PATIENT REGISTRATION PLEASE PRINT

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ MI: ______

DOB: __________ Preferred Name: ______________________ SSN: ______________

Marital Status: ☐ Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Widowed ☐ Separated

Address: ______________________ City: ______________________

State & Zip: ______________________ Cell Phone: ______________________

Home Phone: ______________ Email: ______________________

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Student ☐ Disabled ☐ Retired

Employer: ______________________ Occupation: ______________________

School *(if student)*: ______________________

PHARMACY NAME & PHONE NUMBER: ______________________

PARENT OR GUARDIAN INFORMATION ***(Only complete if patient is under the age of 18)***

Last Name: ______________________ First Name: ______________________ MI: ______

DOB: __________ Preferred Name: ______________________ SSN: ______________

Address: ______________________ City: ______________________

State & Zip: ______________________ Cell Phone: ______________________

Home Phone: ______________ Email: ______________________

EMERGENCY CONTACT INFORMATION

Name: ______________________ Relationship to Patient: ______________________

Home Phone: ______________________ Cell Phone: ______________________

MAY WE CONTACT YOU REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)?

☐ No ☐ Yes, by the above email.

☐ No ☐ Yes, by the above cell phone. Voicemail? ☐ No ☐ Yes Text? ☐ No ☐ Yes

☐ No ☐ Yes, by the above home phone. Voicemail? ☐ No ☐ Yes

DO YOU WANT ANYONE TO HAVE ACCESS TO YOUR PHI? IF SO, WHO?

Name: ______________________ **Relationship to Patient:** ______________________

SIGNATURE: ______________________ **DATE:** ______________

HEALTH HISTORY

Patient Name: ______________________________ **Date of Birth:** ____________

Primary Care Physician: ______________________________

Other Physicians: ______________________________

What is the most important item you would like to address today? ______________________________

____

____

List all medical issues: ______________________________

____

Prior surgeries (major and minor): ______________________________

____

Current medications (including supplements): ______________________________

____

Medication allergies: ______________________________

____

WELLNESS HISTORY

Date of last pap smear: ____________________ History of abnormal pap? ____________________

Any prior procedures on the cervix?: ______________________________

Have you received the HPV vaccine?: ______________________________

Date of last mammogram: ____________________ History of abnormal mammogram?: ____________________

Any prior procedures on the breast?: ______________________________

Date of last colonoscopy: ____________________ Date of last bone density scan: ____________________

MENSTRUAL HISTORY

Age when period first started: ____________________ Number of days between periods: ____________________

Flow (check): ☐ light ☐ medium ☐ heavy Pain with periods?: ☐ yes / ☐ no Days period lasts: ____________

First day of last period: ____________________ OR Age of menopause: ____________________

PREGNANCY HISTORY

Number of pregnancies: ____________ Number of living children: ____________ Number of miscarriages: ____________

Number of vaginal births: ____________ Number of cesarean births: ____________ Number of abortions: ____________

CONTRACEPTION HISTORY

Current contraception: ____________________ Previous contraception: ____________________

HANEY | GYN

KATHERINE C. HANEY, MD, FACOG | p: 615.736.4187 | f: 615.577.0647 | HaneyGYN.com

HEALTH HISTORY

MENOPAUSAL HORMONE TREATMENT HISTORY

Current treatment: ______________________ Previous treatment: ______________________

SOCIAL HISTORY

Current occupation: ______________________

Marital status: ☐ Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Widowed ☐ Separated

Name of spouse/partner: ______________________

Do you exercise regularly?: ☐ yes ☐ no If yes, list type and frequency: ______________________

How many hours do you sleep each night?: ______________________

Do you smoke or use tobacco products? ☐ yes ☐ no If yes, list amount used daily: ______________________

Type of tobacco product used: ______________ Number of years of use: ______________________

If you previously used tobacco products, list the year you quit: ______________________

Do you drink alcohol?: ☐ yes ☐ no If yes, list the number of drinks per week: ______________________

Do you use recreational drugs?: ☐ yes ☐ no If yes, list the type: ______________________

Are you currently sexually active?: ☐ yes ☐ no

Any history of sexually transmitted diseases?: ☐ yes ☐ no If yes, which? (check):

☐ Gonorrhea ☐ Chlamydia ☐ Genital Warts ☐ Genital Herpes ☐ Syphilis ☐ HIV ☐ HPV ☐ Hepatitis

CHECK IF YOU HAVE A PERSONAL OR FAMILY HISTORY OF THE FOLLOWING:

You	Your Family		You	Your Family	
☐	☐	Alcoholism	☐	☐	Kidney Stones
☐	☐	Anemia	☐	☐	Liver disease / Cirrhosis
☐	☐	Depression / Anxiety	☐	☐	Multiple Sclerosis
☐	☐	Deep Vein Blood Clot / DVT	☐	☐	Mitral Valve Prolapse
☐	☐	Diabetes	☐	☐	Osteoporosis
☐	☐	Endometriosis	☐	☐	Pulmonary Embolus
☐	☐	Genetic testing	☐	☐	Rheumatoid Arthritis
☐	☐	GI problems / reflux / IBS	☐	☐	Seizures / Epilepsy
☐	☐	Headaches	☐	☐	Stroke
☐	☐	Heart attack / Heart disease	☐	☐	Thyroid problems
☐	☐	High blood pressure	☐	☐	Transfusions (blood)
☐	☐	High cholesterol	☐	☐	Ulcerative Colitis / Crohn's
☐	☐	HIV / AIDS	☐	☐	Other: ______________
☐	☐	Kidney disease			______________
☐	☐	Kidney infections			______________

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OFFICE POLICIES

Thank you for choosing HaneyGYN! We look forward to working with you to exceed your healthcare goals. The following office policies were created with you in mind to ensure efficient, safe, and exceptional patient care.

PATIENT CARE

- Office hours are 8 am-4 pm, Monday-Friday. Routine business, appointment requests, prescription refill requests, and lab result questions should be addressed during regular office hours. If you have an important need after hours or on weekends, you may contact Dr. Haney to discuss the option of a telehealth or phone consultation. Standard fees will apply. In the unlikely event that Dr. Haney does not respond to an after-hours phone call, please call your primary care doctor or go to an urgent care center.

- Patients are seen by appointment only. Dr. Haney will make every effort to remain on schedule and ask that you do the same. Should you arrive late or miss your appointment you will be responsible for payment for the visit. If you need to cancel or reschedule please give 48-hour notice.

- If you are experiencing a life threatening emergency, call 911 immediately or go to the closest ER. In most cases, Dr. Haney will be notified upon your arrival. If you are experiencing an urgent situation go directly to your nearest urgent care center or ER. Please notify us the next business day so we may coordinate your follow-up care. Do not rely on a message in an emergency as this could delay your treatment.

- Lab test results and imaging results will be communicated to you. Please do not assume they are normal if you do not hear from our office. You may always call our office about your results. Some results may require an office visit or telehealth to discuss or make a treatment plan.

- Dr. Haney does not prescribe narcotic pain medications and HaneyGYN does not have any controlled substances on site.

ELECTRONIC COMMUNICATIONS

- Telehealth visits are offered when appropriate to provide convenience and improved access. There are limitations with this type of visit. In rare circumstances, telehealth could lead to a delay in diagnosis, a breach of privacy of personal health information, and limit a full assessment due to lack of ability to perform a physical exam.

- Communication of any information electronically has inherent security risks. Please know that electronic communication may contain your health, financial and personal identification information. In addition, it is subject to cookies, phishing, hacking, data breaches, misidentifications of senders/recipients, technology failures, user errors, and other breaches. HaneyGYN requires you tell us how you prefer to communicate and who we may communicate with on your behalf.

PAYMENTS

- HaneyGYN does not bill insurance and Dr. Haney is considered out-of-network with all insurance plans. If you have Medicare or Medicaid, please inform us prior to your visit. You will need to sign a waiver in order to be treated.

- All payments are due at the time of service. HaneyGYN will provide a superbill to file with your insurance carrier upon request. This process is the patient's responsibility and HaneyGYN cannot guarantee any insurance reimbursement. We strongly recommend you call your insurance carrier to understand your out-of-network benefits prior to being seen.

Patient/Representative Signature: ____ **Date:** ____________

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AUTHORIZATION FOR EXCHANGE OF HEALTH INFORMATION

I hereby authorize the disclosure of the health information of the individual named below:

Patient Name: ____ Date of Birth: ____________ SSN: _______________

This information is to be disclosed FROM the following individual or organization:

DOCTOR: ____

Address: ____

Phone: ____ Fax: ____

This information is to be disclosed TO:

HaneyGYN | Dr. Katherine C. Haney, MD | Phone: 615-736-4187 | Fax: 615-577-0647

The following information is authorized for use & disclosure:

- ☐ Office visit notes
- ☐ Lab test results
- ☐ Imaging test results
- ☐ Summaries of procedures, operations, hospitalizations
- ☐ Complete record
- ☐ Other (please specify): ____

Reason for use & disclosure:

- ☐ Continuing Care: ________________________
- ☐ Transfer of Care: ________________________

SENSITIVE INFORMATION: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse. _______ (Initials)

REDISCLOSURE: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules. _______ (Initials)

RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization. _______ (Initials)

RIGHT TO INSPECT AND COPY: I understand that I have a right to inspect and receive a copy of the information that is used or disclosed based on this authorization. _______ (Initials)

EXPIRATION: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: *(If you do not specify an expiration date, event, or condition, this authorization will expire in six (6) months.)*

Signature of Patient or Representative: ____

Patient's Name (printed): ____

Date: ____________________