PRIVIA
WOMEN'S HEALTH

Patient Information

Last Name _____
First Name _____
Middle Name _____
Former Last Name _____
Sex _____
DOB _____
SSN _____
Address _____
Address 2 _____
Zip _____
City _____
State _____
Home phone _____
Mobile phone _____
Work phone _____
Email (required) _____
Preferred Pharmacy _____
Contact preference (please circle): HOME MOBILE WORK
Language _____
Race _____
Ethnicity _____
Marital Status _____
Homebound? YES NO
How did you hear about us? **(please circle options below)**

Advertising Primary Care Physician Specialist Physician Word of Mouth

Insurance Patient in Practice Hospital Insurance Co. Other

Specify (if Other, above) _____

Today's Date _____

Guardian

Last Name _____
First Name _____
Middle name _____

Emergency Contact

Name _____
Relationship _____
Home phone _____
Mobile phone _____

Next of Kin

Name _____
Relationship _____
Phone _____

Employment

Employer name _____
Employer phone _____

Guarantor Information

Last Name _____
First Name _____
Middle name _____
DOB _____
Address _____
Address 2 _____
Zip _____
City _____
State _____

Optional Information

Phone _____

Primary Insurance Information

Insurance Plan Name _____

ID/Certification No. _____

Policy/Group No. _____

Secondary Insurance Information

Insurance Plan Name _____

ID/Certification No. _____

Policy/Group No. _____

Primary Policy Holder (if other than patient)

Patient's Relationship to policy holder: _____

Last Name _____

First Name _____

Middle Name _____

Address _____

Address (ctd) _____

City _____

State _____

Zip _____

Date of Birth _____

Policy Holder Sex _____

Employer Name _____

Secondary Policy Holder (if other than patient)

Patient's Relationship to policy holder: _____

Last Name _____

First Name _____

Middle Name _____

Address _____

Address (ctd) _____

City _____

State _____

Zip _____

Date of Birth _____

Policy Holder Sex _____

Employer Name _____

Patient Signature: _____ **Date:** _____

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Preferred Communication:
The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them. This could, for example, include sending correspondence to your office instead of your home. Please tell us your preferred place and manner of communication. **You may update or change this information at any time; please do so in writing.**

Patient Name: _____ **Date of Birth:** _____

I prefer to be contacted in the following manner (check all that apply):

☐ **Send all communication through my Patient Portal.**

☐ **Home Telephone:**_____ ☐ **Cell Phone:**_____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Work Telephone:**_____ ☐ **Written Communication:**_____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Please send all of my mail to my home address on file
- ☐ Please send all mail to THIS address:

_____

_____

☐ **Other:**_____

My Preferred Contacts:

We respect your right to tell us who you want involved in your treatment or to help you with payment issues. Our secure patient portal is our primary means of patient communication, such as to share your test results. **You** have the ability to control access to your patient portal.

Please indicate the person(s) with whom you prefer we share your information below.**Please update this information in writing promptly if your preferences change.**

Please note that in some situations, it may be necessary and appropriate for us to share your information with other individuals. This may include information about your general medical condition and diagnosis (including information about your care and treatment), billing and payment information, prescription information and scheduling appointments.

Note that we generally do not share your information via email; if you wish, you can give another individual access to your secure patient portal. You can set this up yourself through the portal or contact our Patient Experience team at 1-888-774-8428 - Monday – Friday 8 am – 6 pm ET.

•Name:_____**Telephone:**_____**Relationship:**_____
Email::_____

•Name:_____**Telephone:**_____**Relationship:**_____
Email::_____

•Name:_____**Telephone:**_____**Relationship:**_____
Email::_____

ACKNOWLEDGMENT: I understand that HIPAA may permit my provider to share my information with other persons**not** named on this form as needed for my care or treatment or to obtain payment for services provided.

Patient Signature: _____ **Date:** _____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

PRIVIA WOMEN'S HEALTH

Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information. I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification. In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses and attorney's fees incurred by my provider to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment. I voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being; however I may refuse any particular treatment or procedure.

If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time.

My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.

Consent to Call, Email & Text. I understand and agree that my provider may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my provider's staff, by visiting "My Profile" on my myPrivia Patient Portal, or by emailing the Privacy Officer at privacy@priviahealth.com.

HIPAA. I understand that my provider's Privacy Notice is available on my provider's website and at priviahealth.com/hipaa-privacy-notice/ and that I may request a paper copy at my provider's reception desk.

I hereby acknowledge that I have received my provider's Financial Policy as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy, the sharing of my information via HIE,* and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all Privia Health affiliated providers.

Printed Name of Patient: _____ **Email:** _____

Signature: _____ **Date:** _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent.

Name and Relationship of Person Signing, if not Patient: _____

***Note: If you do not want to participate in Health Information Exchange (HIE), it is your responsibility to follow the instructions outlined on the my provider HIE Opt-Out Request Form and/or contact the HIE directly.**

Chesapeake Women's Care, P.A.

NAME_____ AGE_____ DATE _____

MEDICAL HISTORY

Medications currently taking: _____

Vitamins, Herbal Supplements: _____

Medical Illnesses: _____

_____

_____

Allergies: _____

Previous surgeries or hospital admissions *(List dates & reason)* _____

_____

COLPO: _____

LEEP: _____

Have you ever had a blood transfusion? NO☐ YES☐ When? _____

PERSONAL HISTORY:

Marital Status: _____ Smoke? _____ Packs per day _____

Alcohol Consumption: _____ Caffeine Consumption: _____

Recreational Drug use: _____

Have you ever been immunized against rubella (German Measles)? _____

GYN HISTORY:

Last menstrual period (1st day): _____ Normal? Previous period: _____

Age at 1st menstrual period: _____ How frequently do they come? _____

How many days do they last? _____ Flow: Heavy Medium Light Cramps: _____

Bleeding in between periods? _____ Vaginal discharge? _____

Date of last pap smear: _____ Method of contraception: _____

Have you ever had genital herpes or venereal warts? Any Abnormal PAPs? _____

Dates: _____ Treatments: _____

OBSTETRICAL HISTORY: *Please list dates* _____

Full term delilveries: _____

Stillbirths: _____ Premature Deliveries: _____

Abortions: Miscarriages:

Has any BLOOD relative ever had:	No	Yes	Who?
Breast CA	☐	☐	
Ovarian CA	☐	☐	
Other Cancer	☐	☐	
Diabetes	☐	☐	
High Blood Pressure	☐	☐	
Stroke	☐	☐	
Heart Disease	☐	☐	
Birth Defect	☐	☐	

Patient Name: _____

Date of Birth: _____

New Pregnancy Questionnaire

Please allow 20-30 minutes to complete this questionnaire prior to your first prenatal appointment.

What was the date of your last menstrual period?

About

Height (Pre-Pregnancy) ____ ft ____ in

Pre-pregnancy Weight ____ lb

What is your occupation?

Is English your native language? No Yes

What is the name of your partner/spouse?

What is the phone number of your partner/spouse?

Is the father of the baby 40 or older?* No Yes

Sensitive

Has your current partner ever threatened you, or made you feel afraid?* No Yes

Have you ever been in an abusive relationship?* No Yes

Do you feel unsafe in the neighborhood where you live?* No Yes

Pregnancy History

Is this your first pregnancy?* No Yes

Have you ever had a C-Section? No Yes

Do you feel like you had a really stressful experience with any labor and delivery from any previous pregnancy? No Yes

Did you have a forceps assisted delivery in any previous pregnancy? No Yes

Did you ever have Vacuum Extraction delivery assistance on a previous pregnancy? No Yes

Did you deliver a larger than normal infant (baby greater 8lbs,13oz) on a previous pregnancy?	No	Yes
Have you ever lost a pregnancy after 14 weeks gestation?	No	Yes
Have you ever had your uterus rupture during pregnancy, labor, or delivery?	No	Yes
Have you ever had a placental abruption or placental separation?	No	Yes
Have any of your babies been infected with Group B Strep?	No	Yes
Have you ever had a baby who was too small or growth restricted?	No	Yes
Have you had Gestational Diabetes with a previous pregnancy?	No	Yes
Have you been diagnosed with high blood pressure/preeclampsia gestational hypertension or HELLP syndrome in your previous pregnancies?	No	Yes
Were you ever admitted with pre-term contractions or diagnosed with pre-term labor in a previous pregnancy?	No	Yes
Have you had a preterm delivery at less than 37 weeks?	No	Yes
Have you ever been diagnosed with a shortened cervix in a previous pregnancy?	No	Yes
During a previous delivery, did the baby's shoulder get stuck on the way out?	No	Yes
Have you ever had a hemorrhage after delivery with a previous pregnancy?	No	Yes
Have you had postpartum depression?	No	Yes
Were you ever re-admitted to the hospital after a delivery?	No	Yes
Did you have complications during a previous pregnancy or postpartum other than those listed above?	No	Yes

