



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

NG

### PATIENT REGISTRATION FORM

Today's Date:	Primary Care Physician:	Pharmacy & Location:
<b><u>PATIENT INFORMATION</u></b>		
First name:	Middle:	Last:
Preferred Name:	Maiden Name:	Title:                      DOB:
SSN:	Email:	
Address:	City:	State:                      Zip:
Cell#:	Home#:	Work#:
CIRCLE CONTACT# THAT IS PRIMARY: -- Cell -- Home -- Work		Marital Status:                      Race/Ethnicity:
Employer Name:		Phone:
Spouse Name:	Spouse Phone Number:	
Spouse DOB:	Spouse SSN:	
Referred to clinic by:		
<b><u>IN CASE OF EMERGENCY</u></b>		
Name of local friend or relative (not living at same address):		
Relationship to patient:		Home and/or Cell phone #:
<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: _____



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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



**William Groves MD**  
OBSTETRICS AND GYNECOLOGY

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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 under 24 hours of 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.

**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 \$15.00 fee for the completion of a dictated letter and \$25 fee for the completion of all 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 or online via our website (william@grovesmd.com).

I understand & agree that health insurance coverage is an agreement between an insurance carrier and the patient. 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 \_\_\_\_\_



### GYNECOLOGIC INTAKE HISTORY

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State/Zip: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Name of Spouse/Partner: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Home Tel: ( ) \_\_\_\_\_  
 Work Tel: ( ) \_\_\_\_\_  
 Insurance: \_\_\_\_\_  
 Referred by: \_\_\_\_\_

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

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

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

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

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	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Chronic lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Depression/anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Kidney infections/stones	<input type="checkbox"/>	<input type="checkbox"/>	Anemia/blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/convulsions/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>	Bowel trouble	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble/murmur	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/joint pain	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Fracture	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/yellow jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>

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		Living children	

Patient Name: \_\_\_\_\_

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

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

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**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	<input type="checkbox"/>	<input type="checkbox"/>		Osteoporosis with fracture	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>		Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>		Ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding or blood clotting disorder	<input type="checkbox"/>	<input type="checkbox"/>		Other cancer	<input type="checkbox"/>	<input type="checkbox"/>	

**SOCIAL HISTORY: Personal Habits**

	<u>Yes</u>	<u>No</u>				
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day: _____	Years:	_____	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	Drinks per day: _____	Drinks per week:	_____	
Drug use	<input type="checkbox"/>	<input type="checkbox"/>				
Seat belt use	<input type="checkbox"/>	<input type="checkbox"/>				
Regular exercise	<input type="checkbox"/>	<input type="checkbox"/>				

**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?	<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"/>

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

<input type="checkbox"/> Herpes	<input type="checkbox"/> Genital warts	<input type="checkbox"/> Chlamydia
<input type="checkbox"/> Trichomonas	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Syphilis

	Yes	No
Have you had a Pap smear in the last 7 years?	<input type="checkbox"/>	<input type="checkbox"/>
Have you <u>ever</u> had an abnormal Pap smear test?	<input type="checkbox"/>	<input type="checkbox"/>
Did you begin sexual activity before you were 16 years old?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had more than 5 sexual partners in your lifetime?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever tested positive for the HIV virus?	<input type="checkbox"/>	<input type="checkbox"/>
Did your mother take the drug DES when she was pregnant with you?	<input type="checkbox"/>	<input type="checkbox"/>

If so, when? \_\_\_\_\_

Completed by:             Patient                                       Office nurse                                       Physician

Signature of patient: \_\_\_\_\_

Date reviewed by physician with patient: \_\_\_\_\_

Physician signature: \_\_\_\_\_



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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 PHI 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.

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Signature of Patient or Legal Guardian

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Print Patient's Name & Legal Guardian, if applicable

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Date