women's comprehensive healthcare of new jersey

West Long Branch OB/GYN

1019 Broadway, West Long Branch, NJ 07764 * Phone (732) 229-6797 * Fax (732) 229-6893
911 East County Line Road, Suite #201, Lakewood, NJ 08701 * Phone (732) 367-9299 * Fax (732) 367-0433
1270 Route 35 South, Suite B, Middletown, NJ 07748 * Phone (732) 671-3597 * Fax (732) 229-6893

New Patient Information

Please be 15 minutes early for your first appointment. Bring this completed paperwork, your insurance card, and a government-issued ID (such as a driver's license or passport).

Patient Information:

Legal first name: _____ MI: _____ Legal last name: _____

Nickname: _____ Maiden name: _____ Date of birth: _____

Social security #: _____ Email address: _____

Address: _____ Apt #: _____ City/State/Zip: _____

Home phone: _____ Cell phone: _____

Work phone: _____Ext: _____ Preferred phone number: home / cell / work

Insurance Information:

Primary insurance name: _____ Address: _____

ID#: _____ Group #: _____

Subscriber Name: _____ Date of birth: _____

Relationship: self/parent/spouse/other: _____ Address: _____

Social security #: _____ Employer: _____

Secondary insurance name: _____ Address: _____

ID#: _____ Group #: _____

Subscriber Name: _____ Date of birth: _____

Relationship: self/parent/spouse/other: _____ Address: _____

Social security #: _____ Employer: _____

Emergency Contact Information:

Name: _____ Phone #: _____ Relationship: _____

Pharmacy Information:

Local pharmacy name: _____ Phone #: _____

Address: _____ City, State, Zip code: _____

Mail order pharmacy name: _____ Phone #: _____

Employer Information:

Employer name: _____ Occupation: _____

Demographic Information:

Preferred Language: ___ English
___ Other: _____

Ethnicity: ___ Decline to answer
___ Hispanic or Latino
___ Not Hispanic or Latino

Race: ___ Decline to answer
___ American Indian or Alaska Native
___ Asian
___ Black or African American
___ Middle Eastern
___ Native Hawaiian or Pacific Islander
___ White or Caucasian
___ Other: _____

Marital status: ___ Married
___ Single
___ Divorced
___ Separated
___ Widowed

Authorization for Payment:

I authorize the release of medical information necessary to process the claims for medical benefits. I authorize and assign any payment of medical benefits to Women's Comprehensive Healthcare of New Jersey, its successors and assigns, or any individual it may designate for services provided.

I further agree to pay all costs of collection, including attorney's fees associated with collection of any amount due to services rendered and performed. I will pay interest at the prevailing annual rate for all amounts 30 days past due. I understand that I am financially responsible to Women's Comprehensive Healthcare of New Jersey, its successors and assigns and any individual it may designate for any balance not covered by insurance.

_____ _____

Signature of patient or parent of minor Date

Authorization for Medicare:

I request that payment of Authorized Medicare benefits be made either to me or on my behalf to Women's Comprehensive Healthcare of New Jersey for any services furnished to me by the physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature of patient Date

Receipt of Notice of Privacy Practices:

I have received a copy of Women's Comprehensive Healthcare of New Jersey's Notice of Privacy Practices.

_____ _____

Signature of patient Date

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HIPAA Notice of Privacy Practices

Please carefully review our Notice of Privacy. This notice describes how medical information about you may be used and/or disclosed. We are required by law to maintain the privacy of your protected healthcare information. If you have specific questions regarding this Notice of Privacy Practices, please contact the office.

****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.****

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 that relates to your past, present or future physical or mental health care services.

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

Treatment: We will use and disclose your PHI 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.

Payment: Your PHI will be used, as needed, to obtain payment for your healthcare services.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing and conducting or arranging business activities. For example, we call your name in the waiting room when your provider is ready to see you.

We may also use or disclose your PHI in the following situations without your authorization. These situations include, as Required by Law: Public Health issues, Communicable Diseases, Health oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates.

Required Uses and Disclosures: Under the Law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

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 to the extent that your provider or the provider's practice has taken as action in reliance on the use or disclosure indicated in the authorization.

