William Groves MD
OBSTETRICS AND GYNECOLOGY

1890 W. Gauthier Rd., Ste. 130
Lake Charles, LA 70605
P:(337)480-5530 F:(337)480-5531
www.williamgrovesmd.com

PATIENT REGISTRATION FORM

Today's Date:	Primary Care Physician:	Pharmacy:

PATIENT INFORMATION

First name:	Middle:	Last:		Maiden Name:

SSN:	Preferred Name:	Title:	DOB:
Address:	City:	State:	Zip:

Cell#:	Home#:	Work#:
CIRCLE CONTACT# THAT IS PRIMARY: -- Cell -- Home -- Work	Marital Status:	Race:
Employer Name:	Address:	Phone:
Spouse Name:	Spouse SSN:	Spouse DOB:

Spouse Phone Number:	Referred to clinic by:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance: |

Policy holder's name:	Birth date:	Group #:	Policy #:	Co-payment:
				$

Patient's relationship to subscriber:

Please indicate secondary insurance: (if applicable):	Policy holder's name:	Policy and Group#:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

AUTHORIZATION AND ASSIGNMENT FOR INSURANCE PURPOSES: I authorize J. William Groves, Jr., M.D. to furnish information to insurance carriers only concerning my illnesses and treatments for the processing of the applicable claim(s). I assign J. William Groves, Jr., M.D. all payments for medical services rendered to me or to my dependents. I understand that I am responsible for any amount not covered by assigned Insurance. If for any reason should the account becomes delinquent, I agree to pay for all collection and/or legal fees.

PATIENT/GUARDIAN SIGNATURE: ____ DATE: _________________________

CONSENT TO TREATMENT: I, the undersigned do hereby authorize, J. William Groves, Jr., M.D. to provide medical care as may be deemed necessary in the judgement of the physician. This treatment may include but is not limited to: laboratory procedures, non-invasive diagnostic and therapeutic procedures and treatments, administration of pharmaceutical products, such as injections and other therapeutic solutions, and minor surgical procedures such as wound suturing.

PATIENT/GUARDIAN SIGNATURE: ____ DATE: _________________________

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PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives the individual the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual has the right to request confidential communication or communication by alternate means, such as sending correspondence to the individual's office instead of home.

PATIENT'S NAME: ____

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER:

___Home Telephone
    ___OK to leave a message with detailed information.
    ___Leave message with call-back number only.
___Work Telephone
    ___OK to leave a message with detailed information.
    ___Leave message with call-back number only.
___Cell Telephone
    ___OK to leave a message with detailed information.
    ___Leave message with call-back number only

____ ____________________________
PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

IT IS OUR GOAL AS YOUR MEDICAL PROVIDER, TO CALL YOU WITH RESULTS OF ANY TEST ORDERED BY OUR OFFICE WITHIN 1-2 WEEKS, DEPENDING ON THE PARTICULAR TEST PERFORMED. *IF FOR SOME REASON, YOU DO NOT RECEIVE A CALL WITH YOUR RESULTS DURING THIS TIME FRAME, PLEASE CONTACT OUR OFFICE.*

____ ____________________________
PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

I authorize the release of any medical or other information necessary to process claims. I also request payment of benefits either to myself to myself or to the party who accepts assignment on said claims. I authorize J. William Groves, Jr., M.D. to release medical records and reports to the referring physician or any other physicians or health care providers that need access to these records for my medical care. I also authorize any other physician, laboratory, hospital, or other provider to release all medical records and X-rays necessary for my care to J. William Groves, Jr., M.D.

____ ____________________________
PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

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Patient Consent Form
Use of this form is optional and not required under the HIPAA privacy rule.

I hereby give my consent for J. William Groves, Jr., M.D. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by describes such uses and disclosures more completely).

I have the right to review The Notice of Privacy practices prior to signing this consent. J. William Groves, Jr., M.D. reserves the right to revise its Notice of Privacy practices at any time. A revised Notice of Privacy practices may be obtained by forwarding a written request to J. William Groves, Jr., M.D., 1890 W. Gauthier Rd., Ste. 130, Lake Charles, LA 70605.

With this consent, J. William Groves, Jr.,M.D. may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, J. William Groves, Jr., M.D. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential”.

With this consent, J. William Groves, Jr., M.D. may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that J. William Groves, Jr., M.D. restricts how the practice uses or discloses my PIH to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow J. William Groves., Jr., M.D. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, J. William Groves, Jr., M.D. may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

______________________________________ ____________________________
Print Patient’s Name & Legal Guardian, if applicable Date

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PATIENT: ______________________________ DATE: _____________

MEDICATION LIST

PLEASE LIST ALL MEDICATIONS, INCLUDING STRENGTH AND FREQUENCY. INCLUDE VITAMINS, SUPPLEMENTS, AND ALL OVER THE COUNTER MEDICATIONS TAKEN REGULARLY.

MEDICATION	STRENGTH	FREQUENCY

____
J. William Groves, Jr., MD

REVISED 7/23/18

GYNECOLOGIC INTAKE HISTORY

Name: ______________________________ Date: ______/______/______

Address: ______________________________ Birth Date: ______/______/______

City: ______________________________ Home Tel: (   )____________________

State/Zip: ______________________________ Work Tel: (   )____________________

Employer: ______________________________ Insurance: ____________________

Name of Spouse/Partner ______________________________ Referred by: ____________________

REVIEW OF SYSTEMS: Please check any boxes that apply to you now or have applied in the past

	Currently	Past	Notes
1 Constitutional			
Weight loss	☐	☐	
Weight gain	☐	☐	
Fever	☐	☐	
Fatigue	☐	☐	
2 Eyes			
Double vision	☐	☐	
Spots before eyes	☐	☐	
Vision changes	☐	☐	
3 Ears/Nose/Throat/Mouth			
Ear aches	☐	☐	
Ringing in ears	☐	☐	
Sinus problems	☐	☐	
Sore throat	☐	☐	
Mouth sores	☐	☐	
Dental problems	☐	☐	
4 Cardiovascular			
Painful breathing	☐	☐	
Chest pain	☐	☐	
Difficult breathing on exertion	☐	☐	
Swelling of legs	☐	☐	
Palpitations of heart	☐	☐	
5 Respiratory			
Wheezing	☐	☐	
Spitting up blood	☐	☐	
Shortness of breath	☐	☐	
Chronic cough	☐	☐	
6 Gastrointestinal			
Frequent diarrhea	☐	☐	
Blood stool	☐	☐	
Nausea/vomiting	☐	☐	
Constipation	☐	☐	
7 Genitourinary			
Blood in urine	☐	☐	
Pain with urination	☐	☐	
Urgency	☐	☐	
Frequency of urination	☐	☐	
Incomplete emptying	☐	☐	
Stress incontinence	☐	☐	
Abnormal periods	☐	☐	
Painful intercourse	☐	☐	
8 Musculoskeletal			
Muscle weakness	☐	☐	
9 Skin/Breast			
Pain in breast	☐	☐	
Discharge	☐	☐	
Masses	☐	☐	
Rash	☐	☐	
Ulcers	☐	☐	

MD Initials: ____________

REVIEW OF SYSTEMS: (CONTINUED) Please check any boxes that apply to you now or have applied in the past			
10 Neurological	**Currently**	**Past**	**Notes**
Dizziness	☐	☐	
Seizures	☐	☐	
Numbness	☐	☐	
Trouble walking	☐	☐	
11 Psychiatric			
Depression	☐	☐	
Frequent crying	☐	☐	
12 Endocrine			
Dry skin	☐	☐	
Abnormal thirst	☐	☐	
Hot flashes	☐	☐	
13 Hematologic/Lymphatic			
Frequent bruises	☐	☐	
Cuts that do not stop bleeding	☐	☐	
Enlarged lymph nodes	☐	☐	
14 Allergic/Immunologic			
Allergies	☐	☐	
Drug allergy	☐	☐	

PERSONAL PAST HISTORY: Please check any boxes that apply to you now or have applied in the past					
Major Illnesses	**YES**	**NO**	**Major Illnesses**	**YES**	**NO**
Asthma	☐	☐	Cancer	☐	☐
Pneumonia	☐	☐	Ulcers	☐	☐
Chronic lung disease	☐	☐	Depression/anxiety	☐	☐
Kidney infections/stones	☐	☐	Anemia/blood transfusions	☐	☐
Tuberculosis	☐	☐	Seizures/convulsions/epilepsy	☐	☐
Venereal disease	☐	☐	Bowel trouble	☐	☐
Heart trouble/murmur	☐	☐	Glaucoma	☐	☐
Diabetes	☐	☐	Arthritis/joint pain	☐	☐
High blood pressure	☐	☐	Fracture	☐	☐
Stroke	☐	☐	Hepatitis/yellow jaundice	☐	☐
Rheumatic fever	☐	☐	Thyroid disease	☐	☐

OPERATIONS/HOSPITALIZATIONS (Describe reason for operation/hospitalization)

	Date		Date

INJURIES/CHRONIC ILLNESSES (Describe type of injury/illness)

	Date		Date

OBSTETRIC HISTORY

	Number		Number
Births		**Elective abortions**	
Miscarriages/Ectopics		**Living children**	

Patient Name: ______________________________ MD Initials: __________

ALLERGIES- Drug or other (including iodine and latex)

FAMILY HISTORY: Please check yes if a family member has or had one of these illnesses

Illness	Yes	No	Family Member	Illness	Yes	No	Family Member
Diabetes	☐	☐		Osteoporosis with fracture	☐	☐	
Stroke	☐	☐		Breast cancer	☐	☐	
Heart disease	☐	☐		Colon cancer	☐	☐	
High blood pressure	☐	☐		Ovarian cancer	☐	☐	
Bleeding or blood clotting disorder	☐	☐		Other cancer	☐	☐	

