



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.



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

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

Fibroids abnormal PAP smear Other _____

OBSTETRICAL 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

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

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



Authorization to Release Medical Records/Information

_____ (patient name) request Medical Records from:

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

Name _____

Address _____

Telephone Number _____

Fax Number (If Known) _____

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):

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

Patient's signature:

Signature:

Relationship to patient: _____

Date: _____

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