

(Please Print)

CASSANDRA WHITAKER, M.D

PATIENT INFORMATION

NAME _____ DATE _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
 TELEPHONE: _____ CELL _____ WORK _____
 SOCIAL SECURITY NUMBER _____ BIRTHDAY _____
 PATIENT EMPLOYER / SCHOOL _____
 WHOM MAY WE THANK FOR REFERRING YOU? _____
 IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED _____

PRIMARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT _____
 RELATION TO PATIENT _____ BIRTHDAY _____ SOC. SEC # _____
 ADDRESS (if different from patient) _____ PHONE# _____
 CITY _____ STATE _____ ZIP CODE _____
 INSURANCE COMPANY _____
 POLICY / CERTIFICATE # _____ GROUP# _____

ADDITIONAL INSURANCE

IS PATIENT COVERED BY ADDITIONAL INSURANCE? YES ___ NO ___
 SUBSCRIBER NAME _____ BIRTHDAY _____ SOC SEC # _____
 ADDRESS (if different from patients) _____ PHONE _____
 CITY _____ STATE _____ ZIP CODE _____
 PERSON RESPONSIBLE EMPLOYED BY _____
 INSURANCE COMPANY _____
 POLICY / CERTIFICATE # _____

___ I HERBYAUTHORIZE CLEVE WALTERS M.D AND / OR CASSANDRA WHITAKER M.D TO FURNISH MY INSURANCE COMPANY ANY / ALL INFORMATION WHICH SAID COMPANY(S) MAY REQUEST.

___ I HERBYAUTHORIZE CLEVE WALTERS M.D AND / OR CASSANDRA WHITAKER M.D ALL MONEY TO WHICH I AM ENTITLED FOR MEDICAL AND / OR SURIGAL EXPENSIS RELATED TO THE SERVICES RENDERED.

___ I UNDERSTAND THAT I AM FINANCILLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS ASSIGNMENT INCLUDING COSMETIC SERVICES.

___ I AGREE TO PAY ANY BALANCE AFTER INSURANCE PAYMENTS WITHIN 20 DAYS.

___ I AGREE TO PAY ALL COLLECTIONS COSTS, COURTS COSTS AND REASONABLE ATTORNEY FEES IF I FAIL TO PROMPTLY PAY THIS ACCOUNT WHEN DUE & UNPAID BALANCE ISS TURNED TO COLLECTION SERVICE

SIGNATURE _____

Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY!

Our office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examinations and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example

- A Nurse or medical assistant obtains treatment information about you and records it in a health record
- During the course of your treatment, the physician determines he / she will need to consult with another specialist in the area.
- We submit requests for payment to your health insurance company

PLEASE COMPLETE THE FOLLOWING QUESTIONS

- May we leave a message on your home answering machine? _____YES _____NO

The staff at Cleve Water, M.D and / or Cassandra Whitaker, M.D may leave a message regarding appointment or normal test results on my answering machine, or with someone other than myself at my home telephone number.
_____YES _____NO

- May we leave a message for you at work to call us? _____YES _____NO
- Please list name or names and relationships of person or persons that we may discuss your condition

NAME	RELATIONSHIP
_____	_____
_____	_____

A full copy of our HIPAA Privacy Notice is Available upon request.

PATIENT SIGNATURE: _____

GYN

Name: _____ Age _____ DOB _____

Menstrual History

Menstruated first at what age _____ The interval from the first day of one period to the first day of the next period is usually _____ days.

Menstrual flow is usually lasts _____ days.

Menstrual flow is usually: scant _____ moderate _____ Heavy _____ Excessive _____

How many pads _____ or tampons _____ do you usually use on the heaviest day?

When was the first day of your last period? _____ Number of days of flow? _____

Allergies List any allergies _____

Pregnancy History

How many times have you been pregnant? _____

Number of full-term births (including Still births) _____

Number of pre-term births _____

Number of miscarriages or abortions _____

Were any of your pregnancies or deliveries abnormal? _____ if yes, in what way _____

Ages of your children _____

Contraception

Do you presently take birth control pills? _____ if yes, give name of pills _____

If not pills, check contraceptive type used: Tubal Ligation _____ Vasectomy _____ Diaphragm _____

Rubber condom _____ Rhythm _____ withdrawal _____ foam _____ cream _____ IUD _____

Present History-Circle whether you have or have had problems with the following:

1. Pain with periods no / yes explain _____
2. Heavy menstrual flow no / yes explain _____
3. Bleeding or spotting between periods no / yes _____
4. Missed periods no / yes _____
5. Pain with sexual intercourse no / yes _____
6. Bleeding or spotting following sexual intercourse no / yes _____
7. Vaginal discharge no / yes _____
8. Vaginal or genital itching no / yes _____
9. Pain or burning with urination no / yes _____
10. Bloody or dark colored urine no / yes onset _____
11. Uncontrolled urge to urinate no / yes _____
12. Inability to hold urine no / yes _____
13. Abnormal frequency of urination no / yes How many times per day _____ Night _____
14. Change in bowel habits no / yes _____
15. Change in stool no / yes _____
16. Constipation no / yes _____
17. Diarrhea no / yes _____

- 18. Problems getting pregnant no / yes _____
- 19. Abdominal pain no / yes _____
- 20. Chills / fever no / yes _____
- 21. Nausea / vomiting no / yes _____
- 22. Other Problems _____

Previous History

- 23. Serious illness no / yes _____
- 24. Operations or accidents no / yes _____
- 25. Venereal disease such as syphilis or gonorrhea no / yes When ? _____
- 26. Blood disorders (anemia, leukemia, ect) no / yes When ? _____
- 27. Blood transfusions no / yes _____
- 28. Hospitalization no / yes _____
- 29. Do you use drugs regularly no / yes Names and how often? _____

Do you drink alcoholic beverages no / yes How often?

Do you smoke? No / yes How many per day? _____

Do you use laxatives? No / yes How often? _____

Patient and Family History

Circle whether you or immediate family members have or have had the following, if family member state relation.

- 30. Malignancies or cancer no / yes Explain _____
- 31. High Blood pressure no / yes _____
- 32. Heart Disease no / yes _____
- 33. Lung Disease no / yes _____
- 34. Sugar diabetes no / yes _____
- 35. Kidney disease no / yes _____
- 36. Other medical problems involving you or your family _____

What medications do you regularly take? (give dosage and frequency) _____

Do you douche? No / yes How often ? _____

When and where was your last pap smear taken? _____