

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, Syphilis, 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: _____

Tdap: _____

Varicella: _____

MMR: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

BROOKLINE VILLAGE OB/GYN

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 medical 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 and 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

BROOKLINE VILLAGE OBGYN
One Brookline Place, Suite 620
Brookline, MA 02445
Tel: (617) 735-8800 Fax: (617) 278-9358

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 Brookline Village OBGYN.

Print Patient's Name

Date of Birth

Patient's Signature

Date Signed

I authorize payment of medical benefits to Brookline Village OBGYN for services provided at the address above and the Brigham and Women's Hospital.

Print Patient's Name

Date of Birth

Patient's Signature

Date Signed