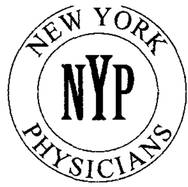

OBSTETRICS & GYNECOLOGY

TODAY'S DATE:____/____/____ **PHYSICIAN:**____________________ **UNIT#:**____________

NAME:______________________________ Date of Birth:___/___/___ Age:________

Address:______________________________ Apt.:________ Social Security#:____/____/____

City, State:______________________________ Zip Code:__________

Telephone: (______)____________________ (______)____________________
EVENING DAYTIME

(______)____________________ ____________________
CELL EMAIL

Occupation:______________________________ Employer:____________________

Marital Status: Married______ Single______ Separated__________ Divorced______ Widowed ________

Domestic Partner's Name:______________________________

Domestic Partner's Occupation:______________________________

For Verification Purposes: Mother's First Name:________________ Father's First Name:________________

Emergency Contact Name:____________________ Telephone#:______________ Relation: ___________

Who referred you to this office?______________________________

PRIMARY INSURANCE:______________________________ Effective Date:____/____/____

Insurance Carrier's Address (on back of card):______________________________

Policy/ID Number:______________________________ Group/Plan Number:________________

Name of Subscriber if different from Patient:____________________ Relation: ______________

Date of Birth of Insured Party:______________________________ Co-Payment:______________
IF APPLICABLE

SECONDARY INSURANCE:______________________________

Insurance Carrier's Address (on back of card):______________________________

Policy/ID Number:______________________________ Group/Plan Number:________________

Name of Subscriber if different from Patient:______________________________ Relation:__________

Date of Birth of Insured Party:______________________________ Co-Payment:______________
IF APPLICABLE

PHARMACY NAME:________________ PHARMACY TELEPHONE #:____________________

MEDICARE	COMMERCIAL INSURANCE
I request that payment of authorized MediCare benefits be made either to me or on my behalf to New York Physicians, LLP for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.	I authorize New York Physicians, LLP to act as my agent to help obtain payment from my insurance carrier(s). This includes my authorization to release information to my insurance company(ies), use this form, or a copy of this form in place of the original, process all insurance submissions, and for my insurance carrier to directly reimburse New York Physicians, LLP for services rendered. I understand that although New York Physicians, LLP will help to process insurance claims, I am responsible for my bill.
______________________________ Patient Signature Date	______________________________ Patient Signature Date

OBSTETRICS & GYNECOLOGY

PATIENT NAME____________________________________ **DATE**:_______________

REASON FOR VISIT:____

GYNECOLOGICAL HISTORY

LAST NORMAL MENSTRUAL PERIOD (FIRST DAY):__________________________________
AGE PERIOD BEGAN:__________ LENGTH OF PERIOD:__________ PERIOD FREQUENCY: __________
ABNORMAL/IRREGULAR PERIODS: YES NO INFERTILITY/AMENORRHEA: YES NO

DATE OF LAST PAP SMEAR:____________ RESULTS:______________________________
HISTORY OF ABNORMAL PAP SMEAR? YES NO

PRESENT METHOD OF BIRTH CONTROL:____
HAVE YOU USED ANY OF THE FOLLOWING (CIRCLE ALL THAT APPLY):

BIRTH CONTROL PILLS	LUNELLE	MORNING AFTER PILL
BIRTH CONTROL PATCH	DEPO-PROVERA	NORPLANT
IUD	DIAPHRAGM	

HISTORY OF ANY OF THE FOLLOWING (PLEASE PROVIDE DATE WHERE INDICATED):

- ☐ COLPOSCOPY______________
- ☐ CRYOSURGERY______________
- ☐ LASER SURGERY______________
- ☐ LEEP/CONE BIOPSY______________

HISTORY OF SEXUALLY TRANSMITTED DISEASES (CIRCLE ALL THAT APPLY):

GENITAL WARTS	GONORRHEA	HIV
HERPES	SYPHILIS	PELVIC INFLAMMATORY DISEASE
CHLAMYDIA	HPV	

HAVE YOU EVER BEEN TESTED FOR HIV? YES NO

HISTORY OF THE FOLLOWING:

ENDOMETRIOSIS	FIBROIDS
OVARIAN CYSTS	DES EXPOSURE

GYNECOLOGICAL CANCER (please specify)________________________

DO YOU PERFORM SELF BREAST EXAMS? YES NO
LAST MAMMOGRAM: __________ MAMMOGRAM RESULTS:__________________________
BREAST DISCHARGE: YES NO BREAST DISEASE:______________________________

