W I L S O N
OB-GYN
2500 Horton Boulevard • P.O. Box 7639 • Wilson, North Carolina 27893 • 252 206-1000 • 1-800-775-8765

PATIENT INFORMATION

Name: _____ Race: _____

Address: _____

City,State,Zip Code: _____

Home Telephone: _____ Cellular: _____

Employer: _____

Employer Address andTelephone: _____

Date of Birth: _____ Social Security Number: _____

Marital Status: (Circle one) Single Married Widowed Separated/Divorced

SPOUSE'S INFORMATION

Name: _____

Date of Birth: _____ Social Security Number: _____

Employer: _____

Employer Address and Telephone: _____

POLICYHOLDERS INFORMATION:

Name _____ Date of Birth: _____

Social Security# _____ Relationship to Insured ___Spouse ___Parent/Guardian

Age: ____ #Pregnancies ____ # Live Births____ # Miscarriages/Abortions _____
First day of last period: _____ Type of birth control used: _____

Medications: _____
Drug Allergies: _____

DO YOU HAVE OR HAVE YOU HAD (Please circle Yes or No)

Abnormal Paps	Y N Year _____	Gonorrhea	Y N
Anemia	Y N	Heart Disease	Y N
Arthritis	Y N	Herpes	Y N
Asthma	Y N	High Blood Pressure	Y N
Bladder Infections	Y N	Kidney Disease	Y N
Blood Clots in Veins	Y N	Liver Disease	Y N
Blood Transfusions	Y N	Mental Disorder	Y N
Breast Lump/Cancer	Y N Year _____	Nipple Discharge	Y N
Bronchitis	Y N	Nerve Disease	Y N
Cancer	Y N Type _____	Ovarian Cysts	Y N
Chlamydia	Y N	Tuberculosis	Y N
Diabetes	Y N Controlled By: Diet Medication Insulin		
Pelvic Inflammatory Disease	Y N	Ulcers	Y N
Pneumonia	Y N	Uterine Fibroids	Y N
Seizures	Y N	Varicose Veins	Y N
Syphilis	Y N	Thyroid Disease/Goiter	Y N

Any other medical problems not listed:

_____

_____

PAST MEDICAL HISTORY

Do you have any medical problems you take medications for every day? If so, what conditions and list medication:

_____

_____

_____

PAST SURGICAL HISTORY

Have you ever had surgery NOT included childbirth?

Operation	Hospital	Year	Complications

GYNECOLOGICAL HISTORY

How old were you when you started your cycle? _____ How often do you have your cycle? Every _____days. Is it regular Yes No How long does it last? _____ days. Do you have mild moderate severe cramping? (Circle One). When was your last mammogram completed? _____ Year. Was it normal? Yes No. Where was it done? _____

PLEASE LIST ALL PREGNANCIES (including miscarriages/abortions).

Year	Sex	Weight	Complications	Type of Delivery	Hospital

SOCIAL HISTORY

Do you smoke? Yes No If so, how much per day? _____ packs
Do you use alcohol? Yes No If so, how many drinks per week? _____

FAMILY HISTORY

Is there a family history of cancer in your family? Yes No If so, what type?

_____

How are you related? _____

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GENETIC SCREENING FORM

In order for us to give you the best prenatal care possible, it is important for us to have some information about your family history. Please answer the questions below. All information will be held in strict confidence.

INFORMATION ABOUT YOU: **CIRCLE ONE**

1. Will you be age 35 or older when this baby is born	YES	NO
2. Have you ever had a miscarriage or stillborn? If yes, explain _____	YES	NO
3. Have you ever had a child with any type of birth defect? If yes, explain _____	YES	NO
4. Has your mother, sisters, brothers, or other close relatives had any of the problems mentioned in questions 2 and 3 above? If yes, explain _____	YES	NO
5. Do you have any close relatives who are mentally retarded? If yes, explain cause (if known) _____	YES	NO
6. Do you drink alcohol? Number of drinks per week _____	YES	NO
7. Do you smoke? Number of packs per week _____	YES	NO
8. During this pregnancy have you:		
a. taken any medicine?	YES	NO
b. taken any "street drugs"?	YES	NO
c. had any x-ray examinations?	YES	NO
d. had a fever over 102 degrees for 2 days?	YES	NO
e. been in a "hot tub"?	YES	NO
9. Do you have diabetes, epilepsy or lupus?	YES	NO
10. Do you have a birth defect?	YES	NO

Edward S. Brezina M.D. Arthur H. Hanson, M.D. Daniel P. Michalak, M.D. Suzanne R. Fiscus, M.D.

11. Are you and the baby's father related in any way? (i.e. - cousins) YES NO

12. Do you or the baby's father have relatives descended from Jewish people from Eastern Europe? YES NO

13. If you or the baby's father is Black, have you been tested for the sickle cell trait? YES NO

INFORMATION ABOUT THE BABY'S FATHER

1. Will he be age 44 or older when this baby is born? YES NO

2. Has he ever fathered a miscarriage, a stillborn, or a child with any type of birth defect? If yes, explain YES NO

_____

3. Has his mother, sisters, brothers, or other close relatives had any of the problems mentioned in question 2? If yes, explain _____ YES NO

4. Does he have any close relatives who are mentally retarded? If yes, explain cause (if known) YES NO

_____

5. Please explain any major concerns you have about this baby or pregnancy, which are not mentioned above:

_____

_____

DOCTOR OR NURSE COMPLETE BELOW:

_____ discussed the above questions with the patient. The patient wants genetic counseling and prenatal diagnosis for: _____

_____

Patient referred for counseling and testing concerning: _____

_____

Date referred: _____ Genetic Center: _____

IF PATIENT DOES NOT WANT GENETIC COUNSELING OR TESTING, SIGN BELOW:

I have discussed the questions, which are answered "YES" with my doctor or nurse and understand that I am at increased risk for _____.

I know that it is usually possible to diagnose an affected fetus and I have decided NOT to have the test performed.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

WITNESS SIGNATURE DATE

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INFORMED CONSENT TO DO AIDS VIRUS (HIV) ANTIBODY TESTING AND TO RECORD TEST RESULTS

The HIV antibody test detects the presence of antibodies to the AIDS virus. These antibodies are substances in the blood produced by the body following infection with the AIDS virus. This is not a test for AIDS. The test will not tell you if you have AIDS or an AIDS-related condition. It does show whether or not you have been infected with the virus that can cause AIDS.

I have been informed about the AIDS virus (HIV) antibody test. I have read or have had read to me the contents of this form. I have had a chance to ask questions concerning the test and these questions were answered to my satisfaction.

I understand that my medical treatment may be changed if my test is positive and that this change in treatment may be beneficial to me. I also understand that letting others know about my test results could cause problems in employment or in obtaining insurance.

I understand that this test and the results will be part of my medical record. I understand that both my test results and my medical record are confidential and will be shared only with health care providers directly involved in my care. I may request that my test results or any part of my record be withheld at the time I give consent for release of that record. I undertstand that omissions may be obvious and may lead to further inquiries, but no information will be released without my permission.

I understand the benefits and risks of the test. I agree to have this test done and the results recorded in my medical record.

_____ _____

PATIENT'S SIGNATURE **DATE**

_____ _____

WITNESS **MEDICAL RECORD NO.**

Edward S. Brezina, M.D. • Arthur H. Hanson, M.D. • Daniel P. Michalak, M.D. • Suzanne R. Fiscus, M.D.

Wilson OB/GYN
Authorization for Release of Information

Name of Patient _____ DOB: _____

Wilson OB/GYN is authorized to release protected health information about the above-named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions. Please read the description of each entity carefully.

Entity to Receive Information. Check each person/entity that you approve to receive information	**Description on information to be released.** Check each that can be given to the person/entity on the left *in the same section.*
▫ Voice Mail	▫ Results of lab tests/x-rays ▫ Other: _____
▫ Give information to employer ▫ Give information to school	▫ Appointment absentee information
▫ Spouse	▫ Family billing demographic information ▫ Financial/insurance information ▫ Medical as follows: _____
▫ Parent (provide name) _____	▫ Family billing information ▫ Financial/insurance information ▫ Medical as follows:
▫Other (provide name) _____	▫ Financial ▫ Medical as follows: _____
▫Support Group (provide name) _____	▫ Demographic Information

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to **Wilson OB/GYN.** I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ Date _____
Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach documentation) _____

Wilson OB/GYN
2500 Horton Boulevard
Wilson, NC 27896/(252) 206-1000

Effective April 14, 2003

HIPAA

(Health Insurance Portability and Accountability Act of 1996)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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This notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. "Protected Health Information" is information about you, including demographic information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your Protected Health Information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT: We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your Protected Health Information, as necessary, to a home health agency that provides care to you, or to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

PAYMENT: Your Protected Health Information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant Protected Health Information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTH CARE OPERATIONS: We may use or disclose, as needed, your Protected Health Information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities, In addition we may use a sign-in sheet at the registration desk, we may provide you with appointment reminders and other necessary medical information by postcards or letters, voicemail messages at home, and requests for a return telephone call at your place of employment. We may also call you by name in the waiting room when your physician is ready to see you.

SPECIAL SITUATIONS

As required by law we will disclose your Protected Health Information when required to do so by international, federal, state or local authorities. Such situations include, but are not limited to, **Averting a Serious Threat to Health or Safety of the public; Business Associates** (disclosure to those who perform functions on our behalf, such as our billing company), **Organ and Tissue Donation; Military and Veterans; Workers' Compensation; Public Health Risks; Health Oversight Activities; Lawsuits and Disputes; Law Enforcement; Coroners, Medical Examiners, and Funeral Directors; National Security and Intelligence Activities; Protective Services for the President and Other Authorized Persons; Inmates or Individuals in Custody.**

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES: Will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time in writing except the extent that your physician or practice has taken an action in reliance on the use or disclosure indicated in the authorization

YOUR RIGHTS

The following is a statement of your rights with respect to your Protected Health Information.

You have the right to inspect a copy of your Protected Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records. Under Federal Law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. If you request a copy of your Protected Health Information, we may charge a reasonable fee for the copying, postage, labor and supplies used in meeting your request.

You have the right to request restrictions of your Protected Health Information which means you have the right to ask us not to use or disclose any part of your Protected Health Information for the purposes of treatment, payment or healthcare operations. You also have the right to request a limit on the Protected Health Information we disclose to someone involved in your care or the payment for your care, such as a family member or friend. To request a restriction, you must make your request in writing to the Practice Manager. **We are not required to agree to your request** if the physician believes it is in your best interest to permit use and disclosure of your Protected Health Information. You then have the right to use another Healthcare Professional.

You have the right to request confidential communication regarding medical matters be given to you in a certain way or at a certain location. This request must be made in writing to the Practice Manager. Your request will specify how or where you wish to be contacted. We will accommodate reasonable requests.

You have the right to have your physician amend your Protected Health Information. If you feel that your Protected Health Information we have is incorrect, or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. This request must be made in writing to our Practice Manager.

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.wilsonobgyn.com.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notice apply to Protected Health Information we already have as well as any Information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Wilson OB/GYN by contacting LouAnn Boykin or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

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We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to Protected Health Information. If you have any objections to this form, please ask to speak with our HIPAA Privacy Officer, LouAnn Boykin in person or by telephone (252) 206-1000 or (800) 775-0474.

Signature below is only acknowledgment that you have received this **NOTICE of our PRIVACY PRACTICES.**

Print Name	**Signature**	**Date**

DOB -