Endocrine History

Do you have an overactive thyroid, or Graves disease?	No	Yes
Do you have an underactive thyroid, or Hashimoto's thyroiditis?	No	Yes
Do you have insulin-dependent or juvenile (Type 1) diabetes?*	No	Yes
Do you have adult-onset (Type 2) diabetes?*	No	Yes

Do you have Polycystic Ovarian Syndrome (PCOS)	No	Yes

Cardiovascular History

Do you have high blood pressure?*	No	Yes
Do you have ITP, history of low platelet count, or a platelet disorder?*	No	Yes
Have you ever had a blood clot in the leg (DVT) or lung (Pulmonary Embolism) or a disorder that makes your blood clot more than usual?*	No	Yes
Do you have any cardiovascular problems (heart/heart valve disease, previous heart surgery, heart defects, aortic aneurysm, arrhythmia, rapid or irregular heartbeat, or postpartum heart failure)	No	Yes

Neurological History

Do you have any type of seizure disorder?	No	Yes
Have you ever been diagnosed with a stroke (CVA, TIA)?	No	Yes
Have you ever been diagnosed with migraines?	No	Yes

Psychiatric History

Do you have problems with anxiety?*	No	Yes
Have you had a problem with depression?*	No	Yes
Have you ever been diagnosed with PTSD?	No	Yes
Have you ever been diagnosed with OCD?	No	Yes
Have you been diagnosed with a bipolar (manic-depressive) disorder?	No	Yes
Do you have schizophrenia?	No	Yes
Have you ever attempted suicide?	No	Yes
Have you ever been diagnosed with ADD (Attention Deficit Disorder) or ADHD (Attention Deficit Hyperactivity Disorder)?	No	Yes

Respiratory History

Do you currently have asthma?*	In Past	No	Yes
Do you have any pulmonary disease or lung problems other than asthma?		No	Yes

Surgical History

Have you ever had any complications with anesthesia?	No	Yes
Have you ever had postoperative complications?	No	Yes
Have you had weight loss/bariatric surgery?*	No	Yes
Have you ever had a blood transfusion?*	No	Yes
Have you ever had back surgery?	No	Yes
Have you ever had abdominal surgery (including c-section)?*	No	Yes
Have you ever had cosmetic surgery (including breast augmentation, tummy tuck)?	No	Yes
Have you ever had transplant surgery	No	Yes

Gastroenterological History

Do you have Ulcerative Colitis?	No	Yes
Do you have Crohn's disease?	No	Yes
Do you have any history of gastrointestinal or digestive disorders other than the conditions noted above?	No	Yes

Urologic History

Have you ever had any urinary tract/urologic surgery?	No	Yes
Do you have any type of kidney/renal disease (including history of kidney stones or kidney infection)?*	No	Yes

General Medical History

Do you have antiphospholipid syndrome (APS) / thrombophilia / hypercoagulability?	No	Yes

Do you have lupus?	No	Yes
Do you have rheumatoid arthritis?	No	Yes
Do you have Sjogrens Syndrome?	No	Yes
Have you ever been diagnosed with or undergone treatment for a Blood Disorder?	No	Yes
Do you have a connective tissue disorder (Ehlers-Danlos or Marfan Syndrome)?	No	Yes
Have you ever been diagnosed with or undergone treatment for Cancer?	No	Yes

Gynecological History

Have you had 3 or more miscarriages?	No	Yes
Have you ever needed IVF or other treatment to get pregnant?	No	Yes
Have you ever had any surgery or procedures on your cervix?*	No	Yes
In a previous pregnancy, have you ever had your cervix sewn or taped closed due to a weak or incompetent cervix?*	No	Yes
Have you ever had a cold knife cone biopsy (conization) to remove tissue from your cervix?*	No	Yes
Have you ever had a LEEP (Loop Electrosurgical Excision Procedure) performed to remove abnormal cells from your cervix?*	No	Yes
Have you ever had cervix cryosurgery to freeze and destroy abnormal tissue in your cervix?*	No	Yes
Have you ever been diagnosed with a uterine anomaly such as a bicorunate, unicorunate, arcuate, or septate uterus?	No	Yes
Do you have (or have you had) uterine fibroids (myomas)?	No	Yes
Have you ever had an operation to remove a fibroid or myoma from your uterus?	No	Yes

Family History

Do you or your partner have an ethnic background of Cajun/French Canadian?	No	Yes
Do you or your partner have an ethnic background of Greek/Mediterranean/Italian?	No	Yes

Do you or your partner have an Ashkenazi/Eastern European Jewish background?	No	Yes
Has anyone in your or your partner's family had a baby with anencephaly?	No	Yes
Has anyone in either your or your partner's family had Canavan Disease?	No	Yes
Have you, your partner or either your or your partner's family had a chromosomal defect?	No	Yes
Has anyone in either your or your partner's family had familial dysautonomia (FD)?	No	Yes
Have you, your partner or either your or your partner's family had a heart defect?	No	Yes
Do you, your partner or either your or your partner's family have sickle cell anemia?	No	Yes
Has anyone in your or your partner's family had sickle cell trait (SCT)?	No	Yes
Has anyone in your or your partner's family had a child with Down syndrome?	No	Yes
Has anyone in your or your partner's family had hemophilia?	No	Yes
Has anyone in your or your partner's family had Muscular Dystrophy?	No	Yes
Do you, your partner or either your or your partner's family have cystic fibrosis?	No	Yes
Has anyone in your or your partner's family had Huntington's Chorea?	No	Yes
Has anyone in your or your partner's family had Fragile X?	No	Yes
Has anyone in your or your partner's family had spinal muscular atrophy (SMA)?	No	Yes
Have you, your partner or anyone in your or your partner's family had von Willebrand Disease?	No	Yes
Do you, your partner or anyone in either family have any birth defects?*	No	Yes
Does anyone in either your or your partner's family have an intellectual disability?	No	Yes
Do you, your partner or either your or your partner's family have any children with special needs?	No	Yes
Has anyone in the family had pre-eclampsia?	No	Yes

Do your or your partner's family have any close relatives (parent, child, sibling) with diabetes?	No	Yes

Infection History

Have you been exposed to tuberculosis?	No	Yes
Have you had a rash or viral illness since your last menstrual period?	No	Yes
Have you ever been diagnosed with MRSA?	No	Yes
Have you ever been diagnosed with Hepatitis B?	No	Yes
Have you ever been diagnosed with Hepatitis C?*	No	Yes
Are you HIV positive?	No	Yes
Have you ever been diagnosed with any sexually transmitted disease (STD) - (Gonorrhea, Chlamydia, Trichomonas, HIV, HPV, or Syphilis?	No	Yes
Have you ever had a genital herpes?	No	Yes
Does your partner have a history of genital herpes?	No	Yes
Have you ever had cold sores?	No	Yes

Vaccination History

Have you ever had COVID 19 or been vaccinated for it?	No	Yes
Have you ever had chickenpox or been vaccinated against it?	No	Yes

Social History

Do you have any objections to blood transfusions?	No	Yes
Do you have a cat?	No	Yes
Do you have exposure to chemicals or radiation?	No	Yes

When was the last time you drank any alcohol?	Never	Years Ago	Weeks Ago	Not Since Pregnant	Current

When was the last time you smoked, vaped, or used any tobacco/nicotine products?	Never Years Ago Weeks Ago Not Since Pregnant Current
Do you vape or use e-cigarettes?	Never Years Ago Weeks Ago Not Since Pregnant Current
When was the last time you smoked a cigarette?	Never Years Ago Weeks Ago Not Since Pregnant Current
When was the last time you used marijuana, cocaine, meth, benzos, and/or opioids?	Never Years Ago Weeks Ago Not Since Pregnant Current
When was the last time you used any marijuana?	Never Years Ago Weeks Ago Not Since Pregnant Current
When was the last time you used any cocaine?	Never Years Ago Weeks Ago Not Since Pregnant Current
When was the last time you used any methamphetamines?	Never Years Ago Weeks Ago Not Since Pregnant Current
When was the last time you used any benzos (such as Valium, Xanax, or Ativan)?	Never Years Ago Weeks Ago Not Since Pregnant Current
When was the last time you used any opioids?	Never Years Ago Weeks Ago Not Since Pregnant Current
Are you exposed to second-hand tobacco smoke?	No Current

Options Counseling

Do you have questions about your options regarding this pregnancy?*	No Yes

Pregnancy History							
Total # of Pregnancies	Full-Term Delivers (37+ Wks)	Premature Deliveries (20-36 Wks)	Abortions Induced	Miscarriages (<20 Wks)	Ectopic Pregnancies	Multiple Births	Living Children

Previous Pregnancy Details							
Date of Delivery	Weeks Gestation	Type of Delivery	Place of Delivery	Birth Weight	Sex M/F	Preterm Labor?	Comments, Complications, Outcomes

Other information, history, or concerns you would like your provider to know: