NEW PATIENT HISTORY FORM

ID #:_____ **Today's Date:** _____

(Please Print) **Date of Birth:** ___/____/_____

Patient's Name: _____ **Age:** _____

Employer: _____ **Marital Status:** ___S__M__W

Occupation: _____

Current Medications (Include Birth Control) **Allergies**_____None

_____ **List all medications you are allergic to:**

_____ _____

Medical History (Check Appropriate Space) **Medical history** (Continued)

Have you ever had:

Blood Transfusion	____	Migraines	_____
High Cholesterol	____	Anemia/Blood Disorder	____
Heart Disease	____	Allergies	_____
Rheumatic Fever	____	Breast Problems	_____
High Blood Pressure	____	Breast Cancer	_____
Asthma	____	Ovarian Cancer	_____
Diabetes	____	Chlamydia	_____
Thyroid Issues	____	Gonorrhea	_____
Liver Disease	____	Herpes	_____
Birth Defects/ Inherited Diseases	_____	Syphilis	_____
Sexual Abuse/ Domestic Violence	_____	AIDS/HIV	_____
Infertility	_____	Hepatitis (Type __)	_____

Other Medical Problems (Please list below)

_____

Hospitalizations/Surgeries (Do not include Pregnancies)

Month/ Year	Illness or Operation
/	
/	
/	

Substance Abuse (Check only those you use)

Alcohol _____Type_____Amount/Day____

Non- Prescribed Pills ___Type___Amount/Day____

Tobacco ___Type_____Amount/Day_____

Pregnancy History (Complete all Info.)

Total # of Pregnancies	# Of Term Births	# of Preterm Births	# of Miscarriages/ Spontaneous Abortions	# of Terminations	# of Living Children
Pregnancy #	Born Mon/Year	Sex of Baby	Birth Weight	Delivery type Vaginal/C-sect.	Complications Yes/No
1	/		lbs oz		
2	/		lbs oz		
3	/		lbs oz		
4	/		lbs oz		

Menstrual History

First day of last menstrual period: ____/____/____

Type_____

Menarche (age of first period)_____ years old

Dates Used_____

Interval (# of days in between periods)_____ days

Sterilization:____Male____Female

Length of Period _____ days

Abnormalities ___ Discharge__Excessive Bleeding___Pain____None

Lifestyle

Have you ever had a pap test? Yes/No

Have you ever had a Mammogram? Yes/No

Date of last pap ____/____/____

Date of last Mammogram___/____/____

Have you ever had an abnormal pap result? Yes/No

Do you perform monthly breast exams? Yes/No

Are you sexually active? Yes/No

If so with Men___Women___Both___

Do you experience pain during intercourse? Yes/No

Have you ever had a Colonoscopy? Yes/No

Do you exercise on a regular basis? Yes/No

Date of last colonoscopy____/____/____

PATIENT

NAME:_____ DATE OF BIRTH:____/____/____ __Age:_____
HOME ADDRESS:_____ **SOCIAL SECURITY #:**_____
TOWN_____ZIP_____ HOME PHONE #:_____
BUSINESS NAME:_____ CELL PHONE #:_____
BUSINESS ADDRESS:_____ BUSINESS PHONE #:_____
_____ E-MAIL:_____
MARITAL STATUS:_____ REFERRED BY:_____
PRIMARY PHYSICIAN'S NAME AND #: PHARMACY NAME:_____
_____ _____
PHARMACY ADRESS:_____
_____

If you cannot reach me, you have permission to leave me detailed messages at this number

_____

INSURANCE

PRIMARY INS:_____ ID#:_____
EFFECTIVE DATE:_____ GROUP #:_____
POLICY HOLDER:_____ BUSINESS NAME:_____
SOCIAL SECURITY #_____ BUSINESS ADDRESS:_____
DATE OF BIRTH:_____ _____
RELATIONSHIP:_____ BUSINESS PHONE #: _____

SECONDARY INS:_____ ID #:_____
EFFECTIVE DATE:_____ GROUP #:_____
POLICY HOLDER:_____ BUSINESS NAME:_____
SOCIAL SECURITY #_____ BUSINESS ADDRESS:_____
DATE OF BIRTH:_____ _____
RELATIONSHIP:_____ BUSINESS PHONE #:_____

EMERGENCY CONTACT

NAME:_____ RELATIONSHIP:_____
HOME ADDRESS:_____ HOME PHONE #:_____
TOWN:_____ CELL PHONE #:_____
BUSINESS PHONE #:_____

I will be responsible to inform this office of any changes in address, phone number, employment, and insurance information by requesting and completing a new information form. Any outstanding balance such as co-pay / co-ins, denials due to change in coverage or non-participating plans is patient responsibility. Related fees 60 days after date of service will be charged a late fee of 1.5% per month on any outstanding balance. Co-pays, which are not paid at the time of service and require a patient billing statement, will be charged an additional processing fee of $25.00.

PLEASE BE AWARE, NOT ALL TESTING MAY BE COVERED BY YOUR HEALTH PLAN. YOU ARE ADVISED TO CONTACT YOUR CARRIER PRIOR TO TESTING. BETHPAGE OB-GYN WILL NOT BE RESPONSIBLE FOR ANY BILLS YOU MAY INCUR.

By my signature I affirm; all of the information included on this form is correct and accurate.

PATIENT'S SIGNATURE:_____ DATE:_____
SECRETARY'S SIGNATURE:_____ DATE:_____

BETHPAGE
Ob-Gyn

Obstetrics–Gynecology

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient's Name:

DOB:

SS#

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth in this form: In accordance with New York State Law and the privacy rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV RELATED INFORMATION only if I place my initials on the appropriate line in item B. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item B, I specifically authorize release of such information to the persons indicated in Item A.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV related information, I may contact the New York State Division of Human Rights at (212)480-2493 or the New York City Commission of Human Rights at (212)306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

HEALTHCARE PROVIDER: BETHPAGE OB/GYN

- **Name of healthcare provider or persons to release information to:**

  _____ **Phone:**_____

- **Include** _____ **Alcohol/Drug Treatment**

  _____**Mental Health Information**

  _____**HIV-related information**

- _____**I DO NOT WANT MY MEDICAL INFORMATION RELEASED TO ANYONE**

PATIENTS SIGNATURE:_____ **DATE:**_____

4277 Hempstead Turnpike • Bethpage New York 11714 Suite 102
Tel: (516) 731-5100 • Fax: (516) 731-3758
www.bethpageobgyn.com

Today's Date: _____

Name: _____ Date of birth: _____

Bethpage OB/GYN
4277 Hempstead Tpke Ste 102
Bethpage, NY 11714

Please answer the following questions to the best of your ability. Circle YES for any of the cancers in your family.

The Following Relatives Should Be Considered:

(1) Mother, Father, Brother, Sister, Children, (2) Paternal & Maternal Aunts/Uncles, Half Siblings, Nieces/Nephews, Maternal/Paternal Grandparents, (3) 1st Cousins, Great Aunts/Uncles, Great Grandparents

(1) 1st degree (2) second degree (3) third degree

Cancer History Description	Circle	YOURSELF or Relatives (see list above)	Paternal/ Maternal	Ages
Colon Cancer before the age of **50** (1st, 2nd degree)	YES			
Uterine/Endometrial cancer before the age of **50** (1st, 2nd degree)	YES			
Three or more of the following cancers (circle): colon, endometrial, gastric, ovarian, brain, pancreatic, small bowel, hepatobiliary tract, renal, or sebaceous adenomas (1st, 2nd & 3rd degree)	YES			
Breast Cancer diagnosed at or before the age of **50** (1st, 2nd degree)	YES			
Ovarian Cancer (1st, 2nd degree)	YES			
Male Breast Cancer (1st, 2nd degree)	YES			
Three or more breast cancers on the same side of the family (1st, 2nd & 3rd degree)	YES			
Three or more of the following cancers on the same side of the family: prostate, pancreatic or breast (1st, 2nd & 3rd degree)	YES			
Any relative diagnosed with breast cancer **twice or in both breasts** (1st, 2nd degree)	YES			
Are you **Ashkenazi Jewish** and have a diagnosis of breast, ovarian, pancreatic cancers in any family members listed above at any age (circle the cancer)	YES			

Have you or any of your family members been tested for the BRCA gene? If no, why not?

If your family history does not match the above criteria, check here ☐

OFFICE USE ONLY

Patient Meet Criteria for testing? Yes ☐ No☐ Discussed Genetic Testing? Yes ☐ No☐ Schedule appointment for counseling? Yes ☐ No☐

If no, state reason: _____

Patient Accepted Yes ☐ No☐ If patient denies, state reason: _____

Patient Signature: _____ MD signature: _____ Date: __/__/__

Notes: