THE COLORADO CENTER FOR
GYNECOLOGIC
ONCOLOGY™

NEW PATIENT PACKET

Thank you for choosing The Colorado Center for Gynecologic Oncology
Our office and staff look forward to caring for you.

Prior to your appointment:

- Please complete the attached New Patient paperwork.
- If you are unable to keep your appointment, please call our office to reschedule your visit.

The day of your appointment:

- There is additional paperwork for you to fill out once you arrive, so please be sure to arrive 20 minutes before your scheduled appointment to complete the registration process.
- Bring a current photo ID (such as a driver's license) and your insurance cards. If you do not have your insurance card, bring a legible copy. If you do not have a copy of your card, please contact your insurance carrier before your visit and bring proof of eligibility with you.
- Be prepared to pay any co-payment required by your insurance at your visit.

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PATIENT INFORMATION
Please Print

Last Name _____ **First Name** _____ **Middle Initial** _____

Date of Birth _____ **Social Security Number**_____

Ethnic Group: ❑ Hispanic ❑ Non-Hispanic ❑ Unknown

Address_____

City_____ **State**_____ **Zip Code**_____

Home Phone _____**Cell Phone** _____ **Work Phone** _____

Preferred Contact: □ Home Phone □ Cell Phone □ Work Phone Okay to leave a message? □ YES □ NO

Email _____

Policy Holder Information (if Different from Patient). If same as responsible, please check here ❑

Spouse_____ **Parent**_____ **Other**_____

Last Name _____ **First Name** _____ **Middle Initial** _____

Date of Birth _____ **Social Security Number**_____

Address_____

City_____ **State**_____ **Zip Code**_____

Telephone # _____

Emergency Contact (Parent / Guardian if patient is a minor)

Name _____ **Telephone #** _____ **Relationship** _____

If we are unable to speak directly with you, please list spouse, family members or friends with whom we can speak regarding your personal health information.

Name _____ **Telephone #** _____ **Relationship** _____

Name _____ **Telephone #** _____ **Relationship** _____

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to evaluation or treatment the assigned healthcare provider may deem necessary to the patient name above.

INSURANCE ASSIGNMENT

I hereby authorize my insurance benefits to be paid directly to Colorado Center for Gynecologic Oncology. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

FINANCIAL RESPONSIBILITY

It is my understanding that I will be financially responsible for all services provided to me by The Colorado Center for Gynecologic Oncology in the course of my treatment.

CONSENT TO RELEASE INFORMATION

The Colorado Center for Gynecologic Oncology has my consent to release to any of my treating physicians any medical records pertaining to my continued medical care. I have also consented to the release of my medical records to any insurance companies through which I am insured (or to the employer if the coverage is through a group insurance plan) necessary to process claims for services provided.

_____ Date_____

PATIENT SIGNATURE

FOR MEDICARE PATIENTS ONLY
MEDICARE PART B SIGNATURE AUTHORIZATION – LIFETIME

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

_____ Date_____

PATIENT SIGNATURE

PREFERRED PHARMACY NAME _____

PHONE NUMBER _____ CITY _____

MEDICATION AND SUPPLEMENTS: Please list all to the best of your knowledge

Name of medication	Dosage	When do you take it?	Who prescribed it?

ALLERGIES: Please list all allergies to medications and materials (i.e. latex, adhesive, etc.) and the type of reaction (for example, hives, rash, swelling of throat, vomiting, etc.)

Medication	Reaction

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MAIN REASON FOR YOUR VISIT: □ cancer □ pelvic mass □ vaginal bleeding □ vulvar issue

□ Fibroids □ abnormal PAP smear □ Other _____

_____

OBESTECTRICAL HISTORY: How many pregnancies have you had? _____

_____ Vaginal _____ C-Sections _____ Miscarriages _____ Abortions _____ Stillbirths

GYNECOLOGIC HISTORY: Date of last menstrual period _____ Age of first period _____

If not menstruating, stopped at age: _____ because of □ menopause □ uterus removed for _____

Date of last PAP smear: _____ □ Normal □ Abnormal

Have you ever had any abnormal PAP smear? □ Yes □ No Treatment: _____

Date of last colonoscopy: _____ □ Normal □ Abnormal □ Never

Date of last mammogram: _____ □ Normal □ Abnormal □ Never

MEDICAL PROBLEMS: Check any problem you have been diagnosed with or received treatment for

□ Anemia
□ Heart Attack
□ Heart Murmur
□ Congestive Heart Failure (CHF)
□ Angina
□ High Blood Pressure
□ Atrial Fibrillation
□ Asthma
□ Allergies/Hay Fever
□ Bronchitis
□ COPD
□ Diabetes
□ Thyroid condition
□ Bone Disease/Osteoporosis
□ Previous Cancer _____
□ Cirrhosis
□ Gallstones
□ Stomach ulcer
□ Hernia
□ Irritable Bowel Syndrome
□ Colitis
□ Chronic Diarrhea
□ Hemorrhoids
□ Arthritis
□ Back/neck/spine problems
□ Migraines
□ Seizures
□ Kidney failure
□ Blood clot in leg or lung
□ Bleeding disorder(von Willebrand)
□ Glaucoma
□ Skin disease _____
□ Depression
□ Anxiety
□ Bipolar
□ Schizophrenia
□ Dementia/Alzheimer's
□ Other _____
_____

DOCTORS: Please list doctors who are actively caring for you.

Specialty	Name	Phone
Gynecologist		
Primary Care		

SURGERY: Please list all previous surgeries

Year	Gyn/Breast Surgery (any surgery on ovary, uterus, cervix, D&C, LEEP, C-section)	Year	Orthopedic Surgery (knee, hip replacement, back or bone surgery)
Year	**Other Abdominal Surgery (colon, hernia, bowel, stomach, gallbladder)**	**Year**	**Heart Surgery (valve or bypass surgery, stents, pacemaker, defibrillator)**
Year	**Other Surgery (eye, lung, kidney, etc.)**		

SOCIAL HISTORY:

Do you smoke? □ Yes □ No Packs per day: ____ Number of years: _____ When did you quit? _____
Do you use alcohol? □ Yes □ No Amount per week? _____ Type: _____
Have you ever used drugs? □ Yes □ No □ Past □ Present What type? _____
Do you exercise routinely? □ Yes □ No How often per week? _____ What type? _____
Marital Status: □ Single □ Married □ Divorced □ Widowed □ Domestic Partner
Occupation: _____ □ Retired □ Disabled due to _____

SYSTEM REVIEW: Check any of the following symptoms that you have now

Constitutional Symptoms:	□ Fatigue □ Weight loss _____lbs □ Night sweats	□ Generalized Weakness □ Fever □ Hot Flashes	□ Altered Taste □ Chills
Pain:	Current pain score □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 Location:	Medication:	
Infectious Disease:	□ Frequent or Severe Infections		
Cardiovascular:	□ Chest Pain	□ Palpitations	□ Swelling
Respiratory:	□ Shortness of breath □ Cough	□ at rest	□ at exertion
Gastrointestinal:	□ Nausea □ Heartburn □ Constipation	□ Vomiting □ Abdominal Pain □ Blood in Stool	□ Difficulty Swallowing □ Diarrhea □ Dark Stool
Genitourinary:	□ Pain with urination □ Urgency	□ Urination during night □ Incontinence	□ Hesistancy □ Blood in urine
Gynecologic:	□ Abnormal Vaginal Bleeding □ Pelvic Pain	□ Vaginal Dryness □ Painful intercourse	□ Vaginal Discharge □ Bleeding after intercourse
Musculoskeletal:	□ Bone Pain □ Back Pain	□ Muscle Pain □ Joint Swelling	□ Joint Pain □ Limited range of motion
Skin:	□ Rash □ Dry Skin	□ Itching	□ Skin lesions
Neurological:	□ Headache □ Paralysis □ Speech Impairment	□ Neuropathy □ Tremor □ Dizziness	□ Focal Weakness □ Seizures
Psychiatric:	□ Nervousness □ Memory Loss	□ Stress □ Confusion	□ Depression □ Hallucinations
Endocrine:	□ Heat Intolerance	□ Cold Intolerance	□ Excessive Sweating
Breasts:	□ Breast Masses _____ location □ Tenderness	□ Nipple Discharge	

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Authorization to Release Medical Records/Information

_____ (patient name) request Medical Records from:

_____ (patient name) authorizes medical records to be sent to:

Name	Colorado Center for Gynecologic Oncology
Address	7780 S Braodway, Suite 300, Littleton, CO 80122
Telephone	303-955-7574

Expiration or revocation of authorization – I understand that I may revoke this authorization at any time.
Use of copies – A copy of this authorization may be utilized with the same effectiveness as an original.

Patient's name (print):

_____

Patient's signature:

_____

Date: _____

Person authorized to sign for patient: (print or type)

_____

Signature:

_____

Relationship to patient: _____

Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

The Colorado Center for Gynecologic Oncology

7780 S. Broadway St., Suite 300 Littleton, CO. 80122

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

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☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient