North Alabama Women's Center

James S. Daniel, M.D., F.A.C.O.G.
P.O. BOX 8037, 721 East 10TH Street
Anniston, AL 36202
Tele: (256) 236-9995, Fax: (256) 236-9908

PLEASE COMPLETE THE FOLLOWING SO THAT WE MAY UPDATE OUR RECORDS

Date: ______________

Last Name First Middle

Mailing Address City State Zip

( ) ( ) ( )

Home Phone Cell Phone Work Phone

Social Security# Race Date of Birth

( ) Single ( ) Married ( ) Divorced ( ) Widow

Pharmacy Phone# Martial Status

Employer **INSURANCE INFORMATION** Phone

Insurance Company Name Policy Number

Group Number Policy Carrier

Relationship with Carrier Date of Birth

( )

Place of Employment Phone

PERSON RESPONSIBLE FOR BILL/SPOUSE, PARENT OR GUARDIAN

Last Name First Middle

Address City-State-Zip Date of Birth

(___)__________________________(____)

Phone-Cell

Employer Phone Relationship

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATIONNECESSARY TO PROCESS CLAIMS AND RECEIVE INSURANCE BENEFITS ON MY BEHALF FOR SERVICES RENDERED.

NOTIFY IN CASE OF AN EMERGENCY

Last Name First Relationship

Phone Cell Address

Employer Work Phone

North Alabama Women's Center

James S. Daniel, M.D., F.A.C.O.G.

Date______________________

Medical History

Name: ________________________ **DOB:**_________________________ **Age:** ________

Reason for your visit today:____

First day of last period_____ **Do you have regular monthly periods?** Y / N

How often do your periods come?_______________ **Age at first period**__________

Periods are: Mild Moderate Heavy **Cramps are** Mild Moderate Severe

Drug Allergies:____

Current birth control:____

Age at first intercourse:_________________ **Number of partners (lifetime)**_________________________

Are you having any libido changes? Y / N (please explain) ____

Do you have pain with intercourse? Y /N (please explain) ____

Sexual Preference: (please circle) Heterosexual Homosexual Bisexual

Have you had a new sexual partner since last exam? Y / N **Do you desire testing for STD's?** Y /N

Have you ever had a sexually transmitted disease? Y / N (circle any that apply)

Gonorrhea Chlamydia Herpes Hepatitis B HIV Syphilis Genital Warts PID Trichomonas HPV

Do you use tobacco products? Y/ N **About** _____ **cigarettes per day**

Do you drink alcohol? Y / N **About** _____ **drinks per week**

Are you experiencing any vaginal or urinary:

Discharge Odor Burning Itching Frequency Urgency Loss of Urine

Other:____

Printed Name:______________________________

Signature:________________________________

For office use only:

___________ ___________
Initials Date

North Alabama Women's Center

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Date______________________

Name: _________________________ **DOB:**_________________________ **Age:** ________

Last pap smear:________/_________ **Results**____

Have you ever had an abnormal pap smear? Y / N

If yes, please give year and any procedures____

Last Mammogram_______/________ **Results**____

Have you ever had an abnormal mammogram? Y / N

If yes, please give year and procedures____

Do you do monthly breast exams? Y / N / Occasionally

Do you diet? Y / N **What type?** ____

Do you exercise? Y /N **How often & how long?** ____

Do you take calcium? Y / N **If so, how much?** ____

Notes:

____

____

Pleas list all surgeries / hospitalizations

Surgery / reason for hospitalization	Date

Printed Name: _________________________________

Signature: ___________________________________

For office use only:

___________ ___________

Initials Date

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Review of Systems

Name:______________________________ DOB: ____________________________________ Age________

Are you currently experiencing any of the following symptoms?

Please check the appropriate box if the answer is yes

Constitutional:	
☐	Fever
☐	Chills
☐	Sweats
☐	Weight change-gain or loss
☐	Weakness
☐	Fatigue
☐	None of the Above
Eyes:	
☐	Change in Vision
☐	None of the Above
Ears, Nose, Mouth, Throat:	
☐	Change in hearing
☐	Nose bleeds
☐	Sore throat
☐	Dry mouth
☐	None of the Above
Cardiovascular:	
☐	Dizziness
☐	Shortness of breath
☐	Chest pain
☐	Loss of consciousness
☐	Palpitations
☐	None of the Above
Respiratory:	
☐	Chest pain
☐	Cough-productive or dry
☐	Shortness of breath
☐	Wheezing
☐	None of the Above
Gastrointestinal:	
☐	Abdominal pain
☐	Nausea, vomiting
☐	Change in bowel habits
☐	Change in appetite
☐	Dark or bloody stool
☐	Indigestion
☐	Constipation or diarrhea
☐	None of the Above
Hematologic / Lymphatic:	
☐	Swollen lymph gland
☐	Easy bruisability
☐	None of the Above

Gynecological:	
☐	Bleeding or pain with intercourse
☐	Unusual vaginal discharge or odor
☐	Vulvar or vaginal itching or burning
☐	Pelvic pain
☐	None of the Above
Urinary:	
☐	Painful urination
☐	Frequent Urination
☐	Urinary urgency
☐	Blood in urine
☐	Urinary incontinence
☐	Getting up at night to urinate
☐	None of the Above
Musculoskeletal:	
☐	Back pain
☐	Weakness
☐	Joint pain, stiffness, swelling
☐	None of the Above
Integumentary/Breast:	
☐	Nodules
☐	Change in mole, freckles
☐	Change in hair-growth, loss, texture
☐	Breast lumps
☐	Breast nipple discharge
☐	Breast pain
☐	None of the Above
Neurological/psychiatric:	
☐	Memory change
☐	Depression
☐	Anxiety
☐	Mood swings
☐	Numbness or tingling
☐	None of the Above
Endocrine:	
☐	Excessive thirst, urination
☐	Tremor
☐	Cold or heat intolerance
☐	Hot flashes
☐	Night sweats
☐	Sleep disturbances
☐	None of the Above

Patient Name: ______________________________

Signature: ______________________________

For Office use only

________ ________

Initials Date

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Date________________________

Name: ___________________________ DOB:____________________________ Age: _________

Please list all pregnancies

Year	Method of delivery	Gestational age	Sex	Weight	Comments/Complications

Medical Problems

Date of Diagnosis	Medical Problem

Printed Name: ____________________________________

Signature: ____

For office use only:

_____________ Initials _____________ Date

North Alabama Women's Center

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Date______________________

Personal and Family History (mark all those that apply)

Disease	**Self**	**Mother**	**Father**	**Maternal Grand-mother**	**Maternal Grand-father**	**Paternal Grand-mother**	**Paternal Grand-father**	**Brother/ Sister**	**Other**
Alcoholism									
Anemia									
Arthritis									
Asthma/lung Problems									
Blood clots									
Bloody stools/ colon polyp									
Cancer									
Diabetes									
Heart disease									
High cholesterol									
High blood pressure									
Kidney-disease /UTIs									
Liver disease									
Loss of urine									
Mental illness									
Osteoporosis									
Seizures									
Stomach ulcers									
Stroke									
Thyroid disease									
Tuberculosis									
Other									

Printed Name:________________________________

Signature:________________________________

For office use only:

____________ Initials ____________ Date

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721 E 10TH Street

Anniston, Al 36207

Telephone: 256-236-9995 Fax: 256-236-9908

DISCLOSURE OF PROTECTED HEALTH INFORMATION

Who to Contact:

I hereby authorize and give permission to North Alabama Women's Center to disclose and discuss any information related to my medical condition(s) to/with the following persons:

______________________________	______________________________
Name	Relationship
______________________________	______________________________
Name	Relationship

Or: ☐ **Do not share my information with anyone.**

I wish to be contacted in the following manner	**Written Communication**
☐ Home/work Telephone_______________	☐ Ok to mail to my home address
☐ Ok to leave message with detailed information	☐ Ok to mail to my work/office address
☐ Leave message with call-back number only	☐ Ok to fax to this number_____________

By my signature below, I authorize the release of any medical or other information deemed necessary by North Alabama Women's Center, including transferring of any medical records to support medically necessary referrals to other health care providers. I also authorize payment of medical benefits to North Alabama Women's Center.

