PATIENT NAMES ____
(last) (first) (middle)

MARITAL STATUS: ________________________ BIRTHDATE _____/_____/_______ AGE______

S.S. NUMBER ______--_____--______ E-MAIL ____

ADDRESS: ____ CITY ____________________ STATE ____ ZIP ___________

PHONE NUMBER: Home (_____)______--________ Cell (_____)______--________ Work (_____)______--________.

EMPOYER: ____________________________________ ADDRESS: ____

SPOUSE NAME: ____
(last) (first) (middle)

BIRTHDATE _____/_____/_______ S.S. NUMBER ______--_____--______ Work (_____)______--________.

SPOUSE EMPOYER: ______________________________ ADDRESS: ____

DO YOU HAVE INSURANCE? _____ IF NOT, HOW DO YOU INTEND TO PAY? ___ CASH ___ CHECK ___CREDIT CARD

INSURANCE INFORMATION

PRIMARY INS. CO. _____________________________________ ADDRESS _____________________________________

POLICY HOLDERS NAME":____ BIRTHDATE ____/____/_____
(last) (first) (middle)

POLICY HOLDER ADDRESS ____ PHONE (_____)______--________.

SECONDARY INS. CO. _________________________________ ADDRESS _____________________________________

POLICY HOLDERS NAME":____ BIRTHDATE ____/____/_____
(last) (first) (middle)

POLICY HOLDER ADDRESS ____ PHONE (_____)______--________.

NEAREST RELATIVE NOT LIVING WITH YOU: _________________________________ PHONE (_____)______--________.

ADDRESS ____ RELATIONSHIP __________________________

HOW DID YOU HEAR ABOUT US? ____

IN CASE OF EMERGENCY PLEASE CONTACT __________________________________ PHONE (_____)______--________.

FINANCIAL INFORMATION

PLEASE READ CAREFULLY

Assignment of Benefits

I herby authorize direct payment of medical benefits to this office for services rendered. I understand that I am financially responsible for any charges incurred by me regardless of insurance coverage.

Release of Information

I authorize the release of any information necessary for medical care or for processing insurance claims.

Financial Policy

Office visit copays are due at the time of service. Arrangements may be made for balances left unpaid by insurance companies. In the event my account is turned over for outside collections I agree to pay all cost related to collections, to include court cost, attorney fees and interest at 18%.

SIGNED ____ **DATE** ______________________

____ **DATE** ______________________

PARENT OR LEGAL GUARDIAN IF PATIENT UNDER 18 YEARS OF AGE.

PATIENT INTAKE HISTORY

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /
NAME YOU WOULD LIKE US TO USE:			
WORK TELEPHONE: ( )	EMERGENCY CONTACT:		
HOME TELEPHONE: ( )	RELATIONSHIP:		
CELL TELEPHONE: ( )	TELEPHONE(S):		
REFERRED BY:	PCP:		
WHY HAVE YOU COME TO THE OFFICE TODAY?			
IF YOU ARE HERE FOR AN ANNUAL EXAMINATION IS THIS A ☐ PRIMARY CARE VISIT OR ☐ GYNECOLOGY ONLY			
IS THIS A NEW PROBLEM?			
PLEASE DESCRIBE YOUR PROBLEM, INCLUDING WHERE IT IS, HOW SEVERE IT IS, AND HOW LONG IT HAS LASTED:			

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

GYNECOLOGIC HISTORY

	PROVIDER'S NOTES
AGE PERIODS STARTED:	
DATE LAST PERIOD BEGAN:	
HOW FAR APART ARE YOUR PERIODS?	
HOW LONG DO THEY LAST?	
WHAT DO YOU USE FOR BIRTH CONTROL?	
WHEN WAS YOUR LAST PAP SMEAR? RESULT:	
HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR?	
WHAT WAS DONE?	
LAST MAMMOGRAM: DATE RESULT:	
BONE DENSITY TEST: DATE RESULT:	
COLONOSCOPY: DATE RESULT:	
ARE YOU SEXUALLY ACTIVE?	
WOULD YOU LIKE TO BE TESTED FOR STD's?	

