

# Premier Women's Health

*of South Jersey*

A Division of Regional Women's Health, LLC

Jeffrey T. Gibson, MD • Vivian Vega, MD  
Byron S. Hapner, DO • Anna Jang-Hanson, MD  
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Your Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Please list all medications that you take, as well as quantity and frequency:

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Echelon One, Suite 300  
Voorhees, NJ 08043

450 Cresson Blvd  
Suite 300  
Oaks, PA 19456

P (856) 669-6050

P (484) 831-0200

Premier Women's Health of South Jersey  
an Axia Women's Health Care Center  
**HIPAA & REGISTRATION UPDATE FORM**

(Please Print)

Date: / /		Primary Care Phys. (PCP):		PCP Phone No.:	
<b>PATIENT INFORMATION</b>					
Patient's Last Name:		First:	Middle:	Gender: F M	Marital Status (circle one): Single / Mar / Div / Sep / Widow
Birth Date: / /	Age:	Social Security No.:	Home Phone No.: ( )	Cell Phone No.: ( )	
Street Address:			City:	State:	Zip Code:
I authorize messages with medical information to be left on voicemail/answering machine at (check all that apply) <input type="checkbox"/> Home <input type="checkbox"/> Cell above. I authorize: <input type="checkbox"/> Brief message details to be left <input type="checkbox"/> Extended message details to be left <input type="checkbox"/> Restrictions:					
<b>PHARMACY INFORMATION</b>					
Local Pharmacy:		Address:		City:	State:
Mail-Order Pharmacy:		Address:		City:	State:
<b>INSURANCE INFORMATION</b>					
Please give your insurance card(s) to the receptionist.					
Name of Primary Insurance Company:		Subscriber's Name:		Subscriber's SSN:	Subscriber's Date of Birth: / /
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Partner <input type="checkbox"/> Other – please explain:					
Name of Primary Insurance Company:		Subscriber's Name:		Subscriber's SSN:	Subscriber's Date of Birth: / /
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Partner <input type="checkbox"/> Other – please explain:					
<b>IN CASE OF EMERGENCY</b>					
Name of contact:		Relationship to patient:		Home Phone No.: ( )	Cell Phone No.: ( )
<b>RELEASE OF MEDICAL AND BILLING INFORMATION</b>					
I authorize the following individual(s) to receive information pertaining to any medical history, treatment received and billing matters:					
Name:		Relationship to patient:		Birth Date: / /	Contact Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell ( )
				/ /	( )
<b>PATIENT PORTAL COMMUNICATION</b>					
We continue to offer secure electronic communications between you and our office via our Patient Portal. Secure messages and information can only be read by someone who knows the right password to log in to the Portal site. The communications are automatically encrypted and for those who want to participate, this secure communication can be a valuable tool to provide administrative and clinical information provided that we maintain your most up-to-date information. <b>Do you wish to either continue to participate or sign up to participate?</b>					
<input type="checkbox"/> Yes, I want to participate, my email is _____ <input type="checkbox"/> No, I do not want to participate at this time.					
<b>MEDICAL CHAPERONE</b>					
I request a female chaperone to be present during my examination. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (family member, partner, etc. will be present)					
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my provider or insurance company to release any information required to process my claims.					
Patient Signature				Date	

Patient's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

## Authorization for Treatment & Payment of Medical Benefits Patient Financial Responsibility Form

Thank you for choosing our practice, an Axia Women's Health Care Center, as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment, and patient financial policies. If you would like to receive a more detailed explanation of our financial policies, please request a copy.

### *Authorization for Treatment & Payment of Medical Benefits*

I give permission to the practice, an Axia Women's Health Care Center, to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to the practice, an Axia Women's Health Care Center.

### *Use of Photography*

I agree that any photo identification taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of identification.

### *e-Prescription Consent for Medication History*

With your consent, we may request and use your prescription medication history information using our e-prescription feature. This is for only informational purposes so that an up-to-date record of your medication is available for your treatment and safety.

- Yes, I give consent to obtain my medication history using the e-Prescribing feature.
- No, I do not give consent to obtain my medication history using the e-Prescribing feature. I understand that my medication information may not be complete when making treatment decisions.

