rate for amounts 30 days past due, as well as costs including attorney's fees, associated with the collection of any amounts due for services rendered. I understand that I am financially responsible to Women's Health Professionals, LLP, its successors and assigns or any individual it may designate, for amounts owed by me in accordance with my health benefit coverage. I acknowledge that I will be responsible for all unpaid claims if I fail to provide insurance information within my health plan's filing limit for services rendered.

_____ _____
Signature of Patient or Parent of Minor Date

Medicare Authorization for Treatment, Payment & Healthcare Operations, Medicare Recipients Sign both Authorizations.

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. I request that payment of Authorized Medicare benefits be made either to me or on my behalf to Women's Health Professionals, LLP for services furnished to me by the providers. I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits for related services rendered.

_____ _____
Patient's Signature Date

Under HIPAA Privacy Regulations, a patient may allow access to her/his Protected Health Information (PHI). Please Complete:

☐ I DO NOT WANT ANY information discussed with anyone. ☐ I hereby give permission to HAMPTONS OB/GYN to discuss:
Physician / Division name

☐ Test/Lab Results ☐ Entire Medical Record ☐ Make/Cancel Appointments with, _____
Print name of person Relationship to patient

Notice of Privacy: ☐ Received ☐ Refused

_____ _____
Signature of Patient or Parent of Minor Date

Intake Form

Name: _____ Date of Birth: ____/____/____

Address: _____ city:_____ zip:_____ Phone #: _____ Cell #: _____

Today's Date:_____/_____/_____

Primary Care Doctor:	**Reason for Visit:**

PERSONAL HISTORY		
Height:	**Weight**:	**Age**:
Allergies to Medications (list):	Current Medications (list):	Vitamins (list):
Exercise: ☐ How Often:	**Cigarettes**: ☐ How Often:	**Alcohol**: ☐ How Often:
Marital Status: Married ☐ Single ☐ Divorced ☐		**Sexually Active** Yes ☐ No ☐
Occupation:		Male ☐ Female ☐ Both ☐
Race: White ☐ African American ☐ Hispanic ☐ Asian ☐ Native American ☐ Other ☐		

Age Periods Began:	Avg. Length of Period (days):	Last Menstruation: _/_/_	Menopause age:
Last Pap Smear: _/_/_	Last Mammogram: _/_/_	Last Colonoscopy: _/_/_	Bone Density: _/_/_

Do you take birth control? Yes ☐ No ☐ Birth control method or prescription:_____

PERSONAL MEDICAL HISTORY. Check **ALL** that apply:					
Diabetes	☐	High Blood Pressure	☐	Asthma	☐
Heart Failure/Heart Attack	☐	Lung Disease	☐	Hepatitis	☐
Heart Disease/Murmur	☐	Gall Bladder Disease	☐	Thyroid Disease	☐
Bleeding Abnormality	☐	Eating Disorder	☐	Breast Cancer	☐
Depression	☐	Migraines	☐	Breast Disease/Biopsy	☐
Osteoporosis	☐	Kidney Disease	☐	Other Disease or Cancers	☐
If "Other" please list:					

TREATMENT HISTORY					
STDs	☐	Abnormal Pap Smears:	☐	Infertility:	☐
Fibroids (of the uterus)	☐	Ovarian Cysts	☐	Endometriosis	☐

PREGNANCY HISTORY						
	Date of Birth	Birth Weight	Check	Weeks	Delivery Type	Complications?
1			Boy ☐ Girl ☐		Vaginal ☐ C-Section ☐	
2			Boy ☐ Girl ☐		Vaginal ☐ C-Section ☐	
3			Boy ☐ Girl ☐		Vaginal ☐ C-Section ☐	
4			Boy ☐ Girl ☐		Vaginal ☐ C-Section ☐	
# of Abortions: _____ Date:____			# of Miscarriages:		Currently trying to get pregnant? Yes ☐ No ☐	

PERSONAL SURGICAL HISTORY
List ANY surgeries you've had:

The Following Relatives Should Be Considered:

You, Mother, Father, Brother, Sister, Children, Paternal Aunt/Uncle, Maternal Aunt/Uncle, Half-Siblings, First Cousins, Nieces/Nephews, Maternal & Paternal Grandparents, Great Aunts/Uncles

NAME: _____ DOCTOR: _____ DATE: __/__/__

Family History

Disease Type	Check	List All Relatives (see list above)	Paternal/ Maternal
Heart Attack	Y ☐ N ☐		
Stroke	Y ☐ N ☐		
Blood Clots (other than stroke)	Y ☐ N ☐		
Diabetes	Y ☐ N ☐		
Depression	Y ☐ N ☐		
Osteoporosis	Y ☐ N ☐		

Cancer History Description	Check	YOURSELF or Relatives (see list above)	Paternal/ Maternal	Age(s) of Diagnosis
Colon Cancer before the age of **50**	Y ☐ N ☐			
Uterine/Endometrial cancer before the age of **50**	Y ☐ N ☐			
Three or more Lynch cancers. Lynch cancers are: colon, endometrial, gastric, ovarian, brain, pancreatic, small bowel, hepatobiliary tract, ureter/renal, or sebaceous adenomas	Y ☐ N ☐			
Breast Cancer diagnosed at or before the age of **50**	Y ☐ N ☐			
Ovarian Cancer diagnosed at **any age**	Y ☐ N ☐			
Male Breast Cancer diagnosed at **any age**	Y ☐ N ☐			
Three or more breast cancers on the same side of the family regardless of age	Y ☐ N ☐			
A relative diagnosed with breast cancer **twice**	Y ☐ N ☐			
You are of **Ashkenazi Jewish** heritage and have a diagnosis of breast, or pancreatic cancers in any family members listed above at any age	Y ☐ N ☐			
Have you or any of your family members been tested for the BRCA gene? If no, why not?	Y ☐ N ☐			

