New Gyn

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 & Location:	

PATIENT INFORMATION

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:			

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	
Relationship to patient:	Home and/or Cell phone #:

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 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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Appointment Cancellation / No Show Policy: We make every effort to provide a reminder 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 SCHEDUELD 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 fee for the missed appointment 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 care. This fee is your responsibility as insurance will not cover this assessment and must be paid prior to scheduling additional appointments and/or refilling prescriptions.

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. 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 prior to appointment time 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 future payments.

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

Completion of Forms Fee: $15.00 for dictated letters; $25.00 for the completion of all forms.

Participating Insurances: We participate with most insurance companies. Copays or deductibles are DUE AT THE TIME OF SERVICE. Our office accepts Medicaid for pregnancy only.
Non-participating insurances and self pay patients: 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. We require a current copy of your insurance coverage and government issued I.D. All new patients must complete our patient information before services are rendered.

I understand and agree that the health insurance coverage is an agreement between the insurance company and the patient. However, patient acknowledges that it is the responsibility of the patient to

_____**understand coverage and participation of providers patient chooses**

_____**understand that some policies have exclusions of some injections and certain diagnosis codes (ie infertility) In the event insurance company deems an injection/visit not covered, the patient will be responsible for payment.**

_____**reconcile payments made to our office against explanation of benefits from health insurance policy. In the event an overpayment is suspected, please call our office for refund request.**

_____**For all Medicaid OB patients, once the patient delivers and is out of the 8 week postpartum period, you will be considered cash pay for all visits.**

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 will make an effort to contact patients with results. Ultimately, it is the responsibility of the patient 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 and agreed to the policies set forth in this document. Copies are available upon request.

Patient's Signature_____Date_____

Revised 2/24/2022

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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

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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

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: _____

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		Living children	

Patient Name: _____ 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
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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		**Living children**	

Patient Name: _____ MD Initials: _____