Lake Champlain
Gynecologic Oncology

Please fill out this form completely and indicate with N/A where applicable. If not completed in it's entirety our front end staff will ask you for any missing information.

REGISTRATION FORM

LAST NAME_____ FIRST NAME_____

MAILING ADDRESS_____

STREET ADDRESS_____

CITY_____ STATE_____ ZIP_____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER_____

RACE _____ ETHNICITY_____ LANGUAGE_____

HOME#_____ CELL#_____ MARITAL STATUS_____

PHARMACY & ADDRESS _____

REFERRING PHYSICIAN_____ PHONE_____

PRIMARY PHYSICIAN_____ PHONE_____

EMERGENCY CONTACT & RELATIONSHIP_____ PHONE_____

PHARMACY NAME & ADDRESS:_____

EMPLOYER INFORMATION

COMPANY NAME_____ WORK PHONE_____ EXT_____

ADDRESS_____ CITY_____ ST._____ ZIP_____

CONSENT FOR GENERAL MEDICAL TREATMENT

This is to certify that I, the undersigned, hereby voluntarily consent to treatment at LCGO, and such diagnostic procedures and medical care by the attending physician, and designates, as is necessary in their judgment. I acknowledge and understand that the practice of medicine is not an exact science, and that no promises or guarantees have been made concerning the outcome of results of my care and treatment at LCGO.

CONSENT TO OBTAIN or RELEASE PATIENT INFORMATION

I HEREBY AUTHORIZE LCGO to **REQUEST** from any physician or physician group any medical information/records pertaining to my care. I ALSO HEREBY AUTHORIZE LCGO to **RELEASE** to any physician or physician group involved in my care any and all information contained in the medical record of the above named patient to any third party payer for whom I may seek payment or reimbursement for expenses related to my treatment: to any entity having responsibility for review, investigation, claim processing, utilization review, or financial audit, in respect to payment for care rendered by LCGO: or any governmental agency requesting information for lawful purposes.

NAME DATE WITNESS IF GUARANTOR HAS SIGNED

INSURANCE FORM

PRIMARY INSURANCE INFORMATION

Subscriber Name_____Relationship_____

Date of birth of subscriber (if other than self) _____

Insurance_____Copay_____

ID#_____Group#_____

Effective date_____ Expiration date _____

SECONDARY INSURANCE INFORMATION

Subscriber Name_____Relationship_____

Date of birth of subscriber (if other than self) _____

Insurance_____Copay_____

ID#_____Group#_____

Effective date_____ Expiration date _____

BILLING INFORMATION

IT IS THE PATIENT'S RESPONSIBILITY TO SEE THAT REFERRALS ARE OBTAINED PRIOR TO THEIR APPOINTMENT IF ONE IS NEEDED IN ACCORDANCE WITH YOUR INSURANCE PLAN. IF THERE ARE ANY CHANGES RELATED TO YOUR INSURANCE INFORMATION (NEW CO., CHANGE OF ID. #, BILLING ADDRESS, ETC.) IT IS YOUR RESPONSIBILITY TO NOTIFY US OF THESE CHANGES AT THE TIME OF THEIR APPOINTMENT. IF CHARGES ARE INCURRED DUE TO ANY OF THE ABOVE REASONS, THE PATIENT WILL BE RESPONSIBLE AND BILLED DIRECTLY FOR THESE CHARGES.

AUTHORIZATION TO ASSIGN INSURANCE BENEFITS

By signing this form the patient (or the policyholder, if the patient is not the policyholder) hereby authorizes and directs that all medical benefits payable to or for the benefit of the Patient under the terms of any applicable insurance policy, be paid directly to Lake Champlain Gynecologic Oncology. By signing this form the patient authorizes Lake Champlain Gynecologic to appeal any claims on their behalf to ensure proper payment of a claim. Patient agrees to sign any additional assignment of benefit forms requested by Lake Champlain Gynecologic Oncology or any insurance company from time to time. Patient understands that she is liable to Lake Champlain Gynecologic Oncology for all related charges, whether or not covered by insurance. **PLEASE BE ADVISED THAT ALL CO-PAYMENTS ARE EXPECTED TO BE PAID AT THE TIME THE SERVICE IS RENDERED.**

AGREEMENT TO PAY LAKE CHAMPLAIN GYNECOLOGIC ONCOLOGY

Patient and guarantor (where applicable) agree that in consideration of the services to be rendered by Lake Champlain Gynecologic Oncology reach personally promises and obligates himself/herself to pay the amount of Lake Champlain Gynecologic Oncology charges in accordance with its regular rates and terms. In the event of non-payment, patient and guarantor (where applicable) understand that such non-payment will be reported to credit reporting agencies and aggress to pay all reasonable costs of collections including attorney's fees. Lake Champlain gynecologic Oncology is authorized to access credit bureau files and reports now and in the future for collection purposes. This information is given pursuant to Title 9 Sec. 2480E of Vermont Statues.

AUTHORIZATION OF MEDICARE BENEFITS

I request payment of authorized Medicare benefits To Lake Champlain Gynecologic Oncology on my behalf for services furnished to me by Lake Champlain Gynecologic Oncology. I authorized any holder of medical and other information about me be released to Medicare and its agents to help determine these benefits or benefits for related services.

NAME DATE WITNESS IF GUARANTOR HAS SIGNED

Lake Champlain
Gynecologic Oncology

Authorization for Protected Health Information

Please indicate how you would prefer us to contact you regarding the following information:

How would you prefer to be contacted for Appointment information or questions?

_____

How would you prefer to be contacted for Medical information or questions?

_____

How would you prefer to be contacted for Billing information or questions?

_____

If you would like any of the above to be via email, please complete a patient portal form.

Please indicate whom (if anyone) we may contact or speak with regarding the following information:

Appointment information: _____

Medical information: _____

Billing information: _____

_____ _____

Signature of Patient/Guardian Date

4/3/12

Lake Champlain
Gynecologic Oncology

Authorization for Protected Health Information

Patient Portal: Yes No

Once you are activated you will receive a confidential username and password which will be sent to the email address provided below.

Please note: If you choose to utilize the patient portal all of your appointment reminders will all be conveyed via email & all medical & billing information will require you to log into the patient portal for viewing utilizing your secure username and password.

Email address _____ (*Please note an email address is required to utilize the patient portal*).

Is this your email address? Yes No

If no, who does this email address belong to: _____

_____ _____
Signature of Patient/Guardian Date

_____ _____
Signature of Email Owner if not the patient Date

8/12/11

Name _____ MRN_____ DOB_____ Date_____

MENSES	
Age at first period	
Last Menstrual Period	
From the first day of my period, to the first day of my next period, my menses occur every _____ days and last for _____ days.	

Check if you have any of the following:	
	Painful periods requiring more than Aspirin or Tylenol
	Excessive bleeding
	Irregular periods or bleeding
	Bleeding more than 7 days
	Spotting or bleeding between menses
	Bleeding after intercourse
	Symptoms that occur before your period that are annoying or bothersome for you now
	Change in menstrual pattern: Describe:
	If menopausal, any bleeding or spotting in the past year

GYNECOLOGY			
Check if you have any of the following:			
	Unusual vaginal discharge/odor/irritation		Vulvar itching or irritation
	Pain with intercourse		Pelvic pressure
	Need to douche		Hot flashes
	Menopausal symptoms		Bulging from the vagina
	Loss of urine with cough or sneeze		
	Uncontrollable loss of urine: ____ Mild ____ Moderate ____ Severe		
	Unsatisfactory personal/sexual relationship		
	History of sexual abuse. Have you talked to somebody about this?		
	Concerns about sexually transmitted diseases (STD's)		
Do you have a current sex partner/s? YES NO How long have you been with this partner?			
My current method of birth control is:			

Check if you have ever had any of the following:			
	Abnormal pap smear		Endometriosis
	Sexually transmitted disease (STD's)		Polycystic ovarian syndrome
	Infection in your tube, ovaries, or uterus		

PREGNANCY HISTORY					
List pregnancies in order (include abortions, prematures, etc.):					
MO/YR	HOSPITAL	WKS/MOS	WGT	SEX	COMPLICATIONS

Name _____ MRN_____ DOB_____ Date_____

OPERATIONS		
DATE	HOSPITAL	OPERATION

IMMUNIZATIONS			
	Tetanus: Date:		Chicken Pox
	Hepatitis B Series		Rubella titer
	Have you ever had chicken pox or shingles? YES NO Date:		

SOCIAL HISTORY					
	Yes	**No**		**Yes**	**No**
Recreational Drugs			Domestic Violence		
Seat Belt Use			Balanced Diet		
Folic Acid Intake			Calcium Intake: ___ mg/day		
Caffeine Intake			Monthly Breast Self Exam		
Vitamins:_____ _____			Regular Exercise: ☐ Cardiovascular ☐ Weight Bearing		
Tobacco Use: # of cigarettes _____/day, for _____ years			Alcohol Use: # of glasses _____/week		
Health hazard at home/work Occupation: _____			Cultural/Religious restrictions		

PERSONAL & FAMILY HISTORY		
Personal History- check here if *you* have the following:		**Family History**- check here if *blood relatives* have the following:
	High Blood Pressure	
	Heart Attacks	
	Diabetes	
	Thyroid Disease	
	High Cholesterol	
	Cancer	
	Bleeding Disorder	
	Hepatitis	
	Down Syndrome	
	Birth Defects	
	Sickle Cell Disease	
	Glaucoma/Blindness (prior to age 50)	