SOCIAL HISTORY: Personal Habits

	Yes	No		
Smoking	☐	☐	Packs per day: ______________	Years: ____________________
Alcohol	☐	☐	Drinks per day: ______________	Drinks per week: ____________________
Drug use	☐	☐		
Seat belt use	☐	☐		
Regular exercise	☐	☐		

PERSONAL PROFILE

Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Sexual orientation: ☐ Heterosexual ☐ Other: ____________________

Number of living children: ____________

Number of people in household: ____________

School completed: ☐ High school ☐ College ☐ Graduate school ☐ Other: ____________________

Current or most recent job: ____

PERSONAL SAFETY	Yes	No
Has anyone close to you ever threatened to hurt you?	☐	☐
Has anyone ever hit, kicked, choked, or hurt you physically?	☐	☐
Has anyone, including your partner, ever forced you to have sex?	☐	☐
Are you ever afraid of your partner?	☐	☐

GYN HISTORY: Please check if you have ever been treated for any of the following infections:

☐ Herpes ☐ Genital warts ☐ Chlamydia

☐ Trichomonas ☐ Gonorrhea ☐ Syphilis

	Yes	No	
Have you had a Pap smear in the last 7 years?	☐	☐	
Have you ever had an abnormal Pap smear test?	☐	☐	If so, when? __________________________
Did you begin sexual activity before you were 16 years old?	☐	☐	
Have you had more than 5 sexual partners in your lifetime?	☐	☐	
Have you ever tested positive for the HIV virus?	☐	☐	
Did your mother take the drug DES when she was pregnant with you?	☐	☐	

Completed by: ☐ Patient ☐ Office nurse ☐ Physician

Signature of patient: ____

Date reviewed by physician with patient: ____

Physician signature: ____

MD Initials: ___________

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Appointment Cancellation / No Show Policy: We make every effort to provide a reminder call of your upcoming appointment; however, it is your responsibility to remember your appointment & cancel or change, if needed. Please call the office at least **THE DAY BEFORE YOUR SCHEDULED APPOINTMENT** to reschedule. **IT IS ACCEPTABLE TO LEAVE A VOICE MESSAGE IF IT IS OUTSIDE NORMAL OFFICE HOURS.** We reserve the right to charge a missed appointment fee of $25.00 to patients who do not show up to a scheduled appointment, or who cancel the same day as their appointment. This allows our office to offer the appointment time to other patients needing immediate care. This fee is your responsibility, since insurance will not cover this assessment & must be paid before any additional appointments can be scheduled. In the event a patient has 3 or more missed appointments or same day cancellations, we reserve the right to terminate future care.

Late Policy: We are committed to prompt service and will work very hard, barring emergencies, to stay on time. Admittedly, this can be difficult in an obstetric/surgery practice, but we value your time. **We may ask you to reschedule if you arrive for your appointment more than 15 minutes after your scheduled appointment.** Always arrive at least 10 minutes early for an appointment to complete any necessary paperwork.

Non-Sufficient Funds Fee: There will be a $25.00 fee for any returned checks. This will be applied to your account and you will be placed on a cash or credit card only basis for all future payments.

Delinquent Accounts: We reserve the right to refer any delinquent account(s) to a collection agency and report them to the credit bureau.

Completion of Forms: There is a $10.00 fee for completion of forms.

Participating Insurances: We participate with most insurance companies. Copays or deductibles are **DUE AT THE TIME OF SERVICE**. Non-participating insurances & self pay: payment **IN FULL** is required at the time of service for any gynecological care; an optional payment plan will be designed for obstetrical care for **SELF PAY** patients only. For ALL insurances: Please review your benefit listings summary. Well Woman or Annual Exams are usually considered preventative care and sometimes covered at 100% by insurance plans. For Medicare: Based on certain criteria, there is coverage for breast, pelvic exam, & pap smears. We require a copy of all insurance cards & ask that you present them at each visit along with your driver's license. All new patients must complete our patient information before services are rendered. The forms of payments we accept are the following: cash, check, Visa, MasterCard, & Discover.

I understand & agree that health insurance coverage is an agreement between an insurance carrier and me. I understand that this office will prepare any necessary reports & forms to assist me in making collections from the insurance company & that any amounts authorized be paid directly to this office. However, I clearly understand & agree that all services rendered to me are charged directly to me.

Lab Results: I understand that it is my responsibility to call and check on any results regarding any test(s) performed. Dr. Groves or staff normally will make an effort to contact patient with results. Ultimately, it is my responsibility to obtain results from the office.

We reserve the right to terminate treatment to any patient with three or more missed appointments or same day cancellations.

I, ____________________________________ (print name), have read, agreed to and received a copy of Dr. William Groves' Financial Policy/Appointment Cancellation/No-Show/Late & NSF Fee Policies of the practice.

Patient's Signature ____ Date______________________________