Eastwind Women's Health

★ Patient Information: ★

(Please print and complete fully)

Legal Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street Address) (Apt/Unit) (City) (State) (Zip)

SS # (required): _____ Birth Date: _____ Age: _____

Marital Status (circle one): Single Married Widowed Divorced Partner

Cell: _____ Home: _____ Work: _____

Do we have your permission to leave a message (circle one): Yes No

Primary Email: _____

Employer: _____ Occupation: _____

★ **Emergency Contact:** Name:_____ Relationship:_____

Emergency Contact Phone: _____

★**Primary Care Physician:** _____ Phone: _____

★**Primary Pharmacy:** _____ Phone: _____

Address: _____ City/Zip: _____

★Medical Insurance Information: (Must present card at each visit)★

****(It is the patient's responsibility to determine coverage / benefits at the time of service)****

Do you Currently Have Insurance? (Circle One): Yes No

Primary Insurance: _____

Subscriber Name: _____ Date of Birth: _____

Relationship to Patient: _____

Secondary Insurance: _____

Subscriber Name: _____ Date of Birth: _____

Relationship to Patient: _____

Consent to Medical Care and Treatment: While at Eastwind Women's Health I Give consent for all medical care, any tests and examinations needed. I will not hold Eastwind Women's Health or any person responsible for the results if I refuse medical treatment or advice. This consent will be valid for one year unless otherwise indicated in writing by either party.

Patient or Guardian Signature: _____ Date: _____

Eastwind Women's Health

★Release of Information:

I understand that Eastwind Women's Health may use or release my medical/ health information for the following reasons as needed:

- Insurance information, billing and payment
- Release to other healthcare providers for billing, payment, referrals and discharge planning
- Quality improvement reviews
- Medicare, Medicaid and other government programs
- Employer, if injured
- Public health reporting
- Legal, regulatory and accreditation agencies
- Eastwind Women's Health may receive or release my health information, whether written, verbal, fax, or electronic using secured internet websites.

★Acknowledgement of Privacy Practices:

Option 1:

_____ I do not want to receive a copy of the privacy policy.

Option 2:

_____ I would like to receive a copy of Eastwind Women's Health Notice of Privacy Practices.

I understand I have a right to keep my medical information private.
If you would like someone (spouse, sister, brother, son, daughter, etc.) to have access to your medical information please fill in the blanks below:

I, _____, hereby allow Eastwind Women's Health, to discuss my medical information with
(Patient Name)

Name: _____ Relationship: _____.

★Payment and Financial Responsibility:

I hereby authorize and/ or assign my Medicare and/or my insurance benefits to be paid directly to Eastwind Women's Health. I realize I am responsible to pay non- covered services as well as any deductibles, copays or coinsurance. I am aware that all unpaid balances and copays are due at the time of my visit. I certify that the information given to me by the practice, in applying for under Medicare and/ or insurance coverage or other protection is correct and complete. I authorize any holder of medical information about me to release to Medicare and/ or the insurance company or its agents, any information needed to determine the benefits payable to related services. I consent to any request for review or appeal by Eastwind Women's Health, to challenge a determination of benefits made by a third party payer or insurer. This assignment will remain in effect until revoked by me if writing. A photocopy of this assignment is considered to be as valid as the original. If you are a self pay patient any quotes provided are strictly estimates.

Print Name: _____ Date of Birth:_____

Patient or Guardian Signature: _____ Today's Date:_____

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★Genetic Cancer Screen★

Patient Name:_____ DOB:_____

If you have already had Genetic Testing (I.E. BRCA or My Risk) please mark one: Yes / No

	Yes	No	Mothers Side (Including Age of Diagnosis)	Fathers Side (Including Age of Diagnosis)
Have you or any family members been diagnosed with Breast Cancer?				
Have you or any family members been diagnosed with Ovarian Cancer?				
Have you or any family members been diagnosed with Colon Cancer?				
Have you or any family members been diagnosed with Pancreatic Cancer?				
Any Male Breast Cancer in the family?				
Do you or anyone in the family have BRCA mutation or any other mutation that increases the risk of cancer?				

Are you of Jewish (Ashkenazi) descent? (Circle one) Yes No

Patient or Guardian Signature:_____ Date:_____