Glen Meade Center for Women's Health

NHRMC Physician Group

GLEN MEADE OBSTETRICS & GYNECOLOGY, P.A. CHART # _____

DATE _____ PATIENT NAME _____

First Middle Last

ADDRESS _____

NUMBER STREET

_____

CITY STATE ZIP CODE

HOME PHONE _____ WK# _____ CELL# _____

SOCIAL SECURITY# _____ BIRTH DATE _____ AGE _____

SEX ☐ MALE ☐ FEMALE REFERRED BY _____

MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

EMPLOYER _____ ADDRESS _____

OCCUPATION _____

SPOUSE/PARENT NAME _____ EMPLOYER _____ WK# _____

SPOUSE/PARENT BIRTH DATE _____ SPOUSE/PARENT SS# _____

RESPONSIBLE PARTY NAME _____

ADDRESS _____

HOME PHONE _____ WORK# _____

EMPLOYER _____

INSURANCE POLICY NO. 1

_____
POLICY HOLDER'S NAME

_____
INSURANCE COMPANY NAME

_____
INSURED'S ID# (INCLUDE ANY LETTERS)

_____
INSURED'S GROUP # (OR GROUP NAME)

_____
INSURED'S SOCIAL SECURITY # DATE OF BIRTH

_____
ADDRESS FOR MAILING CLAIMS

_____
CITY STATE ZIP CODE

INSURANCE POLICY NO. 2

_____
POLICY HOLDER'S NAME

_____
INSURANCE COMPANY NAME

_____
INSURED'S ID# (INCLUDE ANY LETTERS)

_____
INSURED'S GROUP # (OR GROUP NAME)

_____
INSURED'S SOCIAL SECURITY # DATE OF BIRTH

_____
ADDRESS FOR MAILING CLAIMS

_____
CITY STATE ZIP CODE

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I HEREBY AUTHORIZE PAYMENT DIRECTLY TO GLEN MEADE OB/GYN, P.A.

_____
SIGNED DATE

IN CASE OF EMERGENCY PLEASE LIST A CONTACT PERSON

_____
NAME RELATION PHONE#

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Personal Medical History

Patient Identification

Name: _____ Date of Birth: _____ Age: _____

Occupation: _____ Race: _____ Referring Physician: _____

Employer: _____ Primary Physician: _____

Reason for Visit

1 In the lines below, please describe any special problems or symptoms you would like to discuss with the doctor today:

_____

_____

_____

2 How long have you had this problem? ❑ 1 week ❑ 1 month ❑ 1 yr ❑ over 1 yr

3 What treatment have you received for this problem? _____

_____

4 Did the treatment help? ❑ yes ❑ no

Past Medical History

Place an (X) next to any of the following problems for which you or a close family member have been treated or diagnosed:
(close family member = mother, father, brother, or sister only)

	personal history	family history		personal history	family history
High blood pressure	❑	❑	Hepatitis	❑	❑
Heart attack or stroke	❑	❑	Other liver diseases	❑	❑
Disease of heart valves	❑	❑	Irritable bowel syndrome	❑	❑
Other heart disease	❑	❑	Pancreatitis	❑	❑
Asthma	❑	❑	Stomach or duodenal ulcer	❑	❑
Tuberculosis	❑	❑	Arthritis	❑	❑
Other lung disease	❑	❑	Seizure disorder	❑	❑
Melanoma	❑	❑	Depression	❑	❑
Cancer _____	❑	❑	Psychiatric disorder	❑	❑
Diabetes mellitus	❑	❑	Sexual abuse or domestic violence	❑	❑
Thyroid disease	❑	❑	Alcohol or substance abuse	❑	❑
Kidney infection	❑	❑	Anemia or blood disorder	❑	❑
Other kidney disease	❑	❑	Blood clots in lungs or legs	❑	❑
Bladder disease	❑	❑	Blood transfusion	❑	❑
Crohn's disease	❑	❑	Elevated cholesterol	❑	❑
Diverticulitis or diverticulosis	❑	❑	Other_____	❑	❑

Past Obstetric History

How many times have you been pregnant? _____

How many children have you delivered (vaginal and cesarean)? _____

How many were delivered by cesarean section? _____

How many of your children were born prematurely? _____

How many miscarriages have you had? _____

Have you ever had an abortion? ❑ yes ❑ no

If yes, how many? _____

How many ectopic pregnancies have you had? _____

How many of your children are still living? _____

How many twins or multiple births have you had? _____

Place an (X) next to any of the following complications of pregnancy which you have had:

❑ Toxemia or preeclampsia

❑ High blood pressure

❑ Gestational diabetes

❑ Blood transfusion

❑ Stillbirth

❑ Other complications_____

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Past Gynecologic History

Place an (X) next to any of the following problems for which you or a close family member have been treated or diagnosed:

	personal history	family history		personal history	family history
Fibroids or leimyomata	❑	❑	Cancer of the uterus, tubes, or ovaries	❑	❑
Infertility	❑	❑	Abnormal pap smear	❑	❑
Endometriosis	❑	❑	Breast cancer	❑	❑
Pelvic infections	❑		Breast mass or cyst	❑	❑
Sexually transmitted disease	❑		Other_____	❑	❑

Previous Surgeries

Type of operation	Date

Other Hospitalizations

	Date

Medications

List all of your current medications

Allergies

Are you allergic to any medications? ❑ yes ❑ no

Name	Type of reaction

Other Health Information

Marital status

Married ❑ Single ❑
# of yrs_____ Divorced ❑
Name of spouse Separated ❑
_____ Widowed ❑

Menstrual history

1 First day of last menstrual period _____/_____/_____
2 How often do your periods occur? _____
3 Length of period in days _____
4 Age at first period _____
5 Do you have bleeding in between your normal periods? ❑ yes ❑ no

Sexual History

1 Number of lifetime partners ❑ none ❑ one ❑ 2-5 ❑ more than 5
2 Age at first intercourse _____
3 Pain with intercourse ❑ always ❑ sometimes ❑ never
4 Have you ever been raped, sexually or physically abused? ❑ yes ❑ no

Contraception

What is your current method of contraception?

❑ Tubal ligation ❑ Hysterectomy
❑ Vasectomy ❑ IUD
❑ Diaphragm ❑ Condoms
❑ Depo-Provera ❑ Oral contraceptive pill
❑ Other _____ Which one?_____

Substance use

Do you smoke cigarettes? ❑ yes ❑ no
packs per day _____
Do you drink alcohol? ❑ yes ❑ no
amount per week _____
Have you ever used marijuana, heroin, cocaine, or other street drugs? ❑ yes ❑ no
If yes, what? _____
Are you using any of those drugs now? ❑ yes ❑ no
If yes, what? _____

Review of Systems

Are you currently having any of the following problems?

Chest pain	❑ yes	❑ no
Difficulty breathing	❑ yes	❑ no
Abdominal pain	❑ yes	❑ no
Blood in stools	❑ yes	❑ no
Constipation or loose stools	❑ yes	❑ no
Pain with urination	❑ yes	❑ no
Leaking urine	❑ yes	❑ no
Abnormal vaginal discharge	❑ yes	❑ no

Have you ever had a pap smear? ❑ yes ❑ no
If yes, when was your last? _____
Have you ever had a mammogram? ❑ yes ❑ no
If yes, when was your last? _____

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Consent and Acknowledgement

I give Glen Meade Center for Women's Health my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies and for healthcare operations like quality reviews.

I have received the practice *Notice of Privacy Practices* (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction(s), they must follow the restriction(s).

I agree that Glen Meade Center for Women's Health may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

_____ _____

Signature Date

If signed by patient representative, state relationship to patient: _____

Andrew R. Cracker, MD
David P. Mason, MD
Clarence L. Wilson II, MD
H. Kyle Rhodes, MD
Timothy L. Chase, MD
G. Daniel Robison IV, MD
Andrea C. Foiles, MD
Rachel Z. Jones, MD
Cynthia K. Pierson, MD
Pamela R. Novosel, MD
Jeffrey W. Wright, MD, MFM
K. Brooke Chalk, MD
Susan B. Lorencz, FNP
Lauren A. Marshall, WHNP

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PHI Authorization Family/Friend
Glen Meade Center for Women's Health

In accordance with our "Notice of Privacy Practices", we may disclose your personal health information to a family member, relative, friend or other person identified by you. Please list below the names of ALL persons you would permit to have such access to your personal health information.

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

Please Note: In calling our physicians or office for medical information, we prefer to speak with the patient directly unless it is an emergency situation. **Any person calling for you should be able to identify your date of birth, physician name, problem or procedure performed, and your chart number.** This enables us to further protect your right to privacy.

This authorization will continue until revoked or terminated by the patient in writing and received by Glen Meade Center for Women's Health.

Patient Name (Please Print)

Patient Signature _____ Date

Patient Termination of Medical Records Release

I desire to revoke my previous medical records release for:

- ☐ All Listed Parties
- ☐ Individual: Name _____

Patient Signature _____ Date

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Authorization for Release of Medical Records

To _____

_____

_____

I hereby authorize and request you to release my medical records to:

Name _____

Address _____

City, State, Zip _____

For the purpose of _____

_____

I understand that this information may include lab results, ultrasound or imaging results, medications and chart notes. I understand that I may revoke this authorization at any time, in writing, and that the revocation will not apply to information that has already been released. Unless otherwise noted, this authorization will expire six months from the date on which it was signed. I understand that authorizing disclosure of my medical information is voluntary.

Patient Name _____ DOB _____

Social Security # _____

Patient Signature _____ Date _____

Witness _____

Patient Phone Number(s) _____

Date completed _____ By _____

OBSTETRICS GYNECOLOGY MATERNAL FETAL MEDICINE INCONTINENCE ROBOTIC SURGERY

1809 Glen Meade Rd. Wilmington, NC 28403 *Tel:* 910.763.9833 *Fax:* 910.763.5166

1333 S. Dickinson Dr., Suite 110 Leland, NC 28451 *Tel:* 910.763.9833 *Fax:* 910.399.6838

GlenMeadeHealth.com

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Obstetrical Care Policy

As a patient of Glen Meade Center for Women's Health, I realize that I am being cared for by a group practice. Therefore, I will always have a physician from this practice available on call. I will also see each of the obstetrical physicians during my prenatal care so they are all familiar with my pregnancy and care. My vaginal or cesarean section delivery will be done by the physician who is on call at that time.

I also acknowledge that I will not be guaranteed a specific date should an induction or cesarean section be necessary. We will do everything we can to accommodate your induction or cesarean date request; however, we cannot guarantee your first choice.

I acknowledge that lab work will be done, including HIV testing, on all obstetric patients at Glen Meade Center for Women's Health.

I acknowledge and agree to these practice policies as a patient of Glen Meade Center for Women's Health.

_____ _____

Signature Date

If signed by patient representative, state relationship to patient _____

OBSTETRICAL PHYSICIANS

Clarence L. Wilson II, MD
H. Kyle Rhodes, MD
Timothy L. Chase, MD
G. Daniel Robison IV, MD
Andrea C. Foiles, MD
Rachel Z. Jones, MD
Cynthia K. Pierson, MD
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