



## PATIENT REGISTRATION FORM

Today's Date:		Primary Care Physician:		Pharmacy:	
<b><u>PATIENT INFORMATION</u></b>					
First name:		Middle:	Last:		Maiden Name:
SSN:		Preferred Name:		Title:	DOB:
Address:		City:		State:	Zip:
Cell#:		Home#:		Work#:	
<small>CIRCLE CONTACT# THAT IS PRIMARY: -- Cell -- Home -- Work</small>		Marital Status:		Race:	
Employer Name:		Address:		Phone:	
Spouse Name:		Spouse SSN:		Spouse DOB:	
Spouse Phone Number:		Referred to clinic by:			
<b><u>INSURANCE INFORMATION</u></b>					
<i>(Please give your insurance card to the receptionist.)</i>					
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#:	
<b><u>IN CASE OF EMERGENCY</u></b>					
Name of local friend or relative (not living at same address):		Relationship to patient:		Home phone no.:	Work phone no.:
<p><b>AUTHORIZATION AND ASSIGNMENT FOR INSURANCE PURPOSES:</b> 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.</p>					
PATIENT/GUARDIAN SIGNATURE: _____				DATE: _____	
<p><b>CONSENT TO TREATMENT:</b> 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.</p>					
PATIENT/GUARDIAN SIGNATURE: _____				DATE: _____	





## GYNECOLOGIC UPDATE HISTORY

## ALLERGIES- Drug or other (including iodine and latex)

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

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

<b>10 Neurological</b> Dizziness Seizures Numbness Trouble walking	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>11 Psychiatric</b> Depression Frequent crying	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
<b>12 Endocrine</b> Dry skin Abnormal thirst Hot flashes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>13 Hematologic/Lymphatic</b> Frequent bruises Cuts that do not stop bleeding Enlarged lymph nodes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

<b>SOCIAL HISTORY: Personal Habits</b>			
Smoking	<u>Yes</u> <input type="checkbox"/>	<u>No</u> <input type="checkbox"/>	Packs per day: _____ Years: _____
Alcohol	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Drinks per day: _____ Drinks per week: _____
Drug use Regular exercise	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
<b>PERSONAL PROFILE</b>			
Sexual orientation: <input type="checkbox"/> Heterosexual <input type="checkbox"/> Other: _____			
<b>PERSONAL SAFETY</b>		<u>Yes</u>	<u>No</u>
Has anyone close to you ever threatened to hurt you?		<input type="checkbox"/>	<input type="checkbox"/>
Has anyone ever hit, kicked, choked, or hurt you physically?		<input type="checkbox"/>	<input type="checkbox"/>
Has anyone, including your partner, ever forced you to have sex?		<input type="checkbox"/>	<input type="checkbox"/>
Are you ever afraid of your partner?		<input type="checkbox"/>	<input type="checkbox"/>

Have you had any of the following changes in your medical/surgical/family history since your last visit with us?

New Medical/Psychiatric diagnosis/Hospitalizations: \_\_\_\_\_

New surgeries/Procedures/Operations: \_\_\_\_\_

New family cancer diagnoses: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Have you had any of the following changes in your medical/surgical/family history since your last visit with us?

**New Medical/Psychiatric diagnosis/Hospitalizations:**

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**New surgeries/Procedures/Operations:** \_\_\_\_\_

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**New family cancer diagnoses:** \_\_\_\_\_

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Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

MD Initials: \_\_\_\_\_



**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 \_\_\_\_\_