

William M. Jamieson, M.D.
PATIENT REGISTRATION FORM

PATIENT INFORMATION

DATE _____

Name _____ Age _____ Date of Birth _____ Sex _____

Marital Status _____ Soc. Sec. No. _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ ~~CELL OR~~ Business Phone _____

Employer _____ Occupation _____

Employer's Address _____

City _____ State _____ Zip _____

CARDHOLDER INFORMATION

Name _____ Date of Birth _____

Address _____ Soc. Sec. No. _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Employer _____ Occupation _____

Employer's Address _____

City _____ State _____ Zip _____

REFERRED BY: _____

INSURANCE INFORMATION

Insurance Co. _____ Policy No. _____

Group No. _____ Effective Date _____

OTHER MEDICAL COVERAGE

Type _____ ID No. _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name _____ Phone No. _____

ASSIGNMENT OF BENEFITS:

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance guidelines. If you let us know at each time of service exactly what those guidelines are. Unfortunately, if you do not inform us of any special requirement in your contract and we subsequently order services, such as lab work, x-rays, or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility. As the policy holder YOU ARE RESPONSIBLE for knowing the benefits and restrictions of your insurance coverage.

WAIVER: I understand that should my insurance company require a REFERRAL/AUTHORIZATION prior to my receiving medical services and I have not obtained this and/or this office has not received this, I WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED.

CONFIDENTIAL GYNECOLOGY HEALTH HISTORY
WILLIAM M. JAMIESON, M.D.

NAME: _____

BRIEFLY EXPLAIN WHY YOU ARE BEING SEEN IN OUR OFFICE TODAY _____

DATE OF LAST MENSTRUAL PERIOD _____
DO YOU USE A METHOD OF CONTRACEPTION? YES NO IF YES, WHAT TYPE _____

HAS THERE BEEN A CHANGE IN YOUR PERIODS? YES NO IF YES, EXPLAIN _____
DO YOUR PERIODS CAUSE YOU PROBLEMS? YES NO IF YES, EXPLAIN _____
DO YOU EXPERIENCE MENOPAUSAL SYMPTOMS? YES NO IF YES, EXPLAIN _____

DATE OF LAST PAP SMEAR _____ RESULT _____

DATE OF LAST MAMMOGRAM _____ RESULT _____
DO YOU HAVE BREAST CHANGES OR PAIN? _____

ARE YOU PHYSICALLY OR EMOTIONALLY ABUSED? YES NO _____
DO YOU HAVE SEXUAL PROBLEMS? YES NO IF YES, EXPLAIN _____

DO YOU SMOKE CIGARETTES? YES NO HOW MUCH / HOW OFTEN _____
DO YOU DRINK ALCOHOL? YES NO HOW MUCH / HOW OFTEN _____
DO YOU EXERCISE? YES NO HOW MUCH / HOW OFTEN _____
DO YOU USE RECREATIONAL YES NO WHAT / HOW OFTEN _____
OR STREET DRUGS? _____

DO YOU HAVE A PRIMARY CARE PHYSICIAN? YES NO WHO? _____
ARE YOU CURRENTLY TAKING MEDICATIONS? YES NO _____
LIST DRUG NAME & DOSAGE _____

DO YOU HAVE DRUG ALLERGIES? YES NO IF YES, LIST _____

LIST ANY SERIOUS ILLNESSES THAT YOU HAVE: _____

LIST ANY SURGERIES THAT YOU HAD: _____

WE WOULD LIKE TO HELP IDENTIFY OTHER POTENTIAL HEALTH PROBLEMS THAT MAY NEED PROFESSIONAL CARE.

Please check any problems you have and indicate what treatment, if any, you are using for the problem.

- FREQUENT, SEVERE HEADACHES _____
- BACK/JOINT PAIN _____
- CHEST PAIN _____
- SKIN PROBLEMS _____
- URINARY PROBLEMS _____
- BOWEL PROBLEMS _____
- ABDOMINAL PAIN _____
- UNINTENTIONAL WEIGHT CHANGES _____
- EATING DISORDERS _____
- EXCESSIVE FATIGUE _____
- ANXIETY/DEPRESSION _____

IS THERE ANY OTHER INFORMATION WE SHOULD HAVE ABOUT YOUR HEALTH? _____

WILLIAM M. JAMIESON M.D.
Gynecology
2123 Auburn Avenue, Suite 104
Cincinnati, Ohio 45219

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible.

We will do everything possible to help you if you have problems with your insurance; however, it is your responsibility to know your individual coverage. Failing to comply with these suggestions could result in you, the patient, being responsible for all costs incurred. Please remember, your insurance policy is between you and your insurance company and not between your insurance company and your physician.

Signature: _____

Date: _____

SUMMARY OF HIPAA COMPLIANCE

Patients have these rights regarding their medical information under the Health Insurance Portability and Accountability Act:

1. The right to inspect and get a copy of their medical records
2. The right to request corrections to inaccuracies in the records
3. The right to find out where their information has been shared for purposes other than care, payment or health care operations
4. The right to restrict the use or disclosure of health information, including in a hospital directory
5. The right to direct that a provider send health information to a certain address or phone number
6. The right to see a provider's confidentiality policy

ACKNOWLEDGEMENT OF HIPAA NOTICE OF PRIVACY PRACTICES

As required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, our office is required to post its HIPAA Notice of Privacy Practices.

As of April 14, 2003, we must obtain a signature from each of our patients acknowledging their awareness of this notice.

You may review the posted HIPAA Notice of Privacy for the office of Dr. William M. Jamieson.

Sign below acknowledging that you have seen the notice.

Print Name: _____

Date: _____

Signature: _____