### *Patient Financial Responsibilities*

- I (or patient's guardian, if a minor) understand that I am ultimately responsible for the payment of my treatment and care.
- You will assist me by billing your contracted insurers. However, I understand that I am required to provide you with the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, and most major credit cards.
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include (but are not limited to):
  - ♦ Charge for returned checks.
  - ♦ Charge for the copying and distribution of patient medical records.
  - ♦ Charge for forms completion.
  - ♦ Charge for missed appointments.

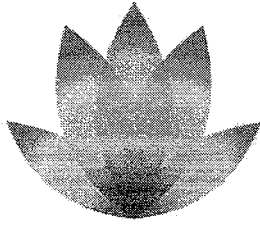
### *Patient Authorizations*

- By my signature below, I hereby authorize the practice, an Axia Women's Health Care Center, to release medical and other information to the necessary insurance companies and third party payers required for payment of rendered health services.
- By my signature below, I hereby authorize assignment of financial benefits directly to the practice, an Axia Women's Health Care Center. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

**I have read, understand, and agree to the provisions of this Authorization for Treatment & Payment of Medical Benefits and Patient Financial Responsibility Form:**

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date



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Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Dear Patient:

The State of New Jersey mandates that every physician office document any barrier to care including physical impairments, cultural and linguistic needs in their medical records.

**Please assist us by answering the following questions:**

Do you have any Impairment – Visual, Hearing, Speech, learning, physical or language/cultural barrier?

What language do you speak, read, or write?

Do you have any religious or culture customs that the provider should know about?

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

34 Colson Lane • Mullica Hill, NJ 08062  
Hofmann Professional Building • 340 W. Front Street, Suite 201 • Elmer, NJ 08318  
100 Lexington Road, Building 100 • Woolwich Township, NJ 08085  
603 North Broad Street, Suite 300 • Woodbury, NJ 08096  
Phone: 856.223.8930 • Fax: 856.223.8948 • www.pwhsj.com

**Premier Women's Health of South Jersey**

<b>PATIENT NAME:</b>	<b>DOB:</b>
<b>EMERGENCY CONTACT &amp; PHONE #:</b>	<b>DATE:</b>

Please fill out the questions below in order to help keep us **UPDATED** on your personal health history and assist us in providing you the highest quality of care. We hope you will feel comfortable discussing any questions or concerns you have with your doctor or nurse. All answers will be kept confidential.

**SINCE YOUR LAST VISIT, HAVE YOU:**

Discovered you are allergic to anything?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	What? _____	Reaction? _____
Had any changes in your health?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	What? _____	
Have you been hospitalized?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Why? _____	
Has anyone in your immediate family been diagnosed with a serious illness?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Has there been a death in your immediate family?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Explain _____	
Have you received any immunizations?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Type? _____	
Any changes or additions to medications?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Additions/Changes? _____	
Do you take Calcium?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Any pregnancies?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Any miscarriages or abortions?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Changes with your period?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Any urinary problems?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Any abnormal bleeding?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Any pelvic pain?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Any symptoms of menopause?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you do self-breast exams?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Any breast changes?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Change of marital status?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Have you changed sexual partners?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Have you had multiple sexual partners?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Any history of physical/emotional abuse?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Have you been treated for any sexually transmitted disease?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you wish to be tested for any sexually transmitted disease?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you wish to be tested for HIV/AIDS?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		

**SINCE YOUR LAST VISIT, HAVE YOU HAD ANY OF THE FOLLOWING PROCEDURES:**

*(If "Yes", please indicate the date of the procedure and where it was performed.)*

Pap Smear?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, Date: _____	Where: _____
Breast exam?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, Date: _____	Where: _____
Mammogram?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, Date: _____	Where: _____
Sigmoid/colon exam?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, Date: _____	Where: _____
Stool check for blood?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, Date: _____	Where: _____
Cholesterol?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, Date: _____	Where: _____
Complete physical?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, Date: _____	With whom: _____

**PERSONAL HABITS:**

Do you use tobacco products?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	How much? _____	How often? _____
Do you drink alcohol?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	How often? _____	What kind? _____
Do you use drugs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	How often? _____	What kind? _____
Do you exercise regularly?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, how often? _____	What type? _____

**DO YOU HAVE ANY PARTICULAR HEALTH CONCERNS AT THIS TIME YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR OR NURSE?** \_\_\_\_\_

**COMPLETED BY:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**REVIEWED BY:** \_\_\_\_\_ **DATE:** \_\_\_\_\_