**Capital Region OBGYN, L.L.C.**

**MEDICAL HISTORY FORM**

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**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_**

**GYNECOLOGIC HISTORY**

|  |  |
| --- | --- |
| LMP (last menstrual period) / / | Present method of birth control: |
| Age periods began: | Have you ever used an intrauterine device (IUD) or birth control pills? |
| Length of periods (number of days of bleeding): | If yes, for how long? |
| Number of days between periods: | When was your last pap test? / / |
| Any recent changes in periods? | What was the result? |
| Are you currently sexually active? □ Yes □ No | Have you ever had an abnormal pap test? □ Yes □ No |
| Have you ever had sex? □ Yes □ No | Do you do breast self-examinations? □ Yes □ No |
| Number of sexual partners (lifetime): | Have you been exposed to diethylstilbestrol (DES)? |
| Sexual partners are: □ Men □ Women □ Both | Have you had the HPV vaccine series (Gardasil)? □ Yes □ No  If yes, when did you complete the series?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| When was your last mammogram? / / | When was your last bone density scan? / / |

**OBSTETRIC HISTORY**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | **Number** | |  | **Number** | |  | | **Number** |
| Pregnancies | | | |  | | Abortions |  | | Miscarriages | |  |
| Premature Births ( < 37 wks) | | | |  | | Live Births |  | | Living Children | |  |
| **No.** | **Birth Date** | **Wt. at Birth** | | | **Baby’s Sex** | **Wks. Pregnant** | | **Type of Delivery (vaginal, c-section)** | | **Physician’s Notes** | |
| 1. |  | |  | |  |  | |  | |  | |
| 2. |  | |  | |  |  | |  | |  | |
| 3. |  | |  | |  |  | |  | |  | |
| 4. |  | |  | |  |  | |  | |  | |
| Any pregnancy complications? | | | | | | | | | | | |
|  | | | | | | | | | | | |
| □ Diabetes □ Hypertension/High blood pressure □ Preeclampsia/Toxemia □ Other | | | | | | | | | | | |
| Any history of depression before or after pregnancy? □ No □ Yes, how treated? | | | | | | | | | | | |

**PAST MEDICAL HISTORY**

|  |  |  |
| --- | --- | --- |
| Please indicate any PAST or CURRENT medical problems | | |
| Heart disease | High blood pressure | Epilepsy/seizures |
| Lung disease (including asthma) | Blood transfusion | Breast Cancer/Biopsies |
| Intestinal problems | Diabetes | DES exposure |
| Urinary problems | Venereal disease/STD | Pelvic inflammatory disease (PID) |
| Muscles/Bones problems | Mental Illness/Depression | Cancers |
| Thyroid disease | Blood disease | Migraines/Headaches |
| Glaucoma/Cataracts |  |  |
| Any conditions not listed? | | |

**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_**

**SURGERY OR MAJOR HOSPITALIZATIONS**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Reason:** | | **Month/Year** | **Reason:** | | | | **Month/Year** |
|  | |  |  | | | |  |
|  | |  |  | | | |  |
|  | |  |  | | | |  |
|  | |  |  | | | |  |
|  | |  |  | | | |  |
| **DRUG ALLERGIES:** | **REACTION** | **In your family, do you have any of the following?** | | | | | |
|  |  | Disease: | |  |  | Relationship | |
|  |  | Heart Disease | | Yes | No |  | |
|  |  | Hypertension | | Yes | No |  | |
|  |  | Stroke | | Yes | No |  | |
|  |  | Breast Cancer | | Yes | No |  | |
|  |  | Ovarian Cancer | | Yes | No |  | |
| **CURRENT MEDICATIONS** | **DOSE** | Colon Cancer | | Yes | No |  | |
|  |  | Other Cancers | | Yes | No |  | |
|  |  | Diabetes | | Yes | No |  | |
|  |  | Epilepsy | | Yes | No |  | |
|  |  | Bleeding disorder | | Yes | No |  | |
|  |  | Kidney disease | | Yes | No |  | |
|  |  | Thyroid disease | | Yes | No |  | |
|  |  | Mental Illness | | Yes | No |  | |
|  |  | Others not listed | | Yes | No |  | |

**SOCIAL HISTORY**

|  |  |  |
| --- | --- | --- |
| Marital status: □ Married □ Living with partner □ Single □ Widowed □ Divorced | | |
|  | **YES** | **NO** |
| Ever smoked? Current smoking: PPD: Years: |  |  |
| Alcohol: Drinks per day: per week: Type of drink: |  |  |
| Drug Use |  |  |
| Seat Belt Use |  |  |
| Regular Exercise: How long and how often? |  |  |
| Dairy product intake and/or calcium supplements: Daily intake |  |  |
| Health hazards at home or work? |  |  |
| Have you been sexually abused, threatened, or hurt by anyone? |  |  |
| Do you have an advance directive (living will)? |  |  |
| Are you an organ donor? |  |  |

**REVIEW OF SYSTEMS**

|  |  |  |  |
| --- | --- | --- | --- |
| Do you regularly have any of the following symptoms? If so, please explain in the space at the bottom. | | | |
| Recurrent fevers | Persistent cough | Excessive thirst | Pain with intercourse |
| Persistent swollen glands | Shortness of breath | Frequent urination | Pain with menses |
| Skin rashes | Wheezing | Blood in your stool | Vaginal discharge or odor |
| Sores on the skin | Chest pain | Severe mood swings | Genital sores |
| Chronic itching | Swelling of your legs | Depression | Leakage of urine |
| Severe headaches | Head/cold intolerance | Anxiety | Hot flashes |
| Episodes of fainting | Significant weight change | Joint pain | Vaginal dryness |
| Seizures | Abnormal hair growth | Difficulty moving joints |  |
| Numbness/muscle weakness | Abnormal bruising/bleeding |  |  |

PATIENT DEMOGRAPHICS

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#:   |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |   Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_  Contact Info: (\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_\_ (\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_\_ (\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_\_  Home Phone# Cell Phone# Work Phone#  Age:\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Marital Status: S M W D SEP  Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employer Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Referred By\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reason for Visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Primary Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_\_\_ |
| **PLEASE PROVIDE SPOUSE’S/SIGNIFICANT OTHER’S INFORMATION:**  Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_  Work Phone# |
| In Case of Emergency, Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(\_\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_  How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Internet News Paper Yellow pages Physician Referral Another Patient  Pharmacy Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Pharmacy Address: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **PATIENT INSURANCE INFORMATION**  Primary Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ID #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Copay: $\_\_\_\_\_\_\_\_\_  Name of Secondary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ID #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I have insurance through my employer: □ Yes □ No  I have insurance through my spouse’s employer: □ Yes □ No  I am covered under my parents’ insurance: □ Yes □ No  **IF COVERED UNDER YOUR PARENT’S INSURANCE PLEASE PROVIDE PARENT’S INFORMATION**  Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: (\_\_\_\_\_)\_\_\_\_\_\_-\_\_\_\_\_\_\_ |
| **INSURANCE AUTHORIZATION AND ASSIGNMENT**  I hereby authorize Dr. Burstyn to submit information to insurance carriers concerning my illness and treatments.  I assign to Dr. Burstyn all payments for medical services rendered to myself or my dependents. I understand and agree that I am responsible for any amount not covered by insurance.  If I do not have any insurance or this office does not participate with my insurance carrier, I understand and agree that full payment is due at the time of my visit.  I understand that if I fail to make payment at the time of my visit of my co-payment or deductible, I will be charged a billing fee of $25.  I understand and agree that I will be held responsible for the entire balance due and subject to dismissal from this practice if I am non-compliant with the payment practices of this office.  Signature on File:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Capital Region OBGYN, L.L.C.**

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**NOTICE OF PRIVACY PRACTICES**

**PATIENT ACKNOWLEDGEMENT**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) I have certain privacy rights regarding my protected health information. I have received this practices’ notice of privacy practices written in plain language. The notice provides in detail the use and disclosures of my personal protected health information, my individual rights, and the practices’ legal duties with respect to my protected health information.

I understand that you may use and disclose my medical records only for the following purposes: treatment, to obtain payment, health care operations and as required by law.

Any other disclosures will be made only with my written authorization.

Do we have permission to:

Leave messages on your answering machine at home? Yes\_\_\_\_ No\_\_\_

Leave messages at your place of employment? Yes\_\_\_\_ No\_\_\_

Discuss your condition with any member of your household? Yes\_\_\_ No\_\_\_

If yes, with whom and where can we reach them?

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE UNDERSTAND THAT WE WILL NOT BE ABLE TO RELEASE ANY INFORMATION ABOUT YOUR MEDICAL CONDITION TO ANYONE NOT AUTHORIZED BY YOU. IT IS YOUR RESPONSIBILITY TO CHANGE/UPDATE THIS INFORMATION AS NECESSARY.

PATIENT SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Capital Region OBGYN, LLC**

**Financial / Payment Policy**

**Dear Valued Patient:**

**Your insurance policy represents a contract between you and your insurance company. As our service to you, we will file your insurance claim for you to have your insurance company pay directly to the doctor. If your insurance company does not reimburse us within a reasonable period of time, we will have to look to you for payment.**

**Many insurance companies deduct a certain amount from a contractually agreed amount between them and your health care provider depending on your policy. This amount is your co-payment. Many patients mistakenly perceive their co-pay to be an additional charge to what the insurance company reimburses the doctor. It is not. It is the difference between what insurance companies agree to pay us contractually and what they actually pay deducting the amount you are responsible for based on your policy. Failure to pay your co-payment, coinsurance, or deductible amount in a timely manner will cause the outstanding bill amount to be subject to be sent to collections.**

**Finally, please keep in mind that not all insurance plans cover all services. In the event that your insurance plan deems a service as “not covered”, you will be responsible for the complete charge.**

***I authorize the release of any medical information necessary to process any claim. I authorize payment of medical benefits to the physician.***

***I have read and understood practice’s financial policy and I agree to be bound by its terms. I also understand and agree that such items may be amended by the practice.***

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of patient (or responsible party if minor) Relationship to Patient**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**