squarecare

Long Island WOMEN'S Health Care Group
OBSTETRICS & GYNECOLOGY

PLEASE PRINT & COMPLETE THE ENTIRE PACKET

PLEASE BRING YOUR INSURANCE CARD & PHOTO ID TO YOUR APPOINTMENT

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**

Do you consent to receiving text messages? ☐ YES ☐ NO

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*_____ *Phone*_____

Pharmacy Name/Address:_____

Pharmacy Phone Number:_____

Imaging Facility:_____ **Location:**_____

INSURANCE INFORMATION

Primary Insurance Name_____

Policy ID#_____ Group #_____

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

Subscriber Name_____ Subscriber DOB_____

Secondary Insurance Name_____

Policy ID#_____ Group #_____

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

Subscriber Name_____ Subscriber DOB_____

>>>>>>>> TURN OVER >>>>>>>>

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 **Square Care Medical Group**, **LLP**, its successors and assigns, or any individual it may designate for services provided. As part of this authorization, Square Care Medical Group 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 understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to; late fees, collection agency fees, court costs, interests and fines. I understand that I am responsible for such additional fees and agree to pay such fees. It will be my personal responsibility to pay in full. I understand that I am financially responsible to Square Care Medical Group LLP and 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. I understand I am responsible for any late or no-show fees when applicable

Patient Signature_____ Date_____

PRIVACY PRACTICES- HIPAA

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan & direct my treatment and follow up among the multiple health providers involved in my treatment**
- **Obtain payment from third party payers**

I understand that as part of my health care, SQUARE CARE MEDICAL GROUP LLP may need to reach me by phone.

☐ **I DO NOT** Authorize SQUARE CARE MEDICAL GROUP LLP to leave messages on my telephone (home, cell or work) regarding any type of testing result or any relevant medical information.

☐ **I DO** Authorize SQUARE CARE MEDICAL GROUP LLP to leave messages on my ____ Cell Phone ____ Home Phone regarding relevant medical information such as laboratory/test results and imaging studies.

RELEASE OF INFORMATION:

☐ **I DO NOT WANT** any information discussed with anyone.

☐ I hereby give permission to SQUARE CARE MEDICAL GROUP LLP to discuss:

☐ Test/Lab Results ☐ Entire Medical Record ☐ Make/Cancel Appointments with,

Name_____ Relationship_____

NOTICE OF PRIVACY PRACTICES

☐ RECEIVED ☐ REFUSED

Patient Signature_____ Date_____

MEDICARE PATIENTS

I authorize the release of my medical information including my prescription history 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 SQUARE CARE MEDICAL GROUP LLP for services furnished to me by the providers. I authorize any holder of my medical information to release the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits for related services rendered.

Patient Signature_____ Date_____

NO SHOW POLICY

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 $25.00 fee.**
- Any established patient who fails to show or cancels/reschedules an appointment **without 24 hour notice a 2nd time will be charged a $30.00 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.

Patient Signature_____ Date_____

LONG ISLAND WOMEN'S HEALTH CARE GROUP

Intake Form

Last Name:	First Name:
Appointment Date:	Date of Birth:
Primary Care Physician:	Who Referred You:
Address:	

What is the reason for your visit? 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
When was your last PAP smear?	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? ☐YES ☐NO	

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?

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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:			

SOCIAL HISTORY

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

PATIENT SIGNATURE_____ **Date**_____

Signature (Parent/Legal Guardian) _____