Chesapeake Women's Care, P.A.

Obstetrics & Gynecology

Name:_____ Date:_____

Patient Date of Birth:_____ SS#_____

Allergies:_____ No Allergies:_____

Current Medications:_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Ph:_____Work Ph:_____Cell Ph:_____

Insurance Company _____

Policy Holder's Name:_____ Relationship:_____

Policy Holder's DOB:_____ SS#_____

Name of Primary Care Physician:_____

Reason for today's visit:

Routine GYN exam and pap smear: _____ Prenatal care:_____

Consult:_____ Referring Doctor:_____

Other:_____

Last Menstrual Period:_____

Signature:_____

NOTE: THE REASON LISTED ABOVE FOR TODAY'S VISIT WILL HELP US BILL YOUR INSURANCE COMPANY PROPERLY AND ACCURATELY. BECAUSE IT IS CONSIDERED FRAUD, WE WILL NOT CHANGE YOUR DIAGNOSIS IF YOUR INSURANCE DOES NOT COVER ANY OF THE SERVICES RENDERED TODAY.
OUR PREFERRED LAB IS LABCORP. IF YOUR INSURANCE DICTATES ANOTHER LAB, PLEASE INFORM US. IF YOU HAVE QUESTIONS ABOUT YOUR LAB BILL, PLEASE DO NOT CALL THIS OFFICE, CALL THE LAB.

RECEIPT OF NOTICE OF PRIVACY PRACTICES Written Acknowledgment
I, _____ have received a copy of Chesapeake Women's Care's Notice of Privacy Practices.

There is a $25.00 charge for returned checks. Accounts not paid in full after 120 days will be forwarded to our collection agency. I understand that I am responsible for charges associated with the collection process added to my account.

Signature of Patient: _____Date:_____

RELEASE OF INFORMATION:

Please tell us how you wish to be contacted. Check all that apply.

Contact Phone #:

(_____) _____

____OK to leave message with detailed information
____Leave message with call back number/name only

___ E-Mail address _____

Please tell us with whom we are allowed to discuss and/or disclose your Personal Health Information.

Circle all that apply: Spouse Adult Children Parents Sibling Personal Representative

Name(s) of above: _____ Phone: (___)_____

_____ Phone: (___)_____

Pharmacy Name / Location: _____

_____

Pharmacy Phone #: (_____) _____

_____ ___/___/___

PATIENT/RESPONSIBLE PARTY SIGNATURE **DATE**