____ ______________________________

Signature of Patient/Legal Guardian Date

____

Print Name of Patient/Legal Guardian

Patient's Name: Insurance Company

Advance Beneficiary Notice (ABN)

Note: You need to make a choice about receiving these health care items or services.

The insurance company will not pay for the service that is provided.

Your insurance company does not pay for all of your health care costs. Your insurance company only pays for covered items and services when your insurance policy rules are met. The fact that your coverage may not pay for a particular item or service does not mean that you should not receive it. There maybe a need for your doctor recommended it. Right now, in your case, your insurance company probably will not pay for:

85014-Hematocrit	$ 8.00	82270-Hemocult	$ 8.00
81002-Urinalysis	8.00	84702-Pregnancy Test (Blood)	30.00
84703-Pregnancy Test	12.00	87210-Wet Mount Smear	7.00

Other Services: ____________________

____

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Ask us to explain, if you don't understand why your insurance company may not pay.

PLEASE CHOOSE ONE BOX AND SIGN & DATE BELOW IT'S YOUR CHOICE

☐ **OPTION 1 YES** I want to receive these items or services. I understand that my insurance company will decide whether to pay unless I receive these items or services. Please submit my claim to my insurance company. I understand you may bill me for items or services and that I may have to pay the bill while my insurance company is making its decision. If my insurance company does pay, you will refund to me payments I made to you that are due to me. If my insurance company denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal my insurance company's decision.

☐ **OPTION 2 NO** I have decided not to receive these items or services, I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance company and that I will not be able to appeal your opinion that my insurance company won't pay.

____________________ Date

____________________ Signature of Patient or Person acting on Behalf

Name: ______________________________ **DOB:** __________

Please list all prescribed medications and over-the-counter medications that you are presently taking.

Name of Medication **Strength** **Directions**

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________
11. ______________________________
12. ______________________________
13. ______________________________
14. ______________________________
15. ______________________________

Allergic Reactions Known

1. ______________________________
2. ______________________________

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice please contact our Privacy Officer, Elizabeth Whatley, Assistant Office Manager, (256) 236-9995.

This is a summary of our Notice of Privacy Practices which describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law. It also describes your rights to access and control you protected health information. We are required by law to maintain the privacy of your protected health information and to provide you with a notice of your legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time and reserve the right to do so. The new notice will be effective for all protected health information that we maintain at that time.

We will use your protected health information as part of rendering patient care, including treatment, payment and healthcare operations.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

We may use or disclose your protected health information in certain situations without your authorization or opportunity to agree or object.

You have the right to request a restriction of your protected health information.
You have the right to request to receive confidential communications of your protected health information.
You have the right to inspect and copy your protected health information.
You have the right to amend your protected health information.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
You have the right to obtain a paper copy of this notice from us.

This summary was published along with the notice of privacy practices.

I, ____________________________________, acknowledge I have received a copy of the notice of privacy practices.

____________________________________ Signature of Patient

__________________ Date

North Alabama Women's Center

James S. Daniel, M.D. F.A.C.O.G.

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of ***North Alabama Women's Center***. Our ***Notice of Privacy Practices*** provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. Our Notice of Privacy Practices is subject to change. If we change our Notice, you may obtain a copy of the revised Notice by visiting our website at danielobgyn.com or on request from your health care team.

Signature__________________________________ DOB_______________________

Patient

Printed Name______________________________ Date Signed__________________

Person Signing for Patient: ____

Signature

________________________________Date________________

Printed Name

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Reasons why the acknowledgement was not obtained:

Patient refused to sign_______________

Other or
Comments____

____

____

____