Long Island
WOMEN'S
Health Care Group
OBSTETRICS & GYNECOLOGY

PLEASE COMPLETE THE ENTIRE FORM (front & back)

TODAY'S DATE _____/_____/_____

LAST Name_____

FIRST Name_____

Date of Birth _____/_____/_____ Age_____ SSN_____-_____-_____

Street Address_____Apt_____
(Mailing)
City_____ State_____ Zip_____

PRIMARY Phone(_____)_____-_____ Alt. Phone(_____)_____-_____
***THIS IS THE PHONE NUMBER AT WHICH YOU PREFER TO BE REACHED**

Email Address_____

Occupation_____

Employer_____

Marital Status *(select one)*: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Race: ☐ Asian ☐ Black ☐ Caucasian ☐ Native American ☐ Pacific Islands ☐ Multi-Racial ☐ Other

Country of Birth_____ Primary Language_____

What is your religion?_____ Are you opposed to blood transfusions? ☐ YES ☐ NO
(*for hospital record if needed*)

Emergency Contact:
*Name*_____ *Relation*_____

*Phone*_____

Primary Care Physician_____

Pharmacy:
*Name*_____ *Phone*_____

*Address*_____

Who referred you to this office?_____

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INSURANCE INFORMATION

Primary Insurance Name_____

Policy ID#_____ Group #_____

Are you the Subscriber? ☐ YES ☐ NO (if no, please fill in below)

Subscriber Name_____ Subscriber DOB_____

Subscriber Relationship to you_____ Copay Amt$_____

Secondary Insurance Name_____

Policy ID#_____ Group #_____

Are you the Subscriber? ☐ YES ☐ NO (if no, please fill in below)

Subscriber Name_____ Subscriber DOB_____

Subscriber Relationship to you_____ Copay Amt$_____

ALL PATIENTS

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 plans filing limit for services rendered.

Further, by signing this document I acknowledge that I have been provided a copy of and have read the Notice of Privacy Practices containing a complete description of my rights, and the permitted uses and disclosure, under HIPAA.
By signing below, I grant Long Island Women's Health Care Group permission to discuss my protected medical information with the following individuals:

☐ I DO NOT WANT ANY INFORMATION DISCUSSED WITH ANYONE

Name_____ Relationship_____

Contact Phone _____

Name_____ Relationship_____

Contact Phone _____

PATIENT SIGNATURE_____

PRINT NAME_____ DATE_____

MEDICARE PATIENTS

I authorize the release of my medical information for purpose 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.

Signature_____ Date_____

LONG ISLAND WOMEN'S HEALTH CARE GROUP
Intake Form

Last Name:	First Name:
Today's Date:	Date of Birth:
Referring Physician Name:	
Primary Care Physician:	

What is the reason for your visit today? Is it a routine visit? ☐YES ☐NO
If no, please explain_____

_____

Do you have any allergies to medications or other substances? ☐YES ☐NO
If yes, please list all allergies and reactions (rash, hives, throat swelling, anaphylaxis)
_____

_____

CURRENT MEDICATIONS; IF NONE, CHECK HERE ☐
List all current medications _____

_____

_____

# of Pregnancies			When was your last menstrual period?	
# of Live Births			Age of your first period?	
# of Vaginal Deliveries			How frequently do you have your period?	
# of C-Sections			If irregular, describe frequency?	
# of Miscarriages			Is your flow heavy?	☐YES ☐NO
# of Tubal Pregnancies			How many days do you bleed?	
# of Terminations *(elective)*			Do you stain/bleed between regular periods?	☐YES ☐NO
# of Living Children			Do you have pain with periods?	☐YES ☐NO

If your periods have stopped, do you have any symptoms associated with menopause?	☐YES ☐NO
Are you currently sexually active?	☐YES ☐NO
Do you have any problems associated with sexual relations?	☐YES ☐NO
Are you currently in a monogamous relationship?	☐YES ☐NO
If yes, *partners gender:* ☐Male ☐Female How long have you been in this relationship?	
Are you currently using birth control? *if yes, which one:*	☐YES ☐NO
Are you trying to get pregnant?	☐YES ☐NO

PATIENT NAME_____ DATE OF BIRTH_____

When was your last PAP smear? ☐YES ☐NO	Have you ever had an abnormal PAP? ☐YES ☐NO
Have you ever been treated for the following? ☐ Vaginosis ☐ Genital Warts ☐ Chlamydia ☐ Herpes ☐ Trichomonas ☐ Gonorrhea ☐ Syphilis	
Have you ever been tested for HIV?	

MEDICAL & SURGICAL HISTORY: Have you ever had (been diagnosed or treated for) any of the following? If yes, please describe

	YES	NO	DESCRIBE
Heart Disorder			
Stomach/Intestinal Disorder			
Skin Disorder			
Clotting Disorder			
Eye Disorder			
Psychiatric Disorder			
Urinary/Kidney Disorder			
Liver Disorder/Hepatitis			
Orthopedic Disorder			
Cholesterol Disorder			
Neurologic Disorder			
Diabetes			
High Blood Pressure			
Arthritis			
Fibroids			
Endometriosis			
CANCER			
Thyroid Disorder			
Lung Disorder			
Neurologic Disorder			
Other			
SURGICAL HISTORY	**YES**	**NO**	**DESCRIBE**
Appendectomy			
Gallbladder			
Tubal ligation			
Breast Surgery			
Hysterectomy			
Other MAJOR SURGERY			
Other MINOR SURGERY			
FAMILY HISTORY	**YES**	**NO**	**WHICH FAMILY MEMBER?**
CANCER *Breast*			
CANCER *Colon*			
CANCER *Cervix*			
CANCER *Uterus*			
CANCER *Ovarian*			
CANCER *Other*			
High Blood Pressure			
Heart Disease			
Stroke			
Diabetes Mellitus			
Thyroid Disease			
Other:			

PATIENT NAME_____ DATE OF BIRTH_____

SOCIAL HISTORY			
	YES	NO	DESCRIBE
Do you currently smoke cigarettes?			*If yes, how many per day?*
Did you previously smoke cigarettes?			*If yes, how many per day?*
Do you currently drink alcohol?			*If yes, how often?*
Do you currently use recreational drugs?			
Do you exercise regularly?			

Answer the following; if not applicable put N/A

When was your last mammogram?_____ Were the results ☐ Normal ☐ Abnormal?

When was your last colonoscopy?_____ Were the results ☐ Normal ☐ Abnormal?

When was your last bone density?_____ Were the results ☐ Normal ☐ Abnormal?

When was your last cholesterol exam?_____ Were the results ☐ Normal ☐ Abnormal?

PATIENT SIGNATURE_____ **Date**_____

Long Island Women's Health Care Group Appointment Cancellation / NO-SHOW Policy

*Please read the following carefully and sign below

Thank you for trusting your medical care to the physicians of Long Island Women's Health Care Group. When you schedule an appointment with Long Island Women's Health Care Group we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an emergency appointment. Please see our policy outline below:

- Effective November 28, 2017 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office by telephone with at least 24 hours' notice will be considered a No Show and charged a $10.00 fee.
- Any established patient who fails to show or cancels/reschedules an appointment without 24 hour notice a 2nd time will be charged a $20.00 fee.
- If a 3rd No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be dismissed from Long Island Women's Health Care Group.
- Any new patient who fails to show for their initial visit will not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above policy will remain in effect.

OUR TELEPHONE NUMBERS ARE AS FOLLOWS:
MINEOLA OFFICE (516) 741-4321 SYOSSET OFFICE (516) 364-8780 NEW HYDE PARK OFFICE *please call Mineola*

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____
Signature (Parent/Legal Guardian) Print Name

_____
Date