THE COLORADO CENTER FOR GYNECOLOGIC ONCOLOGY™

PATIENT INFORMATION
Please Print

Patient's Last Name_____ First Name_____ Middle Name_____

Suffix_____ Social Security Number_____ Date of Birth_____ Place of Birth_____

Race_____ Ethnic Group: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown Preferred Language_____ Marital Status_____

Mailing
Address_____ City_____ State_____ Zip Code_____ County_____
Home
Address_____ City_____ State_____ Zip Code_____ County_____

Home Ph. (____)_____ Cell Ph. (____)_____ Work Ph. (____)_____ Email_____

Primary Care Physician_____ Referring Physician_____

Employment Status ☐ Full-Time ☐ Part-Time ☐ Retired Retire Date_____

Employer_____ Occupation_____

Policy Holder Information (if Different from Patient). If same as patient, please check here ☐

Self_____ Spouse_____ Parent_____ Other_____

Last Name_____ First Name_____ Middle Name_____

SSN_____ Date of Birth_____ Home Ph. (____)_____ Cell Ph. (____)_____ Work Ph. (____)_____

Street Address_____ City_____ State_____ Zip Code_____ County_____

Employment Status ☐ Full-Time ☐ Part-Time ☐ Retired Retire Date_____

Employer Name_____

Insurance Information

Insurance Company _____

Member ID _____ Group # _____

Telephone Number _____

Emergency Contact (Parent / Guardian if patient is a minor)

Name_____ Relationship_____

Home Ph. (_____)_____ Cell Ph. (_____)_____ Work Ph. (_____)_____

PLEASE HAVE YOUR INSURANCE CARD AND DRIVER'S LICENSE READY FOR THE RECEPTIONIST. PAYMENT FOR PROFESSIONAL SERVICES IS DUE AND PAYABLE WHEN SERVICE IS RENDERED.

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to evaluation or treatment the assigned healthcare provider may deem necessary to the patient name above.

_____ Date_____
PATIENT, PARENT, LEGAL GUARDIAN OR ATUHORIZED REPRESENTATIVE

INSURANCE ASSIGNMENT

I hereby authorize my insurance benefits to be paid directly to Colorado Center for Gynecologic Oncology. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

_____ Date_____
PATIENT SIGNATURE

FOR MEDICARE PATIENTS ONLY
MEDICARE PART B SIGNATURE AUTHORIZATION – LIFETIME

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

_____ _____
PATIENT NAME PATIENT SIGNATURE

_____ _____
MEDICARE B# DATE

ADVANCE DIRECTIVE

I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law. Please check one of the following statements:

☐ I HAVE executed an Advance Directive.
(Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate.)

Please provide copes of Advance Directive / Living Will to the receptionist to be included in your medical records.

☐ I HAVE NOT executed an Advance Directive.
(Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate.)

Sinature_____ Date_____

APPOINTMENT DATE: _____ **PHONE (H):** _____

NAME: _____ **(W):** _____

DATE OF BIRTH: _____ **AGE:** _____ **(C):** _____

HOW MANY: **G (pregnancies?)**_____ **P (Live Births?)** _____ **A (miscarriage?)** _____

Marital Status **S □** **M □** **W □** **D □**

REFERRING MD: _____ **PHONE:** _____
First Name, Last Name

PHARMACY: _____ **PHONE:** _____

PRIMARY CARE MD: _____ **PHONE:** _____

REASON FOR SEEING DOCTOR: **(History of present illness) elements**

_____

_____

_____

_____

_____

_____

MEDICAL ILLNESSES: **(Check all that apply)**

□ Diabetes
□ Kidney disease
□ Ischemic heart failure
□ Congestive heart failure
□ Other heart disorders
□ Strokes
□ Migraine headaches
□ Psychiatric / Depression
□ Allergies
□ Rheumatic Fever
□ Tuberculosis
□ Thyroid Condition
□ Bleeding Disorders
□ Anemia
□ Asthma
□ Emphysema, bronchitis
□ Seizures
□ Hypertension
□ Thrombophlebitis
□ Sickle Cell
□ Hepatitis
□ Lymphadema
□ Increased Cholesterol
□ Others: _____

SURGERIES AND YEAR: _____

_____

MEDICATIONS AND DOSAGES: _____

ALLERGIES: _____

Do you use Aspirin, Arthritis Medications or Coumadin? _____

HABITS: □ **Alcohol – Amount** _____ □ **Tobacco – Amount** _____ □ **Exercise**

GYNECOLOGIC HISTORY: (Check or comment)

Last Period: _____ **Chest Pain:** _____

Last Pap Smear: _____ **Short of Breath:** _____

Last Mammogram _____ **Fever:** _____

Abnormal Bleeding: _____ **Painful Periods:** _____

Blood in Urine: _____ **Blood in Stool:** _____

Duration of Flow: _____ **Swelling in Legs:** _____

Interval between periods: _____ **Constipation:** _____

Painful intercourse: _____ **Diarrhea:** _____

Bleeding after intercourse: _____ **Nausea:** _____

Loss of urine: _____ **Infection uterus, tubes or ovaries:** _____

Painful urination: _____ **Vaginal Discharge:** _____

Weight Loss: _____

Contraception (what type and how long): _____

Are there any health problems which you may not have not covered on this form?

_____

FAMILY HISTORY: *Please specify who in your family has/had any of the following:*

Breast Cancer: _____ **Heart Disease** _____

Colon Cancer: _____ **Diabetes:** _____

Ovarian Cancer: _____ **Other Cancer:** _____

SOCIAL HISTORY: **Place of Birth** _____

Religious Affiliation _____

Marital Status _____

CLOT/DVT:

Have you ever had or been diagnosed with a clot, deep vein thrombosis, or pulmonary embolism
☐ yes ☐ no If yes, please detail date and treatment.

_____

OFFICE USE ONLY

Exam: **Height: _____ Blood Pressure _____**

Weight: _____ Temperature _____

BMI: _____

IMPORTANT

PLEASE NOTE THE OTHER DOCTORS INVOLVED IN YOUR CARE

Patient Name: _____

MD	SPECIALTY	PHONE#	CITY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PATIENT HIPAA QUESTIONNAIRE

SECTION A: Please complete the following information for all requests

1. Today's Date: _____

2. Patient's Name: _____

3. Date of Birth: _____ 4. Patient # _____

5. Address: _____
Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFEDENTIAL" ☐ yes ☐ no

I hereby request the following regarding the use of my PERSONAL HEALTH INFORMATION:

1. You may discuss information regarding my treatment and all my medical care with the following family members and/or friends: ☐ Patient ONLY

NAME:	RELATIONSHIP:	TELEPHONE:
_____	_____	_____
_____	_____	_____

2. You may contact me or leave messages regarding my treatment and all medical care at the following numbers:

Home telephone – Ok to leave a voicemail	☐ yes	☐ no
Cell Phone – Ok to leave a voicemail	☐ yes	☐ no
Work telephone – Ok to leave voicemail	☐ yes	☐ no

- **I am fully aware that a cell phone is not a secure and private line**
- **I am fully aware my health information can be transmitted my fax, mail or the internet**

RELEASE OF MEDICAL RECORDS

I hereby authorize the release of medical, physical, alcohol, HIV testing and/or drug abuse information For insurance carriers or for continuing patient care.

Any of the classifications above may be crossed off if the information is not to be released.

_____ _____
Signature of Patient or Guardian Date

THE COLORADO CENTER FOR
GYNECOLOGIC
ONCOLOGY™

Authorization to Release Medical Records/Information

_____ **(patient name) request Medical Records from:**

_____

_____ **(patient name) authorizes medical records to be sent to:**

Name	Colorado Center for Gynecologic Oncology
Address	7780 S Braodway, Suite 300, Littleton, CO 80122
Telephone	303-955-7574

Expiration or revocation of authorization – I understand that I may revoke this authorization at any time.
Use of copies – A copy of this authorization may be utilized with the same effectiveness as an original.

Patient's name (print):

_____

Patient's signature:

_____

Date: _____

Person authorized to sign for patient: (print)

_____

Signature:

_____

Relationship to patient: _____

Date: _____

THE COLORADO CENTER FOR
GYNECOLOGIC
ONCOLOGY™

Acknowledgement of Receipt of Notice of Privacy Practices

The Colorado Center for Gynecologic Oncology
7780 S. Broadway St., Suite 300 Littleton, CO. 80122
9397 Crown Crest Blvd., Suite 310 Parker, CO. 80138

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

SUBMISSION INSTRUCTIONS
Please print out the form and bring it with you on the day of your appointment.