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

Premier Women's Health *of South Jersey*

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

Please fill out the questions below in order to help us provide 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.

ALLERGIES *(Food, Medicine, other)*	REACTIONS *(Rash, swelling, itching, etc.)*

MEDICATIONS *(List all medications that you take, as well as quantity and frequency)*	

GYN HISTORY:

Date of last Period: ___/___/___ Interval between periods _____
Age when Periods began: ____ Yrs. Old
Do you have loss of urine? ☐ No ☐ Yes
Do you have any urinary problems? ☐ No ☐ Yes
Any history of abnormal PAP smears? ☐ No ☐ Yes If "Yes" any treatment ☐ Yes ☐ No
Any prolonged abnormal bleeding? ☐ No ☐ Yes
Any pelvic pain? ☐ No ☐ Yes If "Yes" any treatment ☐ Yes ☐ No
Any abnormal discharge? ☐ No ☐ Yes
Do you have symptoms of Menopause? ☐ No ☐ Yes
Do you take hormonal replacement? ☐ No ☐ Yes
Do you do self-breast exams monthly? ☐ No ☐ Yes
Do you take calcium supplements? ☐ No ☐ Yes

SEXUAL HISTORY:

Are you sexually active? ☐ No ☐ Yes Heterosexual ☐ No ☐ Yes Homosexual ☐ No ☐ Yes Bisexual ☐ No ☐ Yes
Have you had multiple sexual partners? ☐ No ☐ Yes If "Yes" how many? _____
Do you use condoms? ☐ No ☐ Yes
What method of birth control do you use? _____ ☐ None
Have you ever been treated for a sexually transmitted disease? ☐ No ☐ Chlamydia ☐ Gonorrhea ☐ HPV ☐ Hepatitis ☐ Herpes ☐ Syphilis ☐ Other
Have you ever been tested for HIV/AIDS? ☐ No ☐ Yes
Do you wish to be tested for any sexually transmitted disease? ☐ No ☐ Yes

WHEN WAS THE LAST TIME YOU HAD ANY OF THE FOLLOWING *(please give approximate date)*:

Pap smear? ___/___/___ Where? _____
Complete Physical? ___/___/___
Breast Exam? ___/___/___
Mammogram? ___/___/___ Where? _____
Sigmoid/colon exam? ___/___/___ Where? _____
Stool check for blood? ___/___/___

OB HISTORY:

Delivery Date	Vaginal/C-Section	Baby's Sex & Weight	Birth Place	Complications	Current Health of Children

Number of miscarriages: _____ Number of abortions: _____

PLEASE COMPLETE OTHER SIDE

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

LIST ALL SURGERIES **APPROXIMATE DATES**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

LIST ALL REASONS FOR HOSPITALIZATIONS **APPROXIMATE DATES**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING (please ✓)

☐ High Blood Pressure ☐ Breathing Problems ☐ Blood Disorders ☐ Alcohol Abuse ☐ Phlebitis
☐ Diabetes ☐ Thyroid Problems ☐ Blood Transfusions ☐ Drug Abuse ☐ Migraine Headaches
☐ Cancer (Gyn, Breast, Colon, Other_____) ☐ Heart Problems ☐ Osteoporosis ☐ Liver Disease ☐ Other _____
☐ Breast Problems ☐ Depression ☐ Kidney Problems

HAS ANYONE IN YOUR FAMILY HAD ANY OF THE FOLLOWING

☐ Cancer (Gyn, Breast, Colon, Other _____) Who? _____
☐ Osteoporosis Who? _____
☐ High Blood Pressure Who? _____
☐ Heart Disease Who? _____
☐ Diabetes Who? _____
☐ Thyroid Disease Who? _____
☐ Seizures Who? _____
☐ Genetic Disease _____ Who? _____
☐ Bleeding Disorder Who? _____
☐ Autoimmune Disorder Who? _____

Is your father alive? ☐ Yes ☐ No (Age at Death _____)
Is your mother alive? ☐ Yes ☐ No (Age at Death _____)

SOCIAL HISTORY

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Present Occupation? _____
Have you worked with chemicals, paints, asbestos, leads or other hazardous materials? ☐ No ☐ Yes
How many people live with you now? _____
Do you feel threatened by your current relationship? ☐ No ☐ Yes
Have you ever been physically or emotionally abused? ☐ No ☐ Yes

PERSONAL HABITS

Do you use tobacco products? ☐ No ☐ Yes If "Yes" how often? _____ _____ packs per _____
Do you drink alcohol? ☐ No ☐ Yes If "Yes" → What Kind? _____ How Much? _____
Do you use drugs? ☐ No ☐ Yes If "Yes" → What Kind? _____ How Often? _____
Do you exercise regularly? ☐ No ☐ Yes If "Yes" → What Type? _____ How Often? _____
Do you have a "Living Will"? ☐ No ☐ Yes Are you an organ donor? ☐ No ☐ Yes

Patient Signature: _____ **Date:** _____

Reviewed By: _____ **Date:** _____

Axia WOMEN'S HEALTH

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
of South Jersey
A Division of Regional Women's Health, LLC

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

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 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