PREGNANCY HISTORY

NUMBER OF CHILDREN:__________________ YEARS OF AGE:__________________________
TYPE(S) OF DELIVERY:____
COMPLICATIONS:____
NUMBER OF MULTIPLE BIRTHS:__________ YEAR(S):______________________________
NUMBER OF MISCARRIAGES:__________ YEAR(S):______________________________
NUMBER OF ABORTIONS:__________ YEAR(S):______________________________
NUMBER OF ECTOPIC PREGNANCIES:__________ YEAR(S):______________________________
COMPLICATIONS:____

____

SEXUAL HISTORY

ORIENTATION: ☐ HETEROSEXUAL ☐ LESBIAN ☐ BISEXUAL

PAIN WITH SEX: ____________ BLEEDING AFTER SEX: ____________

HISTORY OF SEXUAL ABUSE: ____________

ARE THERE THINGS ABOUT SEX THAT YOU WOULD LIKE TO ASK ABOUT OR DISCUSS? ____________

____

MEDICAL HISTORY (PLEASE CIRCLE ALL THAT APPLY)

HIGH CHOLESTEROL	BOWEL PROBLEM	EATING DISORDER
HEART DISEASE/MURMUR	ANEMIA/BLOOD DISORDERS	ARTHRITIS
HIGH BLOOD PRESSURE/STROKE	BLEEDING PROBLEMS	BONE FRACTURES
ASTHMA	MIGRAINE	DEPRESSION/PSYCH ILLNESS
TUBERCULOSIS	EPILEPSY/SEIZURES	IRREGULAR VAGINAL BLEEDING
DIABETES	PHLEBITIS	SLEEP INTERRUPTIONS
THYROID DISEASE	PULMONARY EMBOLISM	VAGINAL DRYNESS
HEPATITIS/LIVER DISEASE	VARICOSE VEINS	HOT FLASHES
BACK PROBLEMS	LUPUS	EASY BRUISING
URINARY PROBLEMS	CANCER	BLOOD TRANSFUSIONS
GALL BLADDER DISEASE		

ALLERGIES TO MEDICATIONS: ____________

____

CURRENT MEDICATIONS (INCLUDING HORMONES/VITAMINS/HERBS): ____________

____

PREVIOUS SURGERIES OR OPERATIONS:

____

____

PERSONAL HISTORY

EXERCISE (TYPE): ____________ FREQUENCY: ____________ DURATION: ____________

PLEASE DESCRIBE YOUR DIET: ____________

CURRENT OR PAST USE OF THE FOLLOWING:

CAFFEINE (COFFEE/TEA/SODA): ________ CUPS PER DAY CIGARETTES PER DAY: ____________

DRUG USE: ____________ ALCOHOL INTAKE: ____________

FAMILY HISTORY - PLEASE CIRCLE IF ANYONE IN YOUR **FAMILY** HAS/ HAD ANY OF THE FOLLOWING:

CANCER	HIGH BLOOD PRESSURE	DIABETES
HEART DISEASE	HIGH CHOLESTEROL	OSTEOPOROSIS
PREMATURE MENOPAUSE	ALZHEIMER'S DISEASE	THYROID DISEASE
ASTHMA/EMPHYSEMA	BLEEDING DISORDERS	MENTAL RETARDATION
GENETIC DISEASE	SEIZURES	MULTIPLE GESTATION

ACKNOWLEDGEMENT FORM

NOTICE OF PRIVACY PRACTICES

EFFECTIVE APRIL 14, 2003

This Acknowledgement Form is provided to you as required by the Privacy Rule and related Regulations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

You are asked to sign this form so that we can confirm that you have received it. Your signature only confirms that you have received this Form. Your signature does not mean that you agree with any of the policies and procedures outlined herein.

You may refuse to sign this Acknowledgement Form, at which time our staff is required to document the date and time of your refusal, as well as your reason for not signing.

I acknowledge that I have received a copy of New York Physicians LLP Notice of Privacy Practices, as of the date indicated below.

____
Name of Patient

______________________________　　　　　　______________
Signature of Patient　　　　　　　　　　　**Date Signed**

____ **If checked, please see reverse side or page 2 for Patient's Refusal to Sign**

PATIENT'S REFUSAL TO SIGN

ACKNOWLEDGEMENT FORM

NOTICE OF PRIVACY PRACTICES

EFFECTIVE APRIL 14, 2003

The patient listed below refused to sign the Acknowledgement Form for New York Physicians LLP Notice of Privacy Practices. As a staff member of New York Physicians LLP, I am notating that the patient refused to sign the Acknowledgement Form on the date specified and for the reason listed (if given by patient).

____
Patient's Name

____
Staff Member's Name

____ __________________
Staff Member's Signature **Date**

REASON FOR REFUSAL: ____

____