NEW PATIENT INFORMATION PACKET

We’re here for a healthy you.

PATIENT REGISTRATION FORM

Date ____

Patient Information:

First Name ______________________ Last Name ____________________ Mi _____

Preferred Name ____

Date of Birth: _____ -_____ - ______ Age ________________________________

Social Security ____

Address: ____

City: ________________ State: ___________________ Zip: __________________

Preferred Phone _____________________ Work Phone ________________________

Cell Phone ____

Email Address ____

Marital Status: (circle) Single Married Widowed Divorced Separated

Parent or Guardian Information (only if the patient is under 18):

First Name ______________________ Last Name ____________________ Mi _____

Preferred Name ____

Date of Birth: _____ -_____ - ______ Age ________________________________

Social Security ____

Address: ____

City: ________________ State: ___________________ Zip: __________________

Preferred Phone __________ Work Phone ________________ Cell Phone ________________

Email Address ____

Marital Status: (circle) Single Married Widowed Divorced Separated

Patient Employer Information:

Employed: Y or N _________ Full-Time Student ____________ Part- Time Student __________

Employer Name _____________________ Occupation ___________________________

Referred By:

Referring Physician ______________________ Phone ______________________________

Other ____

Emergency Contact:

Relative/Friend ______________________ Phone ______________________________

Relationship ____

Pharmacy Information:

Pharmacy Name ______________________ Phone ______________________________

Methods of Contact:

☐ Text messages are sent 3 days prior to your appointment. If you choose this method, please confirm your appointment with this message. Please list your mobile number.

____

☐ Phone calls are made 3 days prior to your appointment. If you choose this method, please confirm your appointment with this call. Please list your phone number(s).

____

May we contact you regarding your protected health information?

Email: yes no

Cell phone: yes no Leave Voicemail: yes no

Home phone: yes no Leave Voicemail: yes no

Print Patient Name ____

Date ______________________ Signature ______________________________

OFFICE POLICIES

Financial Responsibility and Release of Information

I understand that I am financially responsible to Woods Gynecology P.C. for charges. Payment for services is due at the time of service. I also agree that, should I fail to assume this financial responsibility and credit action is necessary, I will pay for these costs in addition to the amount of these physician's charges.

Woods Gynecology is considered out of network with all insurance plans.

Date ____ Signature of Patient or Guardian__________________________

* I have received a copy of the "Notice of Privacy Practices" for the office of Woods Gynecology P.C.

Please Initial ________

Missed or No-show Appointment Charge

Our offices requires 48-hour notice of cancellation. If proper notice is not given, you will be charged a $150 fee.

Forms and Letters

Our office requires a minimum of 7 days to complete disability forms or letters required by the patient's employer or insurance for illness or surgery. There's also a $50 fee for all paperwork, and must be paid when forms are dropped off to be completed.

Patient Signature: ____________________________ Date: ____

HEALTH HISTORY

Name ______________________________ Age ______________________________

Reason for visit ____

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List all prior surgeries____

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Current medications____

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Medication allergies____

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HEALTH HISTORY

Date of last mammogram ______________________ Date of last pap ____

Any prior procedures on the breast? ____

History of abnormal paps? ______________________ Date of last bone density ______________________________

Any prior procedures on the cervix? ______________ Date of last colonoscopy ______________________________

Menstrual History:

Age when first period started ___________________ Number of days between periods _________________________

Flow (circle): light / medium / heavy Number of days bleeding _______________________________

Pain with periods (circle): yes / no First day of last menstrual period _________________________

Pregnancy History:

No. of pregnancies ______________________________ No. of living children _____________________________

No. of miscarriages ____________________________ No. of abortions _________________________________

Contraception History: What types of contraception have you used to date?

Current ____

Previous ____

Sexual History:

Have you ever been sexually active? yes no

Are you currently sexually active? yes no

Have you ever had any sexually transmitted diseases? yes no

If yes, which? (circle) Gonorrhea Chlamydia Genital warts Genital herpes Syphilis HIV HPV Hepatitis

HEALTH HISTORY

Social History:

Marital status ______________________ Name of Spouse / significant other ______________

Your current occupation ____

Do you exercise regularly? yes no If yes, list type and frequency ________________________

Do you smoke or use tobacco products? yes no If yes, list amount used

And type ______________________ Number of years of use ______________________

If previously used tobacco products, list the year you quit ______________________________

Do you drink alcohol? yes no If yes, list the number of drinks per week ___________________

Do you use recreational drugs? yes no If yes, list the type ____________________________

Check if you have a personal or family history of the following. ___________________________

	You	Your Family		You	Your Family
Addiction	☐	☐	High Cholesterol	☐	☐
Anemia	☐	☐	Kidney Disease	☐	☐
Breast/Ovarian Cancer	☐	☐	Kidney Infections	☐	☐
Cirrhosis/Liver Disease	☐	☐	Kidney Stones	☐	☐
Colon/Pancreatic Cancer	☐	☐	Lupus/MS	☐	☐
Depression/Anxiety	☐	☐	Osteoporosis	☐	☐
Diabetes	☐	☐	Seizures/Epilepsy	☐	☐
DVT/Pulmonary Embolus	☐	☐	Stroke	☐	☐
Endometriosis	☐	☐	Thyroid Problems	☐	☐
GI problems/Reflux/IBS	☐	☐	Transfusions	☐	☐
Headaches	☐	☐	Ulcerative Colitis/Crohn’s	☐	☐
Heart Disease	☐	☐	Other	☐	☐
High Blood Pressure	☐	☐			

Woods Gynecology, PC - Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES 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.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. Uses And Disclosures We May Make Without Written Authorization. We may use or disclose your health information for certain purposes without your written authorization, including the following: Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer. Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain payment for treatment. Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice. Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following: • To avoid a serious threat to your health or safety or the health or safety of others. • As required by state or federal law such as reporting abuse, neglect or certain other events. • As allowed by workers compensation laws for use in workers compensation proceedings. • For certain public health activities such as reporting certain diseases. • For certain public health oversight activities such as audits, investigations, or licensure actions. • In response to a court order, warrant or subpoena in judicial or administrative proceedings. • For certain specialized government functions such as the military or correctional institutions. • For research purposes if certain conditions are satisfied. • In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes. • To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. Disclosures We May Make Unless You Object. Unless you instruct us otherwise, we may disclose your information as described below. • To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment. NOTICE OF PRIVACY PRACTICES - 2

3. Uses and Disclosures With Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. Your Rights Concerning Your Protected Health Information. You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below. • You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are not required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer. • We normally contact you by telephone, mail at your home address and possibly by e-mail if you have given your e-mail address. You may request that we contact you by alternative means or

at alternative locations. We will accommodate reasonable requests. • You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others. • You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete. • You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period. • You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. Changes To This Notice. We reserve the right to change the terms of this Notice at anytime, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Office Manager. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. Contact Information. If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

Office Manager:
Kim Hughes
4322 Harding Pike, Suite 329
Nashville TN 37205
kim@doctorwoods.com

8. Effective Date. This Notice is effective August 1, 2022.