Today's Date _____

## Patient Information

Last Name _____
First Name _____
First Name Used _____
Middle Name _____
Former Last Name _____
Legal Sex _____
Gender Identity ☐ Male ☐ Female ☐ Transgender FTM ☐ Transgender MTF ☐ Gender non-conforming ☐ Choose not to disclose ☐ Other, Please specify:_____
Assigned Sex at Birth ☐ Male ☐ Female ☐ Choose not to disclose ☐ Unknown
Preferred Pronouns ☐ he/him ☐ she/her ☐ they/them
DOB _____
Address _____
Address 2 _____
City _____
State _____
Zip _____
Home phone _____
Mobile phone _____
Work phone _____
Contact preference HOME MOBILE WORK
May we text you? YES NO
Email (required) _____
Preferred Pharmacy _____

_____

_____

Preferred Lab _____
Preferred Radiology _____
Primary Care Physician _____

Marital Status _____
Homebound YES NO
Language _____
Race _____
Ethnicity _____

## 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 _____

How did you hear about us?
☐ Referred by Friend or Relative:_____
☐ Referred by Another Doctor:_____
☐ Privia Provider Online Directory
☐ Insurance company
☐ Advertisement
☐ Online Search
☐ Other, Please specify:_____



## 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 _____

## Guarantor Information

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

## Optional Information

Phone _____

**Patient Signature**: _____ **Date:** _____

**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)**

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 | ☐ | ☐ | |

## 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.**