STEPHANIE WOODWARD, M.D.

PATIENT REGISTRATION

PATIENT NAME: ______________________

ADDRESS: ______________________

CITY, STATE, ZIP: ______________________

DATE OF BIRTH: ____________ AGE: ________

SOCIAL SECURITY NUMBER: ______________

SINGLE MARRIED OTHER

SEX: MALE FEMALE

HEIGHT: __________ WEIGHT: __________

EMPLOYER/SCHOOL NAME & ADDRESS:

____

____

PHARMACY: ______________

HOME PHONE: ______________

WORK PHONE: ______________

CELL PHONE: ______________

E-MAIL: ______________

WHAT ARE YOU BEING SEEN FOR?

____

____

____

ANY FOOD OR DRUG ALLERGIES?

____

____

____

INSURANCE INFORMATION:

PRIMARY INSURANCE

INSURANCE NAME: ______________

POLICY HOLDER'S NAME: ______________

POLICY HOLDER'S SSN: ______________

RELATIONSHIP TO PATIENT: ______________

EMPLOYER: ______________

POLICY HOLDER'S SEX: MALE FEMALE

POLICY HOLDER'S DATE OF BIRTH: ______________

SECONDARY INSURANCE

INSURANCE NAME: ______________

POLICY HOLDER'S NAME: ______________

POLICY HOLDER'S SSN: ______________

RELATIONSHIP TO PATIENT: ______________

EMPLOYER: ______________

POLICY HOLDER'S SEX: MALE FEMALE

POLICY HOLDER'S DATE OF BIRTH: ______________

ARE YOU PREGNANT? YES NO

HOW WERE YOU REFERRED TO OUR OFFICE?

EMPLOYER CO-WORKER

RELATIVE YELLOW PAGES

WALK- IN INS. PROVIDER BOOK

OTHER: ______________

IN CASE OF EMERGENCY, NAME & PHONE NUMBER OF NEAREST RELATIVE:

____

____

____

____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize this physician to release any information required in the course of my examination or treatment to my insurance company and/or to any other provider.

SIGNED: ______________________ DATE: ______________

AUTHORIZATION TO PAY: I hereby authorize payment directly to the business of this physician for the surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance.

SIGNED: ______________________ DATE: ______________

STEPHANIE WOODWARD, M.D. – NEW PATIENT HEALTH HISTORY

Name ______ Date of Birth ______ Today's Date ______

PRESENT ILLNESS

Describe your present medical symptoms: ______

List any drugs you are allergic to (what was the reaction?) ______

List your current medication (s) (Prescription and nonprescription drugs and birth control Pills)

Name:	Dosage	How many times/day?

PAST MEDICAL HISTORY

(1) Surgeries

Date	Type of Surgery	Which Hospital?	Surgeon

(2) Previous significant medical problems/hospitalizations

Date	Type of Illness	Where Treated?

Do you have any of the following illnesses?

	Yes	No	Give any details of illness
Diabetes	☐	☐	
High Blood Pressure	☐	☐	
Lung Disease	☐	☐	
Heart Disease	☐	☐	
Cancer	☐	☐	
Stroke	☐	☐	
Anemia	☐	☐	
Any Other Medical Problems	☐	☐	

FAMILY HISTORY

Do you have relatives with any of the following illnesses?

	Yes	No	RELATIONSHIP/AND DETAILS
Heart Attack (age < 65)	☐	☐	
Ovarian Cancer	☐	☐	
Breast Cancer	☐	☐	
Prostate Cancer	☐	☐	
Colon Cancer	☐	☐	
Any Other Cancer	☐	☐	
Any Other Medical Problems	☐	☐	

STEPHANIE WOODWARD, M.D. – NEW PATIENT HEALTH HISTORY

SOCIAL HISTORY

Marital Status: ______ Occupation: ______

Do you smoke? ______ How much? ______ For how many years? ______

Do you drink alcohol? ______ Drinks of wine/beer/hard liquor per day/week: ______

Do you use marijuana? ______ Cocaine? ______ Intravenous drugs? ______

Do you drink caffeinated beverages? ______ How many cups of Coffee? ______ Soda? ______ Tea? ______

Do you have any risks for HIV exposure? NONE Blood transfusions IV drug use Other ______

REVIEW OF SYSTEMS

Do you have any unusual:	Yes	No	
Fever?	☐	☐	
Night Sweats?	☐	☐	
Chills?	☐	☐	
Fatigue?	☐	☐	
Have you recently gained weight?	☐	☐	how much? ______
Have you recently lost weight?	☐	☐	how much? ______

HEENT	Yes	No
Loss of vision?	☐	☐
Blurry or double vision?	☐	☐
Sore throat?	☐	☐
Runny nose?	☐	☐

RESPIRATORY	Yes	No
Persistent Cough?	☐	☐
Sputum/Phlegm production?	☐	☐
Shortness of breath?	☐	☐

CARDIAC	Yes	No
Do you have any chest pain?	☐	☐
Palpitations?	☐	☐
Shortness of breath with minimal activity?	☐	☐
Shortness of breath when lying flat?	☐	☐
Swelling of legs?	☐	☐
Do you have difficulty walking two blocks?	☐	☐

GASTROINTESTINAL	Yes	No	
Any abdominal pain?	☐	☐	Where? ______
Nausea?	☐	☐	
Vomiting?	☐	☐	
Diarrhea?	☐	☐	
Constipation?	☐	☐	
Blood in your stool?	☐	☐	

URINARY	Yes	No
Too frequent urination?	☐	☐
Any burning with urination?	☐	☐
Trouble starting urination?	☐	☐
Incontinence of urine?	☐	☐
Any blood in the urine?	☐	☐
Any history of STDs?	☐	☐

If yes, what kind of STD? (gonorrhea, chlamidya, syphilis, genital warts, other ______

NEUROLOGIC	Yes	No
Any unusual headaches?	☐	☐
Dizziness?	☐	☐
History of seizures?	☐	☐
History of syncopal episodes?	☐	☐
Weakness in the arms?	☐	☐
Numbness in the arms?	☐	☐
Weakness in the legs?	☐	☐
Numbness in the legs?	☐	☐

MUSCULOSKELETAL	Yes	No	
Any persistent joint ache?	☐	☐	Where? ______
Any swelling in joints?	☐	☐	Where? ______

HEMATOLOGIC	Yes	No
Any history of abnormal bleeding?	☐	☐
Any history of excessive bruising?	☐	☐
Any history of anemia?	☐	☐

SKIN	Yes	No
Rash?	☐	☐
Itching?	☐	☐
Mass or Lesion?	☐	☐

Other? ______

GYNECOLOGICAL **(WOMEN ONLY)**

Date of your last menstrual period? ______

When was your last mammogram? ______

Do you have any symptoms not described above?

______

______

______

STEPHANIE WOODWARD, M.D. - FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please talk to our Business Manager if you have any questions about our fees or Financial Policy.

- All patients must complete our "Patient Registration Form" prior to seeing the doctor.
- Full Payment is due at time of service.
- We accept cash, checks, and Visa/Mastercard/Discover.

REGARDING INSURANCE

Insurance is a contract between you and your insurance company. We are not a party to this contract. You are responsible for the timely payment of your account.

Our practice is contracted with a number of PPO, HMO, and Managed Care network plans. Please see the attached list of most of the major insurance plans we accept. If your insurance company is not listed, please ask the receptionist for more information.

If we accept your insurance, you must pay any co-payments and unmet deductibles at all times of service. Please be aware that some and perhaps all of the services provided may be "non-covered" services and not considered necessary under the Medicare Program and/or other medical insurance. This especially includes services for well care, such as general physicals. If not covered, you will be responsible for payment of these services.

If the reason for your visit is a work-related injury or an accident, please notify the receptionist.

DIAGNOSTIC STUDIES, X-RAY, AND OTHER ANCILLARY SERVICES

If any diagnostic studies such as laboratory tests, x-rays and other ancillary services are required to complete your care, please be aware that these charges are billed directly to you from the facility rendering the care. This is separate from the office charges and may constitute an additional expense for which our office is not responsible.

MISSED APPOINTMENTS

I understand that if I am unable to keep my scheduled appointment time, failure to notify Dr.Woodward 24-hours before my scheduled appointment will result in a $25.00 cancellation fee for office visits and $50.00 cancellation fee for procedures and consultations. **Initials:** ___________

Thank you for understanding and agreeing to our Financial Policy. Please let us know if you have any questions or concerns.

I hereby authorize Stephanie Woodward, M.D. to furnish information to the insurance carriers concerning my illness and treatments. I also authorize to Stephanie Woodward, M.D. all payment for medical services rendered to myself or my dependent. I understand that I am responsible for any amount not covered by insurance.

____

Signature of Patient or Responsible Party   Date

HIPAA
Handout

Stephanie Woodward, M.D.

Notice of Privacy Policy and Practices

Introduction

In accordance with the Health Insurance Portability and Accountability Act of 1996 (Known as HIPAA), our practice is required to protect the privacy of your personal health information. This document will provide notice of our privacy policy and practices including your rights and our legal duties concerning your health information and records. Please review this document; you will be asked to sign a form acknowledging your opportunity to review this notice. A copy will be provided to you upon request.

Summary

Since you are a patient who has consented to receive care from the physician and staff of **Stephanie Woodward, M.D.,** the law allows us to use and disclose your medical information for specific purposes. These include uses and disclosures for purposes of treatment, obtaining payment for services, and health care operations which will be explained below. In addition, the law may authorize disclosures for reasons of public health and interest that include disaster relief, law enforcement, and formal judicial and administrative proceedings. With your permission, your medical information may be disclosed to family members and/or others of your choosing who have involvement of interest in your health status. Any other disclosure will require your written authorization.

You have the following rights that will be respected by this policy:

1. To examine or receive a copy of your medical record of care that had been provide by **Stephanie Woodward, M.D.** and staff. (1st copy is provided without charge. Additional copies will involve a nominal cost.)
2. To receive an accounting of the disclosure of your medical information that does not involve treatment, payment, or health care operations.
3. To request a correction or amendment of your medical record.
4. To specify other restrictions on the use and disclosure of medical information.
5. To request a specific method or avenue in receiving a communication involving confidential information.
6. To file a formal complaint if you feel that improper use of disclosure occurred.

The entire notice will go into more detail regarding the specific issues involved in this policy. Please review it.

Receipt of Notice of Privacy Policy and Practices

I acknowledge that I have received or have been given the opportunity to review a copy of

Notice of Privacy Policy and Practices.

I understand that amendment to this policy may occur in the future and that a current summary of this or the amended notice will be posted in the medical office for my review. A copy of the amended notice will be made available upon request.

____________________________ __________________
Print Name Date

____________________________ ____________________________
Signature Relationship to Patient (if other than patient)

Notice to Patients about Open Payments Database

"The Open Payments data base is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov."

Your signature below constitutes your acknowledgement,

______________________________	____________________
Print Name	Date
______________________________	____________________
Signature	Relationship to Patient (if other than Patient)

Notice to Patients about Open Payments Database

Patient Copy

"The Open Payments data base is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov."