Wellesley Women's Care, P.C.

PPG____

Thank you for taking the time to complete this form. We ask that you complete this entire form once a year **or** when you have any *NEW* information.

PATIENT INFORMATION (Please print clearly)

Name _____ DOB____/____/____ SS#____/____/_____

Street Address_____City/State/Zip_____

Home (_____)_____-_____Cell(_____)_____-_____Work(_____)_____-_____

Emergency Contact_____ _____Day Phone(_____)_____-_____

Email (optional)_____
You are welcome to include your email address, although it is not intended to be a primary contact method for your physician and/or our office.
Primary Care Physician _____Phone(_____)_____-_____

Are we able to leave a voice mail message at the numbers you have provided?	YES	NO
Do you want a chaperone present during your exams?	YES	NO

PRIMARY INSURANCE INFORMATION
Insurance Company / Address_____

Policy / Certificate #_____Group#_____

Policy Holder Name_____ _____Relationship to patient Self / Spouse / Parent / Partner

Policy Holder Employer_____

Policy Holder SS# _____/_____/_____ DOB____/_____/_____

Policy Holders address (if different from patient)_____

Secondary Insurance Information
Insurance Company / Address_____

Policy / Certificate #_____Group#_____

Policy Holder Name_____ _____Relationship to patient Self / Spouse / Parent / Partner

Policy Holder Employer_____

Policy Holder SS# _____/_____/_____ DOB____/_____/_____

Policy Holders address (if different from patient)_____

Insurance Authorization and Assignment (ALL PATIENTS)

I hereby authorize Wellesley Women's Care, P.C. to furnish information necessary to the above insurance carriers concerning my illnesses and treatments. I hereby assign WWC,P.C. all payments for medical services rendered with out a valid referral that may be required by my HMO, all services provided to me, if at the time of service my insurance carrier does not contract with WWC,P.C. and any amount not covered by my insurance.

Patient / Guardian Signature_____Date_____

MEDICARE PATIENTS ONLY MEDICARE AUTHORIZATION AND PAYMENT REQUEST
I certify that the above information given by me in applying for under Title XVII of the Social Security Act is correct. I authorize Wellesley Women's Care, P.C. to release any medical information about me to the Social Security Administration or intermediaries or carriers needed for medical claims. I request that payment of authorized benefits be made on my behalf to WWC, P.C. I assign benefits payable to WWC, P.C. for the services rendered, to WWC, P.C.

Patient / Guardian Signature_____Date_____

Date: _____

Wellesley Women's Care, P.C.
2000 Washington Street, Suite 764
Newton, MA 02462-1628
617-965-7800

Last Name:	First Name:	Date of Birth:	Age:
Address:	Home Phone:	Business Phone:	
	Cell:	Email (optional)	

City:	State:	Zip:	Primary Care M.D.:
Occupation:			Referred by:
Religion (optional):			
Marital Status: S M W D S			Spouse's / Partner's Name:

MEDICAL HISTORY

How Tall Are You?	**What is your usual weight?**	**What is your present weight?**

Check Yes or No	**YES**	**NO**	**MEDICAL (office use)**
Do you now, or have you ever had:			
Weight loss or gain? Eating disorders?			
Migraine headaches? Frequent headaches?			
Contact lenses? Visual problems?			
Frequent nose bleeds? Sinusitis?			
Goiter? Thyroid problems?			
Respiratory Disease?			
Frequent cough? Shortness of breath?			
Pneumonia?			
Night sweats? Tuberculosis?			
Asthma? Hay fever?			
Heart Disease?			
Heart murmur? Mitral valve prolapse?			
Rheumatic fever? German Measles? Chicken Pox?			
Chest pain with exertion?			
High blood pressure?			
Gall Bladder Disease?			
Abdominal pain after meals?			
Blood in bowel movements?			
Any change in bowel habits?			
Hemorrhoids?			
Jaundice? Hepatitis? Mononucleosis?			
Diabetes?			
Kidney Disease?			
Blood, Sugar, or Protein in urine?			
Any kidney stones?			
Kidney or bladder infections?			
Painful urination?			
Loss of urine when coughing or sneezing?			
Anemia? Blood disorder?			
Cancer?			
Varicose veins? Phlebitis?			
Epilepsy? Neurological disorder?			
Psychological problems? Depression?			
Skin Diseases?			
Arthritis? Muscular disorders?			
Are you allergic to any medications: If so, which ones?			

Do you take any medications or hormones? If so, which ones?			

SURGICAL HISTORY			
Check yes or no	**YES**	**NO**	**SURGICAL(office use)**
Have you ever had any surgery? (Tonsillectomy, appendectomy, etc.). If so, what year, hospital, and city?			
1.			
2.			
3.			
4.			
Do you know your Blood Type and RH?			
Have you ever received Rhogam?			
Have you ever received a blood transfusion?			
Have you ever had an anesthesia complication?			
Have you ever had injuries? (Broken bones, auto accident, etc.). If so, what year, hospital, and city?			
1.			
2.			
3.			
4.			
FAMILY HISTORY			
Check yes or no	**YES**	**NO**	**FAMILY(office use)**
Is your mother alive?			
In good health?			
If deceased, cause?			
Is your father alive?			
In good health?			
If deceased, cause?			
Do you have any brothers?			
If yes, how many?			
Do you have any sisters?			
If yes, how many?			
Is your husband / partner in good health?			
In your family (grandparents, parents, and siblings) has anyone had:			
Birth defects?			
High blood pressure?			
Cancer?			
Tuberculosis?			
Diabetes?			
Thyroid Disease?			
Epilepsy?			
Mental illness?			
Twins?			
Blood Disease?			
Stroke?			
Heart Attack?			
Hysterectomy?			
Kidney Disease?			
Is there anything else regarding your medical history, surgical, or family history that you feel we should know?			

SOCIAL HISTORY			
Check yes or no	**YES**	**NO**	**SOCIAL(office use)**
Do you drink coffee? Tea? Cola?			
Do you smoke?			
Do you use alcoholic beverages?			
Do you use street or recreational drugs?			
Have you traveled out of the country in the past two (2 years)?			
Do you desire testing for HIV?			
GYNECOLOGICAL HISTORY			**GYNECOLOGICAL(office use)**
When did your last period start? Day Month or date of menopause?			
At what age did you first menstruate?			
How many days in your cycle? (ex. 28/30)			
How many days do you flow? (ex. 5/7)			
Is your flow: Light? Average? Heavy?			
Check yes or no	**YES**	**NO**	
Do you have any clots?			
Do you have any cramps?			
Do you bleed between periods?			
Do you have excessive vaginal discharge?			
Are you having vaginal itching or irritation?			
Have you had a sexually transmitted disease?			
Do you have any history of Herpes exposure?			
Are you sexually active?			
Are you having any sexual problems?			
Are you using any form of birth control?			
Have you ever had an abnormal PAP?			
Have you had any breast problems?			
Have you had a Mammogram?			
Are you experiencing any Menopausal symptoms?			
Did your mother take Diethylstilbesterol (DES) while pregnant with you?			
Have you ever had any trouble getting pregnant?			
Have you ever had an abortion?			
OBSTETRICAL HISTORY			**OBSTETRICAL(office use)**
Please list the number of times:			
Pregnant			
Premature Births			
Miscarriages			
Abortions			
Living Children			

PREVIOUS PREGNANCIES

No	Date	Outcome of Pregnancy Vaginal, Cesarean, miscarriage, termination	Weeks Pregnant	Hours in labor	Type Anesth	Total weight gain	Fetal sex	Fetal weight	cond	Breast / Bottle	Place of delivery	Complications / Remarks
1.												
2.												
3.												
4.												
5.												
6.												

Wellesley Women's Care

Notice of Privacy Practices

WELLESLEY WOMEN'S CARE share an integrated electronic medical record so that your caregivers at any Partners Health Care System affiliated site can provide you with high quality, coordinated care. Access to the integrated medical record is expressly restricted to those clinicians and staff involved in your healthcare, or to those who need the information for payment or health care operations or other purposes as set forth in this notice. The privacy obligations of Wellesley Women's Care and your health information rights set forth in this Notice also apply to information maintained in the integrated medical record.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record, either an electronic record or a paper record, to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Wellesley Women's Care. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional uses of Information.

Result letters. Your health information will be used by our staff to send you the results of your tests.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights.

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Wellesley Women's Care Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain**.**

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting **Front Desk Receptionist** or the **Practice Manager**. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Practice Manager or U.S. Department of Health & Human Services
Wellesley Women's Care HIPAA Complaint Line: 866-627-7748 2000 Washington Street or Suite 764
http://www.hhs.gov/ocr/hipaa Newton, MA 02462

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is:

Practice Manager
Wellesley Women's Care
2000 Washington Street
Suite 764
Newton, MA 02462
617-965-7800

Effective Date.
This notice is effective on or after April 14, 2003.

Amended Date.
November 4, 2008

WWC-F2000 Acknowledgement of Receipt of Notice of Privacy Practices

Wellesley Women's Care reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the notice of Privacy Practices for Wellesley Women's Care.

Name of Patient (Print)

Signature of patient Date

_____

Printed Name of Patient Representative

(Required if the patient is a minor or an adult who is unable to sign this form)

Signature of Patient Representative Date

Relationship of the Patient Representative to Patient _____