FOLEY OB & AESTHETICS

NEW PATIENT INTAKE

PATIENT INFORMATION

Full Legal Name

Preferred Name

DOB

Pronouns

Race / Ethnicity

Language

SSN

Marital Status Single Married Widowed Divorced

Height

Email

Phone

Preferred Contact Text Call Email Mail

Address

Apt/Suite

City

State

Zip

Occupation

Employer

EMERGENCY CONTACT

Name

Relationship

Phone

PRIMARY INSURANCE

Insurance Name

Member / ID #

Group #

Patient is subscriber

Subscriber Name

DOB

Sex M F

Relationship

SSN

SECONDARY INSURANCE

Insurance Name

Member / ID #

Group #

Patient is subscriber

Subscriber Name

DOB

Sex M F

Relationship

SSN

PHARMACY / REFERRAL / PORTAL

Preferred Pharmacy + Location

How did you hear about us?

OnPatient Portal Invitation Yes No

Preferred Billing Contact Text Call Email Mail Do not mail

PREGNANCY HISTORY - INCLUDE ALL PREGNANCIES

	Pregnancies	Full Term	Preterm	Induced Abortion	Miscarriage	Ectopic	Living	Deceased Children
Never been pregnant								

Please list ALL pregnancies below, including deliveries, miscarriages, induced abortions, and ectopic pregnancies.

Month/Year	Weeks	Sex	Weight	Labor Hrs	Delivery Type Vaginal / C-section / Loss	Hospital / Epidural / Complications

CURRENT PREGNANCY - IF APPLICABLE

LMP

Estimated Due Date

Prenatal vitamins?

Yes No

Preferred Delivery Hospital

Kapiolani Medical Center for Women & Children

The Queen's Medical Center - Punchbowl

Undecided

Current pregnancy concerns / complications

PREGNANCY DETAILS

History of Preeclampsia / Gestational Hypertension?

Yes No

History of Gestational Diabetes?

Yes No

History of Infertility / IVF?

Yes No

IVF Transfer Date (if applicable)

History of Postpartum Depression?

Yes No

Additional pregnancy / delivery details

MENSTRUAL HISTORY

LMP | **Age at first period** | **Cycle length (days)** | **Bleeding lasts (days)** | **Cycles**

Regular Irregular

Menopausal? Yes No **Flow** Light Moderate Heavy

Painful periods? Yes No **Bleeding between periods?** Yes No

SCREENING HISTORY

Last Pap | **Result** | **Abnormal Pap history?** Yes No | **Diagnosis / Treatment**

Last Mammogram | **Result** | **Last DEXA** | **Result**

CONTRACEPTION / REPRODUCTIVE GOALS

Current Birth Control None Pills Patch Depo IUD Nexplanon Other

History of IUD / Implant Yes No **Type**

Dislodged / Expelled? Yes No **Trying to conceive?** Yes No

SEXUAL HISTORY

Sexually Active Yes No **Frequency of Sexual Activity per Week**

Orientation Hetero Bi Homosexual **Relationship** Mono Poly

STI History - select all that apply

- Oral Herpes
- Genital Herpes
- Chlamydia
- Gonorrhea
- Syphilis
- Trichomoniasis
- HPV
- Warts
- HIV
- Hep B
- Hep C
- Molluscum
- Other

CURRENT GYN SYMPTOMS - OPTIONAL

- Pelvic pain
- Abnormal bleeding
- Vaginal discharge
- Vaginal odor
- Itching / irritation
- Pain with sex
- Urinary symptoms
- Breast concern

Other GYN concern / symptom

MEDICAL CONDITIONS - SELECT YES OR NO

Neurological
Yes No

Heart Disease
Yes No

Pulmonary
Yes No

Hypertension
Yes No

Deep Vein Thrombosis
Yes No

Hematology
Yes No

Anesthetic Complications
Yes No

Thyroid Dysfunction
Yes No

Cancer
Yes No

Gastrointestinal
Yes No

Hepatitis / Liver Disease
Yes No

Kidney Disease / UTI
Yes No

Diabetes Type 1 or 2
Yes No

Dermatology
Yes No

Anemia
Yes No

Autoimmune Disorder
Yes No

Hospitalizations
Yes No

Depression
Yes No

Psychiatric Disorder
Yes No

Blood Transfusion
Yes No

High Cholesterol
Yes No

OTHER CONDITIONS / DETAILS

Other condition(s) not listed above

Details for any condition checked Yes

MEDICATIONS / ALLERGIES / SURGERY

Current Medications - name / dose / frequency

Allergies - medication / substance and reaction

Surgical History - year / type / indication

SOCIAL HISTORY

Select one status for each item and enter amount / frequency when applicable.

Social History	Never / No	Current / Yes	Former	Amount / Frequency
Tobacco / Nicotine				
Alcohol				
Recreational / Non-prescribed Drugs				
Caffeine				
Other Stimulants				

IMMEDIATE FAMILY HISTORY

Check maternal (M) and/or paternal (P).

High Blood Pressure	M	P	Autoimmune Disorder	M	P	Cancer Type	M	P
Heart Disease	M	P	Genetic Disorders	M	P	Breast Cancer	M	P
Diabetes	M	P	Alcoholism	M	P	Ovarian Cancer	M	P
High Cholesterol	M	P	Mental Disorders	M	P	Uterine Cancer	M	P
Bleeding Disorder	M	P	Osteoporosis	M	P	Colon Cancer	M	P
Clotting Disorder	M	P	Lung Disorders	M	P	Skin Cancer	M	P

PROVIDERS / TODAY'S VISIT

Primary Care Physician

Specialty Providers

Reason for Today's Visit

Chaperone for pelvic exams / procedures? Yes No

Additional concerns / questions

AESTHETIC SERVICES - SELECT ALL THAT APPLY

Massage Facials Waxing Botox Stretch Therapy Laser Weight Loss

CONSENT FOR USE / DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. The terms of our Notice may change; if we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information (PHI) about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to a requested restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to the use and disclosure of PHI about you for treatment, payment, and health care operations. You have the right to revoke this consent in writing. A revocation will not affect disclosures already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected Health Information (PHI) may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review the Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient may request restrictions on the use or disclosure of information, but the Practice is not required to agree to every requested restriction.
- The patient may revoke this consent in writing; the revocation applies prospectively and does not undo prior permitted disclosures.
- Treatment may be conditioned on execution of this consent to the extent permitted by applicable law.

INITIALS

Patient gives the office permission to forward verified contact information and PHI to patient specialists and to discuss pertinent chart information, laboratory results, prescriptions, and other information involved in the patient's care with appropriate health care providers and other permitted parties. Communications may include fax, email, electronic health information exchange, mail, or other methods used by the Practice as permitted by applicable privacy and security requirements. Treatment-related disclosures may be made as permitted by 45 CFR 164.506. Where required, the Practice will maintain appropriate agreements with business associates.

PRIVACY NOTICE ACKNOWLEDGMENT

INITIALS

I acknowledge that I have had the opportunity to review Foley OB & Aesthetics' Notice of Privacy Practices. I understand that I may notify Foley OB & Aesthetics in writing of requests for restrictions on the use or disclosure of my individually identifiable health information. I understand the Notice includes information regarding electronic access to medication history. Foley OB & Aesthetics may revise the Notice as permitted by law and will make the current Notice available in the office and upon request.

FINANCIAL RESPONSIBILITY

INITIALS

I understand that, in consideration of services provided to the patient, I am responsible for charges incurred for services and procedures rendered at Foley OB & Aesthetics, except to the extent otherwise required by applicable law or contractual arrangements.

INITIALS

I am responsible for applicable deductibles, coinsurance, copayments, and non-covered services as permitted by my health plan and applicable law.

INITIALS

I assign applicable insurance benefits to Foley OB & Aesthetics and authorize the Practice to submit claims and necessary information to insurers and other payers for services provided.

INITIALS

I understand that the Practice's current no-show / late-cancellation fee is $25 when adequate notice is not provided under the Practice's cancellation policy. This fee is generally not billed to insurance. The amount and policy may change from time to time; the current fee and cancellation policy are available from the office.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL

INITIALS

I understand that it is my responsibility to provide Foley OB & Aesthetics with current insurance information and any referral or authorization required by my plan. If I do not have applicable insurance coverage, I will be treated as a self-pay patient. The current self-pay visit fee is $150 unless otherwise quoted by the Practice. Self-pay fees may change from time to time; the applicable fee will be disclosed by the office.

INITIALS

I am financially responsible for amounts properly due for services provided, subject to applicable law and payer contracts. I will notify Foley OB & Aesthetics promptly of changes in my insurance coverage.

RELEASE OF PRESCRIPTION HISTORY

INITIALS

I authorize physicians treating me on behalf of Foley OB & Aesthetics to request and receive information regarding my medication history, including information maintained by the Hawaii Prescription Monitoring Program, as permitted by applicable law.

STD TESTING / BLOOD OR BODY FLUID EXPOSURE

INITIALS

If a Foley OB & Aesthetics workforce member is exposed to my blood or body fluids during my care, testing for HIV, Hepatitis B, Hepatitis C, or other testing related to the exposure may be performed and results may be disclosed as permitted or required by applicable law. Required notice, consent, counseling, confidentiality, and disclosure procedures will be followed.

RESULTS NOTIFICATION

INITIALS

A phone call will be made to patients regarding abnormal results when clinically appropriate. Generally, normal results may be posted to the patient portal, OnPatient, for patients to access. Please allow approximately one week for routine result notification. If I have not received expected results, I understand that I should contact the office.

DISCLOSURE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

INITIALS

I authorize Foley OB & Aesthetics to disclose medical information and records to my insurance company and other third-party payers as permitted for payment and health care operations. I assign applicable benefits payable for covered physician services to the physician or organization furnishing the services and authorize submission of claims to applicable payers.

MEDICAL RECORDS

INITIALS

If I request that medical records be sent to another physician or facility, a separate request or authorization may be required depending on the type of request. For copies requested by me or my personal representative, any fee will be limited to the reasonable, cost-based amounts permitted by applicable law. The amount may vary with the form, format, supplies, and postage requested, and the Practice's fee schedule may change as permitted by law. When required, I will be informed in advance of the approximate fee.

EACH PARTY TO THIS AGREEMENT ACKNOWLEDGES THAT THEY HAVE CAREFULLY READ AND FULLY UNDERSTAND THE MEANING AND CONSEQUENCES OF EACH TERM AND PROVISION OF THIS AGREEMENT.

Print Patient Name

DOB

Parent / Legal Guardian Name - if applicable

Date

Signature of Patient or Legal Guardian

Date