If you don't have any known history of cancer in your family check here ☐

Please list ANY other cancers, along with what relative, and side of the family:

OFFICE USE ONLY:

Appropriate for testing? Yes ☐ No ☐ Discus Genetic Testing? Yes ☐ No ☐ Genetic Testing: Accepted ☐ Denied ☐

MD Signature:_____ If declined state reason: _____

If declined, patient signature: _____ Written information given Yes ☐ No ☐

Update form

FAMILY HISTORY FORM

The Following Relatives Should Be Considered:

Mother, Father, Brother, Sister, Children, Paternal Aunt/Uncle, Maternal Aunt/Uncle, Half Siblings, First Cousins, Nieces/Nephews, Maternal/Paternal Grandparents, & Great Aunts/Uncles

NAME: _____ **DOCTOR:** _____ **DATE:** __/__/___

Cancer History Description	Circle	YOURSELF or Relatives (see list above)	Paternal/ Maternal	Age(s) of Diagnosis
Colon Cancer before the age of **50**	Y ☐ N ☐			
Uterine/Endometrial cancer before the age of **50**	Y ☐ N ☐			
Three or more Lynch cancers. Lynch cancers are: colon, endometrial, gastric, ovarian, brain, pancreatic, small bowel, hepatobiliary tract, ureter/renal, or sebaceous adenomas	Y ☐ N ☐			
Breast Cancer diagnosed at or before the age of **50**	Y ☐ N ☐			
Ovarian Cancer diagnosed at **any age**	Y ☐ N ☐			
Male Breast Cancer diagnosed at **any age**	Y ☐ N ☐			
Three or more breast cancers on the same side of the family regardless of age	Y ☐ N ☐			
A relative diagnosed with breast cancer **twice**	Y ☐ N ☐			
You are of **Ashkenazi Jewish** heritage and have a diagnosis of breast, or pancreatic cancers in any family members listed above at any age	Y ☐ N ☐			
Have you or any of your family members been tested for the BRCA gene? If no, why not?	Y ☐ N ☐			

By checking here you attest that you have NO knowledge of any cancer in your family ☐

Please list ANY other cancers, include relatives, ages, and side of the family:
(ex: prostate, pancreatic, melanoma, etc.)

OFFICE USE ONLY:

Appropriate for testing? Yes ☐ No ☐
MD Signature:_____
If declined, patient signature: _____
Notes:

Discus Genetic Testing? Yes ☐ No ☐
If declined state reason: _____

Genetic Testing: Accepted ☐ Denied ☐
Written information given Yes ☐ No ☐

RX Consent Form

Last Name:_____ First Name:_____

Date of Birth:_____ E-Mail Address:_____

Ethnicity:
Asian_____ Multiracial_____
Black/African_____ Native American_____
Caucasian_____ Pacific Islander_____
Hispanic_____ Other_____

Preferred Language:

English_____ German_____ Other_____
Spanish_____ Japanese_____
French_____ Russian_____
Italian_____ Polish_____

Pharmacy & Location:_____

Medication List:

_____ _____
_____ _____
_____ _____
_____ _____

Any allergies? Yes (If so, please list them below) No

_____
_____
_____

I give Hampton Gynecology & Obstetrics permission to access my health information electronically.

Patient Signature_____ Date_____

CONSENT FORM
HAMPTONS GYNECOLOGY AND OBSTETRICS

In this Consent Form, you can choose whether to allow HAMPTONS GYNECOLOGY AND OBSTETRICS to obtain access to your medical records through computer networks operated by THINC and MedAllies, which are part of a statewide computer network, and by Surescripts, a provider of electronic prescribing services. These computer networks can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow HAMPTONS GYNECOLOGY AND OBSTETRICS to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, HAMPTONS GYNECOLOGY AND OBSTETRICS staff involved in my care may see and get access to all of my medical records through THINC, MedAllies and Surescripts."

If you check the **"I DENY CONSENT"** box below, you are saying "No, HAMPTONS GYNECOLOGY AND OBSTETRICS may not be given access to my medical records through THINC, MedAllies and Surescripts for any purpose."

This kind of sharing of medical records is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask [Name of Provider] for it, or go to the website www.ehealth4ny.org. The three types of computer networks that [Name of Provider Organization] would access based upon this consent are:

- THINC, which is a not-for-profit organization that involves physician practices, community health centers, hospitals, laboratories and other health care organizations in the Hudson Valley. It shares information about people's health electronically and securely to improve the quality of health care services.
- Surescripts, which is a national provider of electronic prescribing services connecting physicians and hospitals with pharmacies.
- MedAllies, which is a provider of information technology services that hosts a service that enables hospitals to share patient information with physicians that care for their shared patients.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices.

☐ **I GIVE CONSENT for HAMPTONS GYNECOLOGY AND OBSTETRICS to access ALL of** my electronic health information through THINC, MedAllies and Surescripts in connection with providing me any health care services, including emergency care.

☐ **I DENY CONSENT for HAMPTONS GYNECOLOGY AND OBSTETRICS to access** my electronic health information through THINC, MedAllies and Surescripts for any purpose, *even in a medical emergency.*

NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through THINC, MedAllies and Surescripts.

Print Name of Patient	Patient Date of Birth
Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)