

MICHAEL J. WOLPMANN, MD, FACOG, FACS

Patient Information

Date: _____ Name: _____ Age: _____

Seasonal Address: _____ City: _____ State: _____ Zip: _____

Permanent Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ SS#: _____ Marital Status: M W S D

Employer: _____ Occupation: _____

Referred by: _____ Primary Care Physician: _____

In Case of Emergency Contact: _____ Phone: _____

Primary Insurance Co: _____

ID/SS#: _____ Group #: _____ Co-pay: _____

Policy Holder: _____ Relationship: _____

Policy Holder's SS#: _____ Policy Holders Date of Birth: _____

Employer: _____ Ins Address: _____

Secondary Insurance Co: _____

ID/SS#: _____ Group #: _____ Co-pay: _____

Policy Holder: _____ Relationship: _____

Policy Holder's SS#: _____ Policy Holders Date of Birth: _____

Employer: _____ Ins Address: _____

This office does not accept all insurance plans. Some insurance's (such as Medicare) do not cover routine annual exams. It is the patient's responsibility to be aware of their company's policies and procedures. Appropriate payment or co-pay is due when service is rendered.

Release of Benefits: I hereby authorize my insurance benefits to be paid directly to this physician and acknowledge that I am financially responsible for any unpaid balance. I also authorize this office to release any information required by my insurance company.

Patient Signature: _____ Date: _____

PATIENT HISTORY FORM

Name: _____ Date: _____ DOB: _____

WHY ARE YOU HERE TO SEE THE DOCTOR? _____

How long have you had this symptom/complaint? _____

Please list any medication(s) you are taking or using for this problem: _____

GYNECOLOGIC HISTORY:

If having periods, are your periods ___Regular ___Irregular ___Light ___Moderate ___Heavy

Date of last menstrual period: _____

Are you taking hormone replacement therapy? ___Yes ___No

If so, what type? _____

Date of last Pap test: _____ History of abnormal Pap test? ___Yes ___No

Date of last mammogram: _____ History of abnormal mammogram? ___Yes ___No

OBSTETRIC HISTORY:

Please list year, vaginal or c-section, sex and weight. Also list any miscarriages or abortions.

MEDICAL HISTORY:

Please list any current medical problems or conditions (such as asthma, diabetes, etc.):

MEDICATIONS:

Please list all medications you are currently taking and the dosage:

ALLERGIES:

Are you allergic to any medication(s)? ___Yes ___No

If yes, please list medication you are allergic to and reaction: _____

HABITS:

Do you smoke? ___Yes ___No If yes, how many/day? _____ Years _____

Do you drink alcohol? ___Yes ___No If yes, how much/day? _____

OTHER:

Do you ever experience urine loss associated with coughing, laughing or sneezing? ___Yes ___No

Do you ever experience urine loss associated with urgency? ___Yes ___No

Do you need to wear a pad for urine loss? ___Yes ___No

PATIENT HISTORY FORM - continued

Name: _____ Date: _____ DOB: _____

SURGICAL HISTORY:

Please list ALL past surgeries you have had:

_____	Date: _____
_____	Date: _____
_____	Date: _____
_____	Date: _____

FAMILY HISTORY:

List all family members with breast, ovarian, uterine, other cancers or disease:

CONSENT TO TREATMENT

I (the patient/parent/guardian/legal representative of the patient acting on the patient's behalf) give permission for medical treatment including laboratory procedures to be performed by the physician, Michael J. Wolpmann, MD and staff. This consent is valid from this day forward.

Relationship to patient: ___Self ___Child ___Dependent ___Other

Printed name: _____

Date of birth: _____

Signature: _____

Today's date: _____

Name: _____ Date: _____ DOB: _____

Financial Agreement

The person signing below agrees whether he/she signs as patient or representative of the patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of Michael J. Wolpmann, MD. Should the account be referred to an attorney for collection, the person signing below shall pay reasonable attorney's fees and collection expenses.

"I assign payment for the unpaid charges for certain medical treatment furnished by Michael J. Wolpmann, MD and staff and by attending physicians for whom the office is authorized to bill. I understand that I am responsible for any health insurance deductibles and coinsurance at the time services are rendered

Medicare and/or Medicaid Certification

The person signing below certifies that he/she has read this document and is the patient, or is duly authorized by the patient as the patient's representative, to execute the above and accepts its terms.

"I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Administration is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration of its intermediaries/carriers any information needed for this or related Medicare claim, I, request that payment of authorized benefits be made on my behalf."

Assignment and Release of Benefits

I hereby authorize my insurance benefits be paid to the physician, Michael J. Wolpmann, MD, and acknowledge that I am financially responsible for any unpaid balance. I also authorize the physician, Michael J. Wolpmann, MD, to release any information required by my insurance company(s).

Relationship to Patient: Self Child Dependent Other _____

Printed Name: _____

Signature: _____

Date: _____

The Women's Centre at Bayside Gynecology
Michael J. Wolpmann, MD, FACOG, FACS

To Our Valued Patients:

The misuse of protected health information has been identified as a national problem causing some patients inconvenience, aggravation and money. We want you to know that all of our employees/managers periodically receive training to assist them in understanding and complying with the government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with a particular emphasis on the "Privacy Rule." We strive to achieve the highest standards of ethics and integrity in performing services for our patients.

When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. Other entities may have indirect treatment relationships with you (such as the physician reading your x-ray) and we may have to disclose personal health information for purposes of treatment or payment. These entities are most often not required to obtain patient consent.

You may refuse, in writing, the consent to the use or disclosure of your personal health information. Under this law, we then have the right to refuse to treat you should you refuse to disclose your personal health information. At any time in the future you may request to refuse all or part of disclosure of your personal health information. However, you may not revoke actions that have already been taken which relied on this or previously signed consent.

It is our policy to determine appropriate uses of personal health information in accordance with the government rules, laws and regulations. We want to ensure that our office never contributes in any way to the growing problem of improper disclosure of personal health information. We have implemented a program we believe will help prevent any such inappropriate use of personal health information.

We also know that we are not perfect. Because of this fact, our policy is to listen to our patients and employees regarding any event they feel may compromise our policy of integrity. Moreover, we welcome your input regarding any service problem so that we may remedy the situation promptly. If you have any questions, please speak to our Privacy Officer, Joy Guffy. Thank you for your continued confidence in our care.

Signature of Authorizing Person

Date