Shenandoah Women's HealthCare

PATIENT INTAKE HISTORY

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

OBSTETRIC HISTORY

NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY OR MISCARRIAGE (VAGINAL, CESAREAN, ETC.)	COMPLICATIONS?
1.						
2.						
3.						
4.						
5.						
6.						

PROVIDER'S NOTES ON OBSTETRIC HISTORY:

PERSONAL PAST HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES (DATE)	NO	PROVIDER'S NOTES
ASTHMA			
KIDNEY INFECTIONS/STONES			
SEXUALLY TRANSMITTED DISEASE			
DIABETES			
HIGH BLOOD PRESSURE			
STROKE			
BLOOD CLOTS IN LUNGS OR LEGS			
CANCER			
REFLUX/HIATAL HERNIA/ULCERS			
DEPRESSION/ANXIETY			
BLOOD TRANSFUSIONS			
HIGH CHOLESTEROL			
PCOS			
THYROID DISEASE			
INJURIES			
OTHER:			

Shenandoah Women's HealthCare

PATIENT INTAKE HISTORY

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

SOCIAL HISTORY

	PROVIDER'S NOTES
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ ENGAGED	
SEXUAL HISTORY: ☐ NEVER SEXUALLY ACTIVE	
☐ NOT CURRENTLY SEXUALLY ACTIVE	
☐ CURRENTLY SEXUALLY ACTIVE WITH: ☐ MEN ☐ WOMEN	
LEVEL OF SCHOOL COMPLETED:	
OCCUPATION:	
LANGUAGE SPOKEN:	
EXERCISE: ☐ MINIMAL ☐ REGULAR ☐ DAILY	
DIET: ☐ REGULAR ☐ TYPE:	
TOBACCO: ☐ NEVER ☐ PAST USE, QUIT ______ ☐ CURRENT	
CAFFEINE: ☐ NEVER ☐ RARE ☐ MINIMAL ☐ MODERATE	
ALCOHOL: ☐ NEVER ☐ RARE ☐ MINIMAL ☐ MODERATE	
RECREATIONAL DRUGS: ☐ NEVER ☐ PAST ☐ CURRENT, TYPE ______	

CURRENT MEDICATIONS
(Including hormones, vitamins, herbs, nonprescription medications)

NAME	DOSE	HOW MANY TIMES/DAY	TAKEN FOR WHAT CONDITION?	WHO PRESCRIBED IT?

ALLERGIES

MEDICATION	REACTION

GYN SURGERIES (ex: C-section, tubal ligation, ovarian cysts, LEEP, hysterectomy, etc.)

DATE	SURGERY	REASON	PROVIDER'S NOTES

OPERATIONS/HOSPITALIZATIONS

DATE	SURGERY	REASON	HOSPITAL

Shenandoah Women's HealthCare

PATIENT INTAKE HISTORY

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

IMMUNIZATIONS/TEST

	YES	NOT SURE	NO	DATE		YES	NOT SURE	NO	DATE
TETANUS-DIPTHERIA BOOSTER					INFLUENZA VACCINE (FLU-SHOT)				
HEPATITIS A VACCINE					HEPATITIS B VACCINE				
VARICELLA VACCINE					PNEUMOCOCCAL VACCINE				
TUBERCULOSIS (TB) SKIN TEST					MEASLES-MUMPS-RUBELL (MMR) VACCINE				
RESULT:									

FAMILY HISTORY

MOTHER: ☐ LIVING ☐ DECEASED--CAUSE: AGE:

FATHER: ☐ LIVING ☐ DECEASED--CAUSE: AGE:

SIBLINGS: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):

CHILDREN: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):

ILLNESS	WHICH RELATIVE(S) AND AGE OF ONSET	PROVIDER'S NOTES
CANCER - BREAST		
CANCER - COLON		
CANCER - OVARY		
CANCER - UTERUS		
STROKE (CVA) / BLOOD CLOTS		
DEPRESSION		
DIABETES		
HEART DISEASE		
HIGH CHOLESTEROL		
HYPERTENSION		
THYROID DISEASE		
HEART ATTACK (MI)		
OSTEOPOROSIS		

PROVIDER'S NOTES:

Shenandoah Women's HealthCare

PATIENT INTAKE HISTORY

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

REVIEW OF SYSTEMS **Please check (x) if any of the following symptoms apply to you now or since adulthood**

	NOW	PAST	PROVIDER'S NOTES
1. GENERAL			
FATIGUE	☐	☐	
WEIGHT CHANGE	☐	☐	
2. EYES			
GLASSES / CONTACTS	☐	☐	
3. EARS/NOSE/THROAT			
HEARING PROBLEMS	☐	☐	
4. CARDIAC			
CHEST PAIN	☐	☐	
SHORTNESS OF BREATH WITH EXERCISE	☐	☐	
IRREGULAR HEART BEAT	☐	☐	
5. RESPIRATORY			
COUGH	☐	☐	
SHORTNESS OF BREATH	☐	☐	
6. GASTROINTESTINAL			
CONSTIPATION	☐	☐	
DIARRHEA	☐	☐	
BLOOD IN STOOL	☐	☐	
7. GENITOURINARY			
PAIN WITH URINATION	☐	☐	
LEAKING URINE	☐	☐	
VAGINAL BLEEDING	☐	☐	
8. MUSCULOSKELETAL			
MUSCLE/JOINT PAIN	☐	☐	
9. SKIN			
RASH	☐	☐	
MOLES	☐	☐	
10. BREASTS			
MASSES	☐	☐	
11. NEUROLOGIC			
HEADACHE	☐	☐	
12. PSYCHIATRIC			
DEPRESSION / ANXIETY	☐	☐	
13. ENDOCRINE			
HEAT / COLD INTOLERANCE	☐	☐	
14. HEMATOLOGIC			
FREQUENT BRUISES	☐	☐	
15. ALLERGIES			
SEASONAL	☐	☐	
16. RHEUMATOLOGIC DISEASE			
ARTHRITIS	☐	☐	
OTHER	☐	☐	
17. UROLOGIC PROBLEMS			
URINARY INCONTINENCE	☐	☐	
RECENT UTI	☐	☐	
OTHER	☐	☐	
18. OTHER MEDICAL PROBLEMS			

FORM COMPLETED BY: ☐ PATIENT ☐ OFFICE NURSE ☐ PHYSICIAN ☐ OTHER:

SIGNATURE OF PATIENT:	REVIEWED BY:

Right to a Paper Copy of This Notice. 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 website, www.swhc.net.

Changes to this Notice: We reserve the right to change this notice and make the revised notice effective for information we already have about you as well as any future information. We will post a copy of the current notice in the office. Each time you register at the office we will offer you a copy of the current notice.

Complaints:
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

To file a complaint with the office,

Contact Officer: Tracey E. Meadows (Practice Manager) or email – tmeadows@swhc.net

Telephone: 540-438-1314 Toll Free: 877-438-1314 Fax: 540-438-0797

Address: 240 Lucy Drive, Harrisonburg, VA 22801

Other Uses of Medical Information:

Other uses and disclosures of information not covered by this notice will be made only with your written permission. You may revoke that permission in writing at any time. Understand that we are unable to take back any permitted disclosures, and that we are required to retain records of your care.

HIPAA Notice of Privacy Practices

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 Pledge Regarding Medical Information:

We understand that medical information about you and your health is personal. We are committed to protecting your medical information. We create a record of the care you receive at this office to provide you with quality care and to comply with legal requirements. This notice will tell you about the ways in which we use and disclose your medical information. We also describe your rights and the obligations we have regarding the use and disclosure of medical information. We are required by law to make sure that medical information that identifies you is kept private; give you this notice of our privacy practices with respect to your medical information; and follow the terms of the current notice.

Who Will Follow This Notice:
This notice describes our office's practices. We may share information with each other for your care.

How We May Use and Disclose Medical Information About You:

For Treatment. We may use information about you to provide you with medical treatment. We may disclose medical information about you to office staff and others involved in your care.

For Payment. We may use and disclose information about you for insurance and payment services.

For Health Care Operations. We may use and disclose information about you for practice operations to make sure that you receive quality care and for learning purposes.

Appointment Reminders. We may use and disclose information to contact you about appointments.

Phone Messages. We may call and leave messages with whoever answers the phone at your house or on your answering machine unless directed otherwise.

Treatment Alternatives. We may use and disclose information to tell you about treatment options.

Health-Related Benefits and Services. We may tell you about health-related benefits or services.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in or helps pay for your medical care. We may disclose medical information about you to assist in a disaster relief effort.

As Required By Law. We will disclose information about you when required to do so by law.

To Avert a Serious Threat to Health or Safety. We may use and disclose information about you to prevent a serious threat to your health and safety, the public or to another person.

Special Situations:

Organ and Tissue Donation. If you are an organ donor, we may release information to organ banks.

Military and Veterans. We may release information about military personnel as required.

Workers' Compensation. We may release information about you for workers' compensation.

Public Health Risks. We may disclose information about you for public health activities.

Health Oversight Activities. We may disclose information to a health oversight agency.

Lawsuits and Disputes. We may disclose information about you in response to a court or administrative order, a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request.

Law Enforcement. We may release information to a law enforcement official as required by law.

Coroners, Medical Examiners and Funeral Directors. We may release information to a coroner, medical examiner or funeral director as necessary.

National Security and Intelligence Activities and Protective Services for the President. We may release information about you to authorized federal officials for national security activities.

Inmates. We may release information about inmates to a correctional institution or law enforcement.

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy your medical information. This includes medical and billing records, but does not include psychotherapy notes. You must submit your request in writing to Shenandoah Women's HealthCare. We may charge a fee for the costs of copying. We may deny your request to inspect and copy. You may request that the denial be reviewed. Another neutral health care professional, not the person who denied your request, will review your request and the denial. We will comply with the outcome of the review.

Right to Amend. If you feel that your information is incorrect or incomplete, you may ask us to amend the information. You may request an amendment as long as the office has this information. Your request must include the reason, be made in writing and submitted to Shenandoah Women's HealthCare. We may deny your request if you ask us to amend information not created by us, unless the person that created the information is no longer available; is not part of the information kept by the practice; is not information which you would be permitted to inspect and copy; or is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request a list of the accounting of disclosures we made of your medical information. You must submit your request in writing to Shenandoah Women's HealthCare. Your request must state a time period, not longer than six years, and indicate whether you want the list on paper or electronic. Your first requested list within a year is free.

Right to Request Restrictions. You have the right to request a restriction or limitation on the information we use or disclose about you for treatment, payment, and health care operations or to someone who is involved in your care or the payment for your care. **We are not required to agree to your request.** If we agree, we will comply with your request unless the information is needed in an emergency. You must make your request in writing to Shenandoah Women's HealthCare. You must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or location. You must make your request in writing to Shenandoah Women's HealthCare. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We have the right to deny your request.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Shenandoah Women's HealthCare may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Shenandoah Women's HealthCare's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Shenandoah Women's HealthCare reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Shenandoah Women's HealthCare Privacy Officer at 119 University Blvd., Ste. B, Harrisonburg, Va 22801.

With my consent, Shenandoah Women's HealthCare may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Shenandoah Women's HealthCare may mail to my home or other designated 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 my consent, Shenandoah Women's HealthCare may e-mail to my home or other designated 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 Shenandoah Women's HealthCare restrict how it uses or discloses my PHI to carry out TPO.

However, 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 Shenandoah Women's HealthCare's use and disclosure of 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, Shenandoah Women's HealthCare may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

____________________________________ ____________________
Patient's Name Date

____
Print Name of Patient or Legal Guardian