

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 - continued

Name: _____ Date: _____ DOB: _____

Other

Do you ever experience urine loss associated with coughing, laughing, sneezing, or exertion? 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 Only when leaving home
Do you get up at night to go to the bathroom? Yes No If so, how many times? _____
Do you ever feel your bladder is "falling down" or experience vaginal pressure? Yes No
Are you sexually active? Yes No If yes, do you have any pain during intercourse? Yes No

Past Surgical History

Procedure	Date	Procedure	Date
Hysterectomy		Mastectomy	
Heart Bypass		Joint replacement	
Carotid artery surgery		Other:	
Leg artery bypass		Other:	
Abdominal aneurysm repair		Other:	
Gallbladder removed		Other:	
Appendix removed		Other:	

Family History

Any family history of: Breast Cancer Uterine Cancer Ovarian Cancer
 Colon Cancer Heart Disease starting before age 65

Social History

Marital Status: Single Married Divorced Widowed Occupation: _____
Do you smoke? Yes No If so, how many per day? _____ How many years _____
Do you drink alcohol? Yes No If so, how often? _____

Health Maintenance

Please describe your previous health maintenance testing.

Colonoscopy Date: _____ Last Pap Smear Date: _____ Abnormal? Yes No
 Bone Density Date: _____ Last Mammogram Date: _____ Abnormal? Yes No

Review of Systems

Please check any symptoms/problems that you currently or commonly experience.

- Excessive Fatigue
- Chest pain
- Shortness of breath
- Wheezing
- Palpitations
- Swelling
- Dizziness
- Numbness / tingling
- Hoarseness
- Weight loss / gain
- Leg cramps
- Passing out
- Insomnia
- Diarrhea
- Constipation
- Balance problems
- Memory loss
- Frequent urination
- Burning with urination
- Nausea
- Abdominal pain
- Hearing loss
- Ringing in ears
- Heat / cold intolerance
- Blurred vision
- Balance problems
- Menstrual changes
- Sexual problems
- Cough
- Easy bruising
- Increased thirst
- Rash / changing mole
- Joint pain / stiffness
- Fever / chills
- Severe sweating
- Depression
- Anxiety
- Back pain
- Trouble swallowing

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: _____

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, M.D. and staff. This consent is valid from this day forward.

Relationship to patient: Self Child Dependent Other

Printed Name: _____

Signature: _____ Today's 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

