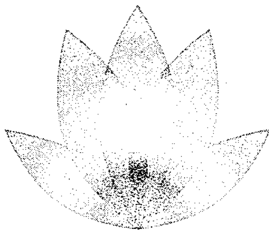


Premier Women's Health
of South Jersey
An Axia Women's Health Care Center

Jeffrey T. Gibson, MD • Vivian Vega, MD
Byron S. Hapner, DO • Anna Jang-Hanson, MD
Leisa D. O'Flynn, DO • Lynsey M. Beams, DO
Karen Norton, MSN, CRNP

Your Name: ______________________________ Date of Birth: ____________________

Today's Date: ____________________________

Last Menstrual Period ______________________

Please list all allergies and type of reaction: ______________________

____

____

____

Please list all medications that you take, as well as quantity and frequency:

____

____

____

____

____

____

____

____

____

34 Colson Lane • Mullica Hill, NJ 08062
Hofmann Professional Building • 340 W. Front Street, Suite 201 • Elmer, NJ 08318
100 Lexington Road, Building 100 • Woolwich Township, NJ 08085
603 North Broad Street, Suite 300 • Woodbury, NJ 08096
Phone: 856.223.8930 • Fax: 856.223.8948 • www.pwhsj.com

227 Laurel Road
Echelon One, Suite 300
Voorhees, NJ 08043

P (856) 669-6050

450 Cresson Blvd
Suite 300
Oaks, PA 19456

P (484) 831-0200

Premier Women's Health of South Jersey
an Axia Women's Health Care Center

HIPAA & Registration Update Form

(Please Print)

Date: / /	Primary Care Phys. (PCP):	PCP Phone No.:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Gender: F M	Marital Status (circle one): Single / Mar / Div / Sep / Widow

Birth Date: / /	Age:	Social Security No.:	Home Phone No.: ( )	Cell Phone No.: ( )

Street Address:	City:	State:	Zip Code:

I authorize messages with medical information to be left on voicemail/answering machine at (check all that apply) ❑ Home ❑ Cell above.
I authorize: ❑ Brief message details to be left ❑ Extended message details to be left ❑ Restrictions:

PHARMACY INFORMATION

Local Pharmacy:	Address:	City:	State:
Mail-Order Pharmacy:	Address:	City:	State:

INSURANCE INFORMATION

Please give your insurance card(s) to the receptionist.

Name of Primary Insurance Company:	Subscriber's Name:	Subscriber's SSN:	Subscriber's Date of Birth: / /

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Partner ❑ Other – please explain:

Name of Primary Insurance Company:	Subscriber's Name:	Subscriber's SSN:	Subscriber's Date of Birth: / /

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Partner ❑ Other – please explain:

IN CASE OF EMERGENCY

Name of contact:	Relationship to patient:	Home Phone No.: ( )	Cell Phone No.: ( )

RELEASE OF MEDICAL AND BILLING INFORMATION

I authorize the following individual(s) to receive information pertaining to any medical history, treatment received and billing matters:

Name:	Relationship to patient:	Birth Date:	Contact Phone: ❑ Home ❑ Cell
		/ /	( )
		/ /	( )

PATIENT PORTAL COMMUNICATION

We continue to offer secure electronic communications between you and our office via our Patient Portal. Secure messages and information can only be read by someone who knows the right password to log in to the Portal site. The communications are automatically encrypted and for those who want to participate, this secure communication can be a valuable tool to provide administrative and clinical information provided that we maintain your most up-to-date information. ***Do you wish to either continue to participate or sign up to participate?***

❑ Yes, I want to participate, my email is ______________________________ ❑ No, I do not want to participate at this time.

MEDICAL CHAPERONE

I request a female chaperone to be present during my examination. ❑ Yes ❑ No ❑ Other (family member, partner, etc. will be present)

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my provider or insurance company to release any information required to process my claims.

______________________________ ______________________________
Patient Signature *Date*

Premier Women's Health of South Jersey
an Axia Women's Health Care Center

Patient's Name: ______________________ DOB: ____________

Authorization for Treatment & Payment of Medical Benefits
Patient Financial Responsibility Form

Thank you for choosing our practice, an Axia Women's Health Care Center, as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment, and patient financial policies. If you would like to receive a more detailed explanation of our financial policies, please request a copy.

Authorization for Treatment & Payment of Medical Benefits

I give permission to the practice, an Axia Women's Health Care Center, to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to the practice, an Axia Women's Health Care Center.

Use of Photography

I agree that any photo identification taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of identification.

e-Prescription Consent for Medication History

With your consent, we may request and use your prescription medication history information using our e-prescription feature. This is for only informational purposes so that an up-to-date record of your medication is available for your treatment and safety.

☐ Yes, I give consent to obtain my medication history using the e-Prescribing feature.

☐ No, I do not give consent to obtain my medication history using the e-Prescribing feature. I understand that my medication information may not be complete when making treatment decisions.

Patient Financial Responsibilities

- I (or patient's guardian, if a minor) understand that I am ultimately responsible for the payment of my treatment and care.
- You will assist me by billing your contracted insurers. However, I understand that I am required to provide you with the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, and most major credit cards.
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include (but are not limited to):
    - Charge for returned checks.
    - Charge for the copying and distribution of patient medical records.
    - Charge for forms completion.
    - Charge for missed appointments.

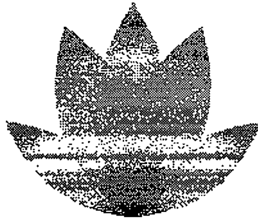
Patient Authorizations

- By my signature below, I hereby authorize the practice, an Axia Women's Health Care Center, to release medical and other information to the necessary insurance companies and third party payers required for payment of rendered health services.
- By my signature below, I hereby authorize assignment of financial benefits directly to the practice, an Axia Women's Health Care Center. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

I have read, understand, and agree to the provisions of this Authorization for Treatment & Payment of Medical Benefits and Patient Financial Responsibility Form:

____

Signature of Patient or Guardian Date



Premier Women's Health
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Karen Norton, MSN, CRNP

Patient Name ______________________________

Date of Birth ______________________________

Dear Patient:

The State of New Jersey mandates that every physician office document any barrier to care including physical impairments, cultural and linguistic needs in their medical records.

Please assist us by answering the following questions:

Do you have any Impairment – Visual, Hearing, Speech, learning, physical or language/cultural barrier?

What language do you speak, read, or write?

Do you have any religious or culture customs that the provider should know about?

Patient Signature ______________________________

Date ______________________________

34 Colson Lane • Mullica Hill, NJ 08062
Hofmann Professional Building • 340 W. Front Street, Suite 201 • Elmer, NJ 083[illegible]
100 Lexington Road, Building 100 • Woolwich Township, NJ 08085
[illegible] North Broad Street, Suite 300 • Woodbury, NJ [illegible]
Phone [illegible] • Fax [illegible] 8948 • www.pwhsj.com

Premier Women's Health ***of South Jersey***

PATIENT NAME:	DOB:
EMERGENCY CONTACT & PHONE #:	DATE:

Please fill out the questions below in order to help keep us UPDATED on your personal health history and assist us in providing you the highest quality of care. We hope you will feel comfortable discussing any questions or concerns you have with your doctor or nurse. All answers will be kept confidential.

SINCE YOUR LAST VISIT, HAVE YOU:

Discovered you are allergic to anything?	☐ No	☐ Yes	What? ______ Reaction? ______
Had any changes in your health?	☐ No	☐ Yes	What? ______
Have you been hospitalized?	☐ No	☐ Yes	Why? ______
Has anyone in your immediate family been diagnosed with a serious illness?	☐ No	☐ Yes	
Has there been a death in your immediate family?	☐ No	☐ Yes	Explain ______
Have you received any immunizations?	☐ No	☐ Yes	Type? ______
Any changes or additions to medications?	☐ No	☐ Yes	Additions/Changes? ______
Do you take Calcium?	☐ No	☐ Yes	
Any pregnancies?	☐ No	☐ Yes	
Any miscarriages or abortions?	☐ No	☐ Yes	
Changes with your period?	☐ No	☐ Yes	
Any urinary problems?	☐ No	☐ Yes	
Any abnormal bleeding?	☐ No	☐ Yes	
Any pelvic pain?	☐ No	☐ Yes	
Any symptoms of menopause?	☐ No	☐ Yes	
Do you do self-breast exams?	☐ No	☐ Yes	
Any breast changes?	☐ No	☐ Yes	
Change of marital status?	☐ No	☐ Yes	
Have you changed sexual partners?	☐ No	☐ Yes	
Have you had multiple sexual partners?	☐ No	☐ Yes	
Any history of physical/emotional abuse?	☐ No	☐ Yes	
Have you been treated for any sexually transmitted disease?	☐ No	☐ Yes	
Do you wish to be tested for any sexually transmitted disease?	☐ No	☐ Yes	
Do you wish to be tested for HIV/AIDS?	☐ No	☐ Yes	

SINCE YOUR LAST VISIT, HAVE YOU HAD ANY OF THE FOLLOWING PROCEDURES:
(If "Yes", please indicate the date of the procedure and where it was performed.)

Pap Smear?	☐ No	☐ Yes	If Yes, Date: ______	Where: ______
Breast exam?	☐ No	☐ Yes	If Yes, Date: ______	Where: ______
Mammogram?	☐ No	☐ Yes	If Yes, Date: ______	Where: ______
Sigmoid/colon exam?	☐ No	☐ Yes	If Yes, Date: ______	Where: ______
Stool check for blood?	☐ No	☐ Yes	If Yes, Date: ______	Where: ______
Cholesterol?	☐ No	☐ Yes	If Yes, Date: ______	Where: ______
Complete physical?	☐ No	☐ Yes	If Yes, Date: ______	With whom: ______

PERSONAL HABITS:

Do you use tobacco products?	☐ No	☐ Yes	How much? ______	How often? ______
Do you drink alcohol?	☐ No	☐ Yes	How often? ______	What kind? ______
Do you use drugs?	☐ No	☐ Yes	How often? ______	What kind? ______
Do you exercise regularly?	☐ No	☐ Yes	If Yes, how often? ______	What type? ______

DO YOU HAVE ANY PARTICULAR HEALTH CONCERNS AT THIS TIME YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR OR NURSE? ______

COMPLETED BY: ______ **DATE:** ______

REVIEWED BY: ______ **DATE:** ______