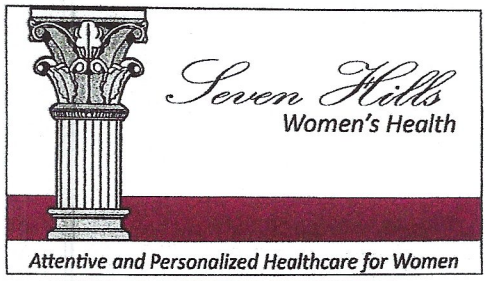


Genoveva Nicoleta Prisacaru, MD, FACOG
Obstetrics & Gynecology
phone 512.442.2300
Fax 512.442.2303

PATIENT INFORMATION

Name _____
Last First Middle Maiden

Address _____
Street City State Zip

SS # _____-_____-_____ DOB_____ Age_____ Race: _____

Home Phone_____Work #_____ Marital Status: M S W D SEP

Occupation_____
Employer Position

Address_____

In case of emergency, notify:_____

Phone number_____ or _____

Next of kin not living at your address_____

Address_____ Phone #_____

Spouse Name_____DOB_____

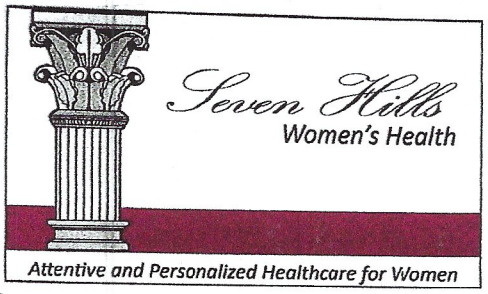
Spouse Employer_____Phone#_____

Insurance Information (PATIENT TO COMPLETE)

	Primary	Secondary
Insurance Company	_____	_____
Policy/member #	_____	_____
Group Number	_____	_____
Policy Holder	_____	_____
Employer of policy holder	_____	_____

Were you referred by anyone? YES NO If so, Who?_____

Primary Doctor's name _____



Genoveva Nicoleta Prisacaru, MD, FACOG
Obstetrics & Gynecology
phone 512.442.2300
Fax 512.442.2303

Acknowledgement of Receipt
Of Practice Notice and Record of Disclosure

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI).

I understand that as a part of my healthcare, Seven Hills Women's Health originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, as well as plans my future care or treatment. I understand that as a part of Seven Hills Women's Health's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above.

I certify that I understand the privacy risks of the mail, phone calls, and email. I hereby authorize a representative or my physician to mail, call, or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Seven Hills Women's Health in writing.

Patient/Parent Signature _____ Date: _____

Print Name: _____ Birth date of patient: _____ _____

Healthcare entities must keep records of PHI disclosures. Information provided below, if completely properly, will constitute an adequate record.

I give permission to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s), and/or close personal friend(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If we need to reach you regarding test results between 8-5, M-F, how many we reach you? Please check all that apply:

- ☐ Home phone _____
  - ☐ Leave a message with detailed information
  - ☐ Leave a message with call back number only
- ☐ Work phone _____
  - ☐ Leave a message with detailed information
  - ☐ Leave a message with call back number only
- ☐ Cell phone _____
  - ☐ Leave a message with detailed information
  - ☐ Leave a message with call back number only
- ☐ Written communication
  - ☐ Mail to my home address

Should we need to reach you for an emergency, which number is best? (Please circle)

Home Cell Work Other _____

Do we have your permission to send you test results via secured encrypted email? Please circle Yes No
Email address: _____

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices.

I certify that I have read and been offered a copy of the Patient Information Privacy Policy.

Signature of Patient / Legal Guardian _____ Date: _____ _____

(To be completed if patient refuses to sign acknowledgement)

Date: _____ *Name of person providing notice:* _____ _____

Seven Hills
Women's Health
Attentive and Personalized Healthcare for Women

Patient Financial Responsibility Statement

Seven Hills Women's Health, PLLC

Financial Policy Acknowledgement: Seven Hills Women's Health has preferred provider status with most insurance companies. Please contact your insurance company to determine if our practice has an in-network contract with your specific plan. You are responsible for knowing your insurance policy. Any and all payments will be collected at the time of service. Any payment for services not covered by insurance will be the patient's responsibility. Whether you have insurance or are self-pay, payment of any remaining account balance with Seven Hills is due within thirty (30) days of receipt of your billing statement.

Patient Insurance Plan: Please do not assume that your health insurance will cover 100% of services provided. Any service deemed as "non-covered" by the insurance company becomes the patient's financial responsibility. The patient is responsible for all charges if the insurance provided is not valid or active on the date of service. It is the patient's responsibility to inform the office of any changes with insurance coverage.

Primary, Secondary, Tertiary Policies: It is the patient's responsibility to inform the office of **ALL** existing insurance policies. Failure to provide all coverage policies will result in the patient's financial responsibility for services. A valid photo I.D. and insurance card are **required** at the time of the appointment; if the patient cannot present both, the appointment must be rescheduled.

Self-Pay: If the patient is self-pay (not covered by any medical insurance) on the date of service, payment is due in full at the time of appointment. If you are not able to pay for necessary medical services, you may be eligible for a payment plan through Care Credit (you can ask our office for more details). It is your responsibility to inform the office of your financial and coverage status.

No Show Policy: A **$40.00 fee** will apply for failure to inform the office of an appointment cancellation. To cancel and appointment please contact the office no less than 24 hours prior to the scheduled appointment. Failure to arrive within 15 minutes of a scheduled appointment will result in a missed appointment.

Paperwork Fees: Seven Hills will provide copies of the patient's medical records within 15 days of receipt of a signed record release form. A fee of **$25.00** will apply for printed medical records. A fee of **$25.00** will apply for completion of forms such as FMLA, insurance, disabilities, etc. These forms will be completed within 7-10 business days of receipt. Fees must be paid prior to completion of any form.

Termination From Our Practice: Our office values patient relationships and aims to protect patients' rights. We terminate patient relationships only with cause and after careful consideration. Reasons for termination may include, but are not limited to: repeatedly not showing up for scheduled appointments, failure to comply with recommended medical care, and failure to render payment.

I have read, understand, and agree to abide by the terms stipulated in the practice policies above. I understand that the charges incurred at or through Seven Hills Women's Health are my responsibility and that my insurance coverage is a contract between the insurance company and myself. I am responsible for all fees and will ensure they are paid in reasonable time. I authorize the release of any medical or other information necessary to process insurance claims. I have read and fully understand the office policies of Seven Hills Women's Health and agree to these terms. I understand that the financial policies may be amended by the practice at any time without prior notification.

Patient (over 18) or Responsible Party Signature _____ Date _____

Printed Name _____ Date of Birth _____

Seven Hills Women's Health

Attentive and Personalized Healthcare for Women

OBGYN Health History

Seven Hills Women's Health, PLLC

NAME

____/____/____

DATE

PREGNANCY HISTORY

	Total #	Date	Hospital/Location	# weeks	Vaginal or C/S	Fetal Weight	Complications/Problems
Pregnancies							
Deliveries							
Miscarriages							
Terminations							
Ectopics							
Multiples (Twins)							

FAMILY HISTORY

Disease	Relative	Disease	Relative
□ Adopted/Unknown		□ Heart Disease	
□ Arthritis		□ High Blood Pressure	
□ Autoimmune		□ Hepatitis	
□ Anemia		□ Immune Disorder	
□ Breast Cancer		□ Osteoporosis	
□ Cervical Cancer		□ Ovarian Cancer	
□ Colon Cancer		□ Thyroid Disorder	
□ Diabetes		□	
□ Uterine Cancer		□	

SURGICAL/HOPSITAL HISTORY

Type of surgery or hospitalization (including diagnosis)	Date

GYNECOLOGICAL/SEXUAL HISTORY

Are you experiencing:
□ unusual vaginal discharge/odor
□ vaginal dryness
□ breast pain / lump
□ nipple discharge
□ pelvic pain (unrelated to period)
□ painful intercourse

□ I am not satisfied with my current birth control method because:

_____

_____

Are you sexually active? □Yes □No
Request an STD screen? □Yes □No
Age at first intercourse:_____ yrs
Number of sexual partners in the last 6 months:_____
My sexual partners are:
□Men □Women □Men & Women

□ I have never been sexually active

SOCIAL HISTORY

Y / N Do you exercise? Type:_____ for _____ hrs/wk

Y / N Have you ever smoked tobacco? □ Current □ Former (year that you quit_____) □ Vape/E-Cig □ Cigarettes _____packs/day

Y / N Do you drink alcohol? #_____drinks/day _____days/wk

Y / N Do you have a history of substance abuse?

Y / N Have you ever used illicit drugs?_____

REVIEW OF SYSTEMS

Check or Circle only the items that you have experienced in the last 3 months (90 days) or are currently experiencing:

Constitutional	Integument (Skin)	Head/ENT	Endocrine
□ fever/chills □ sweats □ edema □ persistent fatigue □ weight gain/loss □ loss of consciousness/fainting □ easy bruising/bleeding □ numbness or tingling	□ chronic rash / sores □ chronic facial / body acne □ hair growth / loss □ tattoos / body piercings □ change in moles/lesions □ warts	□ vision problems □ severe/frequent headaches □ severe/frequent dizziness □ hearing problems □ dental Infection □ persistent nasal congestion	□ excessive thirst □ temperature intolerance □ hot flashes □ reduced libido (sex drive) □ pre-menstrual syndrome (PMS) □ increased urine output
Chest/Musculoskeletal	**Gastrointestinal**	**Psychiatric**	**Genitourinary**
□ persistent cough □ shortness of breath □ wheezing □ chest pain □ heart palpitations □ joint pain □ chronic/severe back pain □ muscle weakness	□ nausea / vomiting □ chronic diarrhea / constipation □ bloody stool □ persistent abdominal/stomach pain □ hemorrhoids □ heart burn/acid reflux	□ anxiety □ severe depression □ difficulty sleeping □ suicidal thoughts □ victim of abuse (verbal / physical sexual / emotional) □ mental illness_____ _____	□ painful urination □ blood in urine □ urinary frequency / urgency □ bladder leakage □ difficulty emptying bladder □ genital lesions / sores □ nighttime urination

Seven Hills Women's Health

Attentive and Personalized Healthcare for Women

OBGYN Health History

Seven Hills Women's Health, PLLC

NAME

____/____/____

DATE

REASON FOR VISIT:_____ **AGE:**_____ **D.O.B.:**_____

MEDICAL ALLERGIES

Drug Name/Type	Reaction

MEDICATIONS

Drug Name	Dose	How Often	Drug Name	Dose	How Often

PHYSICIAN USE ONLY

HT	ft/in
WT	lbs
B.P.	
H.R.	bpm

MEDICAL HISTORY

□ Asthma	□ Diabetes (Type:)	□ Heart Disease	□ Ovarian Cysts
□ Anxiety Disorder	□ D.V.T.	□ High Blood Pressure	□ P.C.O.S.
□ Arthritis	□ Endometriosis	□ Hepatitis_____	□ Stroke
□ Anemia	□ Fibroids_____	□ H.I.V.	□ S.T.D._____
□ Blood Disorder	□ Infertility	□ Kidney Disease	□ Seizures/Epilepsy
□ Cancer_____	□ GERD/Acid Reflux	□ Liver Disease	□ Thyroid Disorder
□ Colon Polyps	□ Gall/Kidney Stones	□ Lung Disease	□ Tuberculosis
□ Depression	□ G.I. Disease_____	□ Migraines	□ _____
□ Diverticulitis	□ Heart Attack	□ Osteoporosis	□ _____

HEALTH SCREENING

List the date (month/year) of most recent:
Pap smear___/_____ Mammogram___/_____
Bone Density___/_____ Blood Work ___/_____
Are your vaccinations current? (Y) (N) If no, please explain:_____
Do you have a Living Will, Advanced Directive, or DNR Order? (N) (Y)_____

Have you ever had:
HPV/Gardasil Vaccine (Y) (N) Year:_____
Abnormal Pap smear (Y) (N) Year:_____
If yes, list treatment or follow-up below:
□ Repeat Pap in _____ months □ None
□ Colposcopy (Year:_____ Result:_____)
□ Cone Biopsy/CKC □ LEEP □ Laser/Cryo

MENSTRUAL HISTORY

First day of last period:____/____/_____
Age at menarche:_____ yrs
Each menstrual cycle lasts ____ days
Menstrual flow (period) lasts ____ days

Current birth control method:
□Abstinence □Condoms □Depo Shot
□Diaphragm □Essure □Hysterectomy
□IUD □NuvaRing □Nexplanon □None
□Pills □Patch □Partner Vasectomy
□Postmenopausal □Same sex partner
□Spermicide □Tubal Ligation/Sterilization

Are you seeking pregnancy?.....□Yes □No
Are your periods regular (monthly)?.....□Yes □No
Do you bleed in between periods?.....□Yes □No
Are your periods very painful?.....□Yes □No
Are you in menopause?.....□Yes (at age:____) □No
Vaginal bleeding after menopause?.....□Yes □No
Hormone Replacement Therapy?.....□Yes □No
Any procedures on the female organs?.....□Yes □No
If yes please explain:_____