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

Updated
Gyn

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 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

Patient Name: ______________________

GYNECOLOGIC UPDATE HISTORY

ALLERGIES- Drug or other (including iodine and latex)

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 in 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: ______________

10 **Neurological** 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	☐ ☐ ☐	☐ ☐ ☐	

SOCIAL HISTORY: Personal Habits

	Yes	No		
Smoking	☐	☐	Packs per day: ____________	Years: ____________
Alcohol	☐	☐	Drinks per day: ____________	Drinks per week: ____________
Drug use	☐	☐		
Regular exercise	☐	☐		

PERSONAL PROFILE

Sexual orientation: ☐ Heterosexual ☐ Other: ________________

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?	☐	☐

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: ________________

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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___________________

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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