Heights Women's Health & Aesthetics

Datar Singh, MD & A. Durham, PA-C 724-904-7062

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last Middle First

SSN: _____ Male: ☐ Female: ☐ Birthdate: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Person to contact in case of Emergency: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

Pharmacy Address: _____

RESPONSIBLE PARTY *(fill out if patient is a minor)*

☐ Same as above

Name of person responsible for this account _____ Relationship to patient

Address: _____ City: _____ State: _____ Zip: _____

Drivers License #: _____ Birthdate: _____

PATIENT HISTORY FORM

REASON FOR VISIT: **DOB:** **AGE:**

MENSTRUAL CYCLE

First day of last period:

DAYS BETWEEN

DAYS LAST

FLOW (circle)

Normal Light Heavy

Spotting ☐ YES ☐ NO

Pain w/ cycle ☐ YES ☐ NO

Age of Onset ☐ YES ☐ NO

Age of Menopause _____

STD HISTORY

Chlamydia ☐ YES ☐ NO

Gonorrhea ☐ YES ☐ NO

Vag Warts ☐ YES ☐ NO

HPV Pap ☐ YES ☐ NO

Herpes ☐ YES ☐ NO

Trichomonas ☐ YES ☐ NO

Syphilis ☐ YES ☐ NO

HIV ☐ YES ☐ NO

Hep B ☐ YES ☐ NO

Hep C ☐ YES ☐ NO

SEXUAL DYSFUNCTION

Pain w/ Intercourse ☐ YES ☐ NO

Bleeding ? ☐ YES ☐ NO

Vag Dryness ☐ YES ☐ NO

Lack of desire ☐ YES ☐ NO

PAP SMEAR HISTORY

Last Pap Smear _____

Any Abnormals? ☐ YES ☐ NO

HPV Testing Done? ☐ YES ☐ NO

GARDISIL HISTORY (age 9-26)

Received HPV Vaccine ☐ YES ☐ NO

MAMMOGRAM HISTORY

Last Mammo Date: _____

Any Abnormals? ☐ YES ☐ NO

Family Hx Breast CA? ☐ YES ☐ NO

Self Breast Exams? ☐ YES ☐ NO

Breast Lumps? ☐ YES ☐ NO

Nipple Discharge? ☐ YES ☐ NO

URUNARY HISTORY

Pain w/ Urination ☐ YES ☐ NO

Urgency ☐ YES ☐ NO

Frequency ☐ YES ☐ NO

Leaking of Urine ☐ YES ☐ NO

Bedwetting ☐ YES ☐ NO

SKELETAL

Any history of the following?

Bone fractures ☐ YES ☐ NO

Loss of height ☐ YES ☐ NO

Mom having fracture ☐ YES ☐ NO

Mom with osteoporosis ☐ YES ☐ NO

Hormone Replacement ☐ YES ☐ NO

Past Steroid Use ☐ YES ☐ NO

Past Dexascan Test ☐ YES ☐ NO

BIRTH CONTROL

CURRENT METHOD

PAST METHODS

SOCIAL

Do you smoke? ☐ YES ☐ NO

Amount? _____

Drink Alcohol? ☐ YES ☐ NO

Amount? _____

Use street drugs? ☐ YES ☐ NO

Type? _____

Caffeine Intake? ☐ YES ☐ NO

Amount? _____

Threatened of Abused? ☐ YES ☐ NO

Living Will in place? ☐ YES ☐ NO

Advanced Directive? ☐ YES ☐ NO

ALLERGIES: _____

CURRENT MEDICATIONS: _____

OBSTETRICAL HISTORY

PAST DELIVERY SUMMARY

List number of the following:	YEAR	SEX	WEIGHT	DEL TYPE	ANESTHESIA	LABOR DURATION	COMMENTS
Pregnancies:	1)						
Full Term Births:	2)						
Preterm Births:	3)						
Miscarriages:	4)						
Abortions:	5)						
	6)						

HOSPITALIZATIONS / SURGERY HISTORY

YEAR	HOSPITAL	TYPE OF SURGERY/ILLNESS	SURGEON	COMMENTS

MEDICAL AND FAMILY HISTORY - Place (X) in box that applies

	Patient	Family	Comments		Patient	Family	Comments
Headaches				Asthma			
Thyroid Dx				Tuberculosis			
Parathyroid Dx				Gastric Ulcer			
Psychiatric Dx				Constipation			
Seizure Disorder				Diarrhea			
Cardiac Dx				Liver Dx			
Hypertension				Diabetes			
Stroke				Bladder/Kidney Dx			
Blood Disorder				Cancer			
Phlebitis/Clotting				Auto Immune Dx			
Other:				Other:			

CONSENT TO TREATMENT, PAYMENT AND ACKNOWLEDGMENT

Patient Name: _____ DOB: _____

Heights Women's Health & Aesthetics, Datar Singh, M.D.

CONSENT TO TREATMENT

I request those physicians and other healthcare professionals who care for me to perform routine examinations, diagnostic procedures, hospital care and therapeutic treatments, which in their judgment, become necessary while I am being treated by the Physician Practice named above. Routine diagnostic procedures and medical treatments include but are not limited to ECGs, x-rays, physical therapy, blood tests and administration of medications. I also consent to medical photography necessary in the judgment of my physician, to document the course of my injury or illness and to provide appropriate medical care.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations. I authorize the Physician Practice named above to retain, preserve and use for scientific, or educational purposes, or dispose of at their convenience, any specimens or tissue taken from my body. If I undergo any procedure that requires the submission of tissue for pathologic examination, I authorize the use of any excess tissue for educational purposes.

I understand that the Physician Practice, in order to deliver quality healthcare, develops and maintains health information which may include physician notes, history and physical, medication reports, tests and test results, and treatment plans. I concur that this health information is used for the following:

- care and treatment plans
- billing statements
- communication between interdisciplinary healthcare providers
- verification of services by third party payers and government payers
- quality control by the Physician Practice

CONSENT TO APPEAL

In the event that my insurance company denies payment for my service, I authorize the Physician Practice to appeal for payment on my behalf, however, I understand that i have the right to rescind my consent to appeal at any time during the appeal process.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIAN AND PATIENT

I request that payment of authorized Medicare benefits be made either to me or on my behalf of the Physician Practice for any services furnished to me by that provider or service. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

STATEMENT TO PERMIT OF MEDICAID BENEFITS TO PROVIDER AND PHYSICIAN

I certify that the information given by me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Department of Public Welfare (D.P.W.) or its intermediaries or carries any information needed for this or a related Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services orauthorize such physician or organization to submit a claim to D.P.W. for payment.

ASSIGNMENT OF INSURANCE OR PAYOR BENEFITS

I recognize that I am primarily liable for payment for services rendered. In the event that I am entitled to medical care benefits or insurance of any type whatsoever, I hereby assign those benefits and my rights to insurance payment to the Physician Practice named above and the appropriate health care providers to apply for benefits and insurance on my behalf for services rendered to me. I certify that the insurance or other coverage benefit information supplied by me is correct, in accordance with provider or insurance policies or agreements. If my insurance carrier requires per-authorizations for services I will receive, I understand that it is my responsibility to obtain the required per-authorization. If I fail to do so, I will be liable for all or part or otherwise covered expenses.

ACKNOWLEDGMENT OF RESPONSIBILITY FOR PAYMENT OF MEDICAL BILL

I guarantee payment of all charges incurred for services rendered by the Physical Practice named above for the Patient named above. The amount due for non-insurable charges including co-payment, deductibles, etc., shall be paid in full at the time of service. Should my account be referred to an attorney for collection, I agree to pay of otherwise covered expenses.

II. ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that i have received a copy of the West Penn Allegheny Health System Notice of Privacy Practices ("Notice"). I understand that information the Physician Practice named above acquires or creates about me will only be disclosed to others for treatment, payment and health care operations as set forth in the Notice or as authorized by me in writing.

I CERTIFY THAT I HAVE READ THIS FORM OR HAD IT READ TO ME AND UNDERSTAND ITS CONTENTS.

_____ _____

Signature Date/Time Witness Date/Time

_____Patient _____Substitute Decision Maker

_____ _____

If substitute Decision Maker, state relationship If Substitute Decision Maker, state reason

Heights Women's Health & Aesthetics Consent to Communicate

Patient name _____ DOB: _____

List the family members or other persons, if any, whom we may inform about your healthcare and payment related to healthcare:

Name: _____ Phone Number: _____

Relationship: _____

Name: _____ Phone Number: _____

Relationship: _____

List the family members or other persons, if any, whom are authorized to pick up health related items and information, such as records, prescriptions, etc. on your behalf

Name: _____ Phone Number: _____

Relationship: _____

Name: _____ Phone Number: _____

Relationship: _____

Print the phone number(s) where your provider's office may contact you to discuss appointments, test results, medications and other healthcare information:

If you are unavailable, may we leave detailed messages on an answering machine or voicemail?

☐ Yes Phone Number: _____

☐ No

If yes above, may we also leave messages with whomever answers the phone?

☐ Yes ☐ No

You can communicate with me via email at _____
(Please note that emails via Heights Women's Health Aesthetics that contain health information are encrypted. A separate consent to communicate by unsecured email form must be signed in order to receive unencrypted emails.)

Signature of patient _____ Date: _____

If representative, specify relationship to patient _____