17 Case Street
Norwich, CT 06360
860-886-2461

330 Washington St, Suite 340
Norwich, CT 06360
860-887-4198

David Kalla, MD
Suzelle Hendsch, MD
Melissa Welch, MD

Matthew Brown, M.D.
Julie Belcher M.D.
Kellen Sikora, M.D.

Erin Kalla, MD
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Melissa Bergfeld, A.P.R.N
Olivia Carson, APRN
Grace Sanfilippo APRN

Anya Krause, LNM
Anna Dennis, LNM

PAST HISTORY FORM

Patient Name: _____ D.O.B: _____ Date: _____

Pharmacy/Town: _____ Primary Language: _____

ALLERGIES: List medications you are allergic to and reaction (ie: hives, vomiting, difficulty breathing, etc)

_____

MEDICATIONS: List medications and supplements that you take- Please include the dose and how often you take it:

_____
_____
_____
_____
_____

LAST MENSTRUAL PERIOD:_____ Are you currently on contraception? Yes_____ No_____
If so, what form of contraception: _____

PAST MEDICAL HISTORY: write all that apply

_____
_____
_____
_____

PAST SURGICAL HISTORY:

_____
_____
_____
_____
_____

OBSTETRIC HISTORY(PREGNANCIES): List all deliveries:

Month/Day/ Yr | Vaginal/Cesarean | Weight/Weeks | Location | Complications

_____
_____
_____
_____

List any miscarriages, terminations, ectopic (tubal) pregnancies, or molar pregnancies:

_____
_____

GYNECOLOGIC HISTORY:

_____
_____
_____
_____

SOCIAL HISTORY: Circle all that apply

Smoking: Never Current everyday (packs per day_____) Current some days Former (YR quit_____)
Alcohol Use: Never More than 10 drinks/week Less than 10 drinks/week Alcoholic
Substance Use: Never Cocaine Heroin Prescription Drugs Other Former use (what/when) _____
Sexual Activity with: Men Women Both Other_____
Domestic Violence/Abuse: Never Former Current

FAMILY MEDICAL HISTORY: (Please specify family member, ie mother, father, sister, brother, etc)

_____
_____
_____
_____
_____

OB/GYN–RELATED CANCER HISTORY: (Please specify family member & age of diagnosis)

Breast Cancer Ovarian Cancer Colon Cancer Uterine Cancer Other: _____

SCREENING TESTS: (when preformed and what Doctor/facility)

Last Mammogram: _____ Last Colonoscopy: _____
Last PAP Smear: _____ Last Bone Density/DEXA Scan: _____

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Release of Information

____ DECLINED TO RELEASE INFORMATION

I authorize OB-GYN Services, P.C. to disclose the following information to the party listed below. When my information is disclosed, pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the rights to revoke this authorization in writing, except to the extent that OB-GYN Services, P.C. has acted in reliance upon this authorization. My written revocation must be submitted to OB-GYN Services, AATN: Privacy Officer, 17 Case Street, Norwich, CT 06360.

Type of protected health information to be disclosed (check all that apply)

- [ ] Medical treatment, past
- [ ] Medical treatment, planned (to include appointment information)
- [ ] Prescription information
- [ ] Financial information (i.e., account balance and insurance status)
- [ ] Other (specify):_____

To be disclosed to: _____ _____
Name Relationship

_____
Address

_____
Phone Number

_____ _____
Patient Name Date of Birth

_____ _____
Signature of patient Date

_____
OB-GYN Services, P.C. Representative

Financial Policy

Thank you for choosing OB GYN Services for your Healthcare needs. Please understand that payment of your bill is considered your responsibility. The following is a statement of our finanical policy which we require you to read and sign prior to any treatment. To achieve the practice goals of providing the finest medical care at the lowest possible cost, we need your assistance in the following:

PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, DISCOVER, AMERICAN EXPRESS, AND MASTERCARD.

If you have insurance coverage, we will file the claim for you. Payment for treatment is your responsibility. All copays and deductibles are due at the time of service and must be paid prior to any treamtment or surgery.

If an insurance problem occurs, you may be asked to assist us in contacting your insurance carrier. Please be aware that some of the services provided may be non-covered and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

We will check the status of the your insurance benefits when we schedule any procedure. If your deductible has not been met, we will require payment of that amount and any additional co-insurance or co-pay responsibility.

Returned checks may be subject to any bank fees and collection fee of $25.00 per check.

If you have any questions about financial arrangements, please feel free to talk to our billing office at 860-889-2902. We will make every effort to clarify any concerns regarding your financial responsibility.

Thank you for your assistance in this matter.

I HAVE READ THE ABOVE FINANCIAL POLICY AND AGREE TO ABIDE BY ITS TERMS.

Signature_____ Date_____

Print Name_____ Date of Birth_____

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MISSED APPOINTMENT POLICY

OB-GYN Services does not charge for missed appointments or late cancellations. However, we ask you to show consideration by notifying our office at least 24 hours in advance if you are unable to keep your appointment. This will allow our physicians to have the option to offer that appointment to another patient who needs to be seen.

If you miss **THREE** appointments without notifying our office, you may be **DISMISSED** from the practice. If you are dismissed from our practice, you will not be able to schedule any further appointments.

I have read and understand OB-GYN's missed appointment policy.

_____ _____

Patient or Patients Representative Signature Date

Patient Information

Date: _____ Name: _____

Address_____ Town_____ State & Zip code_____

Home phone: _____ Work phone: _____

Date of Birth: _____

Insurance Coverage Information

Primary Insurance Co.: _____

Group #: _____ ID #: _____

Policy Holder: _____ Relationship: _____

Employer: _____ Address: _____

Secondary Insurance Co.: _____

Group #: _____ ID #: _____

Policy Holder: _____ Relationship: _____

Employer: _____ Address: _____

This office does not accept all Insurances. Some Insurances (such as Medicare) do not cover routine annual gyn exams. It is the patient's responsibility to be aware of their insurance's policy and procedures. Appropriate payment or co-pay is due when service is rendered.

RELEASE OF BENEFITS

I hereby authorize my insurance benefits be paid directly to OB-GYN Services, P.C. and acknowledge that I am financially responsible for any unpaid balance. I also authorize this office to release any information required by my insurance company.

Patient Signature: _____ Date: _____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

OB-GYN Services, P.C. has my consent to use and disclose my protected health information with their office to carry out treatment, payment and all other healthcare operations.

I have read a copy of OB-GYN Services, P.C.'s Notice of Privacy of Practice. I understand that OB-GYN services, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy may be obtained by forwarding a written request to OB-GYN Services, P.C., Attn: Privacy Officer at 17 Case Street, Norwich, CT 06360.

OB-GYN Services, P.C. has my consent to call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the proactive in carrying out all healthcare operation, such as appointment reminders, messages for me to call regarding insurance items, my clinical care, including laboratory results.

OB-GYN Services, P.C. has my consent to mail to my house or designated location any items that assist the practice in carrying out all healthcare operations, such as appointment reminders and patient statements as long as they are marked Personal and Confidential.

OB-GYN Services, P.C. has my consent to e-mail to my home or other designated location any items that may assist the practice in carrying out all healthcare operation. I have the right to request that OB-GYN Services, P.C. restrict how it uses or discloses any of my personal healthcare information for their healthcare operations. However, the practice is not required to agree to requested restrictions, but if it does, it is bound by this agreement.

By Signing this form, I am consenting to let OB-GYN Services, P.C. use and disclosure of my personal health information to carry out all healthcare operation. I understand that I may revoke my consent in writing except to the extent that the practice has already make disclosures in reliance upon my prior consent. If I do not sign this consent, OB-GYN Services, P.C. may decline to provide me with treatment.

_____ _____

Signature of patient or Legal Guardian | Relationship to Patient

_____ _____

Patient's Name | Date

_____

OB-GYN Services, P.C. Represented