You have the right to inspect and copy your PHI. 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 PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI may be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If the provider believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Provider.

You have the right to request confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your provider amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

For any complaints, please contact our HIPAA Officer, at 732-229-6797 x11.

This notice was published and becomes effective on or before April 14, 2003
Modified July 10, 2020

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Medical History Form

Name: _____ **Date of Birth:** _____ **Height:** _____

Please be 15 minutes early for your first appointment. Bring this completed paperwork, your insurance card, and a government-issued ID (such as a driver's license or passport).

Reason for your first visit:

_____

_____

_____

_____

Allergies (include medications, latex, and foods):

Allergen	Reaction	Allergen	Reaction
1		4	
2		5	
3		6	

Current Medications:

Medication	Dose	Medication	Dose
1		6	
2		7	
3		8	
4		9	
5		10	

Pregnancy History:

Total # of pregnancies	# of Full Term Deliveries	# of Preterm Deliveries	# of Abortions	# of Miscarriages	# of Ectopic Pregnancies	# of Living Children

	Delivery date	# of babies	Outcome (birth, abortion, miscarriage, ectopic)	Boy or girl	Baby's weight at birth	Vaginal or c-section	Weeks of gestation	Anesthesia (epidural, none)	Delivery location (hospital)	Notes/Complications
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										

Gynecologic History:

First day of your last period: _____ Age at first period: _____ Age at menopause: _____

Have you received the Gardasil vaccine for HPV? _____ What year was your last Pap smear? _____

Any abnormal Pap smears in the past? _____ What year? _____ What was the abnormality? _____

Any history of STDs? _____ Type(s): _____

How often do you get a period? _____ How many days does your period last? _____

Current birth control method: _____

Year of most recent: Mammogram _____ Colonoscopy _____ Bone density scan _____

Are you sexually active? _____ Do you have any sexual health problems? _____

Family History:

Relation	Problem(s)	Age at Death

Social History:

Do you smoke cigarettes? _____ How many packs per day? _____ How many years have you smoked? _____

What is your occupation? _____ How often do you exercise? _____

Special dietary guidelines: _____ Marital status: _____ Sexual orientation: _____

Do you drink alcohol? _____ Drinks per week: _____ Do you use illicit drugs? _____ Type: _____

How many caffeine drinks per day? _____ Do you perform a monthly breast exam? _____

Surgical History, including c-sections:

Year	Procedure	Complications

Medical History:

Problem	✓	Details	Problem	✓	Details
Anemia			Liver Problems		
Anesthesia Complications			High Cholesterol		
Anxiety			Hypertension		
Arthritis			Infertility		
Asthma			Kidney Problems		
Birth Defects			Lung Disease		
Breast Problems			Mental Health Problems		
Cancer			Musculoskeletal Problems		
Depression			Neurologic Problems		
Diabetes			Low Bone Density		
Endometriosis			PCOS		
Fibroids			Blood Clotting Disorders		
GI Problems			Thyroid Problems		
Migraines			Varicose Veins		
Heart Disease			Other		

Care Team:

Who is your primary care physician? _____ Office phone: _____

Any other information you would like us to know:

_____

_____

_____

_____

Please be <u>15 minutes early</u> for your first appointment. Bring this <u>completed</u> paperwork, your insurance card, and a government-issued ID (such as a driver's license or passport).

Signature: _____ Date: _____

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Patient Disclosure Instructions

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

❑ **Home Telephone (List number below)**

_____

❑ Okay to leave message with detailed information
❑ Leave message with call back number only

❑ **Cell Phone (List number below)**

_____

❑ Okay to leave message with detailed information
❑ Leave message with call back number only

❑ **Written Communication**
❑ Okay to mail to my home address
❑ Okay to mail to my work/office address
❑ Okay to fax to number indicated _____
❑ Okay to send email to _____

I allow you to give my clinical information to or answer questions from (check all that apply):

❑ Spouse _____
❑ Parent _____
❑ Child _____
❑ Other (specify): _____
❑ Do not give my clinical information to anyone but myself.

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate