BROOKLINE VILLAGE OBGYN

PATIENT INFORMATION SHEET
PLEASE COMPLETE ALL INFORMATION

Date: _____

PATIENT:

Last Name _____ Address _____

First Name_____ City _____

Middle _____ State _____ Zip _____

Date of Birth_____ Phone # _____

Social Security # _____ Cell # _____

Marital Status: Single _____ Married _____ Employer _____

Partner _____ Widowed _____ Divorced _____ Emp. Address _____

Email _____ City _____ State _____

Occupation _____ Zip _____ Phone _____

SPOUSE: (or any other party responsible for payment besides patient)

Last Name _____ Address _____

First Name _____ City _____ State_____

Middle _____ Zip _____

Date of Birth _____ Phone # _____

Social Security # _____ Employer _____

Relationship to Patient _____ Address _____

Occupation_____ City _____ State_____

Zip_____ Phone_____

REFERRAL SOURCE: _____

INSURANCE INFORMATION:

Primary Insurance _____ Policy # _____

Billing Address _____ Subscriber _____

Group# _____

Secondary Insurance _____ Policy # _____

Billing Address _____ Subscriber _____

Group # _____

Brookline Village OBGYN
New Patient Questionnaire

Name: _____ DOB: __/__/____
Address: _____
Phone- Home: _____ Cell: _____ Work: _____
Email: _____ Enrolled in Patient Gateway: [ ] Yes [ ] No

Reason for visit: _____
_____

Reproductive History:
Total # of pregnancies: _____ # of Miscarriages: _____

Date of delivery/Outcome or complication/Baby Name/Birth weight/Vaginal or C/Section:
1:_____ 4: _____

2:_____ 5:_____

3:_____ 6:_____

Have you had problems getting pregnant? [ ] Yes [ ] No
If yes, please explain _____

Last Menstrual Period: __/__/__
Age at 1st menstrual period:_____ How often is your period? _____
days of menstrual flow: _____
Is your flow: [ ] Heavy [ ]Moderate [ ] Light
If your period is painful, is the pain: [ ] Mild [ ] Moderate [ ] Severe

List all contraceptive types used in the past: _____
When was it last used? _____

Do you experience problems with intercourse? (i.e. pain, lack of lubrication, low libido)
_____

Date of last Pap smear __/__/__ Did you ever have an abnormal Pap? [ ] Yes [ ] No
If abnormal, please list what kind of treatments you received and dates _____
_____

Have you ever tested positive for HPV? [ ] No [ ] Yes If yes, when _____

Did you receive the Gardasil vaccine? [ ] No [ ] Yes If yes, please list approximate dates
_____
Have you ever been diagnosed with an STD? [ ] No [ ] Yes
If yes, please circle: Herpes, Genital warts, Chlamydia, Gonorrhea, Trichomonas, Syphillis, Hepatitis B or C, HIV. Please list treatments and dates: _____

Did your mother take DES when she was pregnant with you? [ ] Yes [ ] No

Brookline Village OBGYN
New Patient Questionnaire

Personal Medical History: (check and explain)

[ ] Neurologic (headache, migraines, seizures)_____
[ ] Heart Disease/ High blood pressure/ Murmur_____
[ ] Breathing Problems/ Asthma/ Tuberculosis_____
[ ] Thyroid problems_____
[ ] Diabetes_____
[ ] Depression/Anxiety_____
[ ] Hepatitis/Jaundice_____
[ ] Stomach problems_____
[ ] Intestinal problems_____
[ ] Kidney problems (stones, infections) _____
[ ] Chronic pain/ Joint problems_____
[ ] Anemia_____
[ ] Bleeding or clotting problems_____
[ ] Autoimmune disease/ Lupus_____
[ ] Skin disorders_____
[ ] Breast problems_____
[ ] Cancer_____

Past Surgeries (with dates):
_____
_____

Drug Allergies with reactions: _____
_____

Medications: (current with dosages)
_____ _____
_____ _____
_____ _____

Immunizations: (please list dates if known)
Influenza: _____ Varicella: _____
Tdap:_____ MMR: _____

Brookline Village OBGYN
New Patient Questionnaire

Family History (please list age and medical problems):

Mother: _____
Father: _____
Siblings: _____
Maternal Grandparents: _____
_____
Paternal Grandparents: _____
_____
Any congenital defects or syndromes? [ ] No [ ] Yes _____
Any intellectual developmental disorder? [ ] No [ ] Yes_____
Ethnicity: _____

Habits: Do you smoke? [ ] Yes [ ] No Have you ever smoked? [ ] Yes [ ] No
If yes, how much? _____ How many alcoholic drinks per week? ____
Any other drugs (cannabis, cocaine, heroin, prescription drugs)? _____
Exercise? _____ Special diet? _____

Social History:

Marital status (circle): Single Married Divorced Widowed Partner
Occupation: _____
Cats: [ ] No [ ] Yes Do you empty the litter box? [ ] No [ ] Yes
Partner's age: _____ Occupation: _____
Partner's ethnicity: _____
Any health problems? _____

Any history of domestic violence? [ ] Yes [ ] No _____
Do you currently feel safe? [ ] Yes [ ] No _____

Primary Care Physician: Name _____
Phone _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Brookline Village OB/GYN

Jeffrey E. Katz, M.D.
Carolyn A. Cline, M.D.
Tracy R. Zinner, M.D.
Joan S. Hier, M.D.
Barbara S. Frank, M.D.
One Brookline Place, Suite 620
Brookline, MA 02445
Phone: (617) 735-8800 Fax: (617) 278-9358

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____

I HEREBY AUTHORIZE BROOKLINE VILLAGE OB/GYN TO:

_____ Release my records to Myself

_____ Release my medical records to: _____ Obtain my medical records from:

Name/Facility: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip Code: _____

INFORMATION TO BE RELEASED

_____ Entire Record _____ Past 5 years
Only those items checked below:
____ History & Physical ____ Laboratory Tests
____ Radiology Reports (i.e. Ultrasounds, Mammograms, etc.)
____ HIV Status/STD Screening
____ Other: _____
(please specify)

_____
Print Name

_____ _____
Signature Date

BROOKLINE VILLAGE OBGYN
ONE BROOKLINE PLACE, SUITE 620
BROOKLINE, MA 02445
(617) 735-8800

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

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

--basis for planning your care and treatment
--means of communication among the many health professionals who contribute to your care
--legal document describing the care you received
--means by which you or a third-party payer can verify that services billed were actually provided
--tool in educating health professionals
--source of data for medical research
--source of information for public health officials charged with improving the health of the nation
--source of data for facility planning and marketing
--tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

--ensure its accuracy
--better understand who, what, when, where, and why others may access your health information
--make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

--request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522. This request must be made in writing. We are not required to agree to this request.

--obtain a paper copy of this notice of information practices upon request

--inspect and obtain a copy of your health record as provided for in 45 CFR 164.524. This request must be made in writing and with your signature.

--amend your health record as provided in 45 CFR 164.528. This request must be made in writing with reasons given for the amendment.

--obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528. This request must be made in writing and indicate a limited time period for the accounting.

--request communications of your health information by alternative means or at alternative locations. This request must be made by written request. We will accommodate reasonable requests.

--revoke your authorization to use or disclose health information except to the extent that action has already been taken.

--provide an authorization for other uses and disclosures not identified by this notice.

Our Responsibilities

This organization is required to:

--maintain the privacy of your health information
--provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
--abide by the terms of this notice
--notify you if we are unable to agree to a requested restriction
--accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will make available to you a revised notice.

We will not use or disclose your health information without your authorization, except as described In this notice.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.
For example: Information obtained by a nurse, physician, or other member of your healthcare team Will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will record the actions he or she took and his/her observations.

We will use your health information for payment.
For example: A bill may be sent to you or a third-party payer. The information on or accompanying The bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations.
For example: Members of the medical staff or quality assurance manager may use information in your health record to assess the care and outcomes in your care and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Other Permitted or Required Uses and Disclosures

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, and certain laboratory tests. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Health Management: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post-marketing surveillance information to enable product recalls, repairs or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact Brookline Village OBGYN at (617) 735-8800.

If you believe your privacy rights have been violated, you can file a complaint with our office or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

BROOKLINE VILLAGE OBGYN
ONE BROOKLINE PLACE, SUITE 620
BROOKLINE, MA 02445
(617) 735-8800

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of
Patient Name

Brookline Village OBGYN's Notice of Privacy Practices.

_____ _____
Print Patient's Name Date of Birth

_____ _____
Patient's Signature Date signed

_____ _____
Signature of Patient or Patient's Representative to Patient Relationship

JEFFREY E. KATZ, M.D.
CAROLYN A. CLINE, M.D.
TRACY R. ZINNER, M.D.
JOAN S. HIER, M.D.
BARBARA S. FRANK, M.D.
ONE BROOKLINE PLACE, SUITE 620
BROOKLINE, MA 02445
617-735-8800

I authorize the release of my medical or other information necessary to process this claim. I also request payment of benefits either to myself or to Dr. Jeffrey E. Katz, Dr. Carolyn A. Cline, Dr. Tracy R. Zinner, Dr. Joan S. Hier, or Dr. Barbara Frank.

Print Patient's Name	Date of Birth	Date Signed
_____	_____	_____

Signature of Patient or Patient's Representative	Relationship to Patient
_____	_____

_____
Print Name of Patient's Representative

I authorize payment of medical benefits to Dr. Jeffrey E. Katz, Dr. Carolyn A. Cline, Dr. Tracy R. Zinner, Dr. Joan S. Hier, or Dr. Barbara Frank for services provided at the address above and the Brigham and Women's Hospital.

Print Patient's Name	Date of Birth	Date Signed
_____	_____	_____

Signature of Patient or Patient's Representative	Relationship to Patient
_____	_____

_____
Print Name of Patient's Representative