Gyn Cancer & Pelvic Surgery LLC

Patient Information

Social Security #: Date of Birth: Age:

Last Name: First Name: M.I.: Maiden or Nickname:

Address: Apt #:

City: State: Zip:

Home Phone #: ( ) Work Phone #: ( ) Ext:

Cell Phone #: ( ) Email Address:

Can we call you at home? Yes / No (Please circle one) If no, call:

Marital Status: O Single O Married O Divorced O Widowed O Other

Race: Language(s) Spoken: Ethnicity:

Patient's Employer Information

Employer's Name: Patient's Occupation:

Address: If Student: O Full time O Part time

City: State: Zip:

Insurance Information Primary/Secondary/Other

Do you have health insurance? Yes / No (Please circle one)

Primary Insurance Company Name:

Who is the Primary Insurance Subscriber? O Self O Parent O Spouse O Other

Secondary Insurance Company Name:

Who is the Secondary Insurance Subscriber? O Self O Parent O Spouse O Other

Spouse's Information or Parent's Information (If Patient is Covered by Parent's Insurance)

Spouse's or Parent's Name Spouse or Parent's Date of Birth:

Spouse's or Parent's SS#: Employer's Phone #: ( )

Spouse's or Parent's Employer:

Spouse's or Parent's Employer's Address:

City: State: Zip:

Other

How did you hear about us?

Referring Physician: Phone #: ( )

Referring Physician's Address:

Primary Care Physician: Phone #: ( )

Primary Care Physician's Address:

Authorization for Payment

I authorize the release of medical information necessary to process the claims for medical benefits. I authorize and assign any payment of medical benefits to Gyn Cancer & Pelvic Surgery, LLC, its successors and assigns, or any individual it may designate for services provided.

I further agree to pay all costs of collection, including attorney's fees, associated with collection of any amount due to services rendered and performed, I will pay a ten dollar surcharge for every month a balance is due. I understand that I am financially responsible to Gyn Cancer & Pelvic Surgery, LLC, its successors and assigns and any individual it may designate for any balance not covered by insurance.

Signature of Patient or Parent of Minor Date

Authorization for Medicare

I request that payment of Authorized Medicare benefits be made either to me or on my behalf to Gyn Cancer & Pelvic Surgery, LLC for services furnished to me by the provider. 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.

Signature of Patient Date

Gyn Cancer & Pelvic Surgery LLC

Practice limited to Gynecologic Oncology, Reconstructive Pelvic Surgery and Consultative Gynecology

THAD R. DENEHY, M.D., FACOG, FACS
BOARD CERTIFIED IN GYN ONCOLOGY & OB/GYN

OFFICE FINANCIAL POLICY

All patients must complete our Patient Registration Sheet before seeing the doctor.

You are responsible for supplying our staff with your insurance identification cards. If you do not have the proper forms of identification, you must either reschedule or pay for services in full before seeing the doctor. Subsequently, if we are paid by your insurance or HMO, we will refund you the amount of overpayment.

It is your responsibility to understand which insurance plans your doctor participates with. If he does not participate with your plan, the bill is your responsibility and is due at the time of service. Your insurance policy is a contract between you and your insurance company. Our office is not part of that contract.

As to non-participating insurance companies, "usual and customary rates", our office is committed to providing the highest quality of treatment to our patients, and we charge what is usual and customary for our geographical area and specialty. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. There will be a $10 surcharge for every month a balance is due. There will be an administrative fee of $10 per form for completing all patient forms (disability, SSDI, FMLA, legal documents, etc.). Patients will be charged $25 for a missed appointment.

Thank you for understanding our Office Financial Policy. Please feel free to let our Billing Office know if you have any questions or concerns. I have read the above and agree to and understand its terms.

Signature of Patient _____ Date _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Gyn Cancer & Pelvic Surgery, LLC's Notice of Privacy Practices

Signature of Patient _____ Date _____

Atkins-Kent Building • 101 Old Short Hills Road, Suite 400 • West Orange, NJ 07052
973-243-9300 • Fax 973-325-8254

Gyn Cancer & Pelvic Surgery LLC

Practice limited to Gynecologic Oncology, Reconstructive Pelvic Surgery and Consultative Gynecology

THAD R. DENEHY, M.D., FACOG, FACS
BOARD CERTIFIED IN GYN ONCOLOGY & OB/GYN

CREDIT/DEBIT CARD CHARGE AUTHORIZATION

I hereby authorize GCPS (the "Practice") to charge my Credit Card whatever amounts are listed on each of "Outstanding Balance Due" bills which the Practice sends me for the health care services it provides to me at various times during the entire period that I am a patient of the Practice. This is a continuing authorization which shall remain in force and in effect until I deliver to the Practice a written, signed, and dated revocation of this authorization.

Your privacy is of the utmost importance to us. Accordingly, this information will be scanned into encrypted electronic files; this paper copy will be shredded immediately.

Type of card: _____

Name as it appears on card: _____

Account #: _____

Expiration date: _____

Three digit security code: _____

Zip code: _____

I certify that the information provided above is complete and correct.

_____ _____
Signature of Patient Date

_____ _____
Print Patient's Name Date of Birth

Atkins-Kent Building • 101 Old Short Hills Road, Suite 400 • West Orange, NJ 07052
973-243-9300 • Fax 973-325-8254

Gyn Cancer & Pelvic Surgery LLC

New Patient Medical Information Sheet

Please fill in information sheet completely and bring with you to your office visit.

Patient's Name: _____ Date of Birth: _____

Today's Date: _____ Reason for Visit: _____

Do you have any allergies to medications? O Yes (list below) O No Known Drug Allergies

_____

_____

_____

Do you take medications/vitamins on a regular basis? O Yes (list below) O No Daily Medications

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Past Medical History: O Yes (see list below) O No Past Medical Problems

O Diabetes	O Hepatitis/Liver Disease	O Osteoporosis
O Heart Disease	O Blood Clots in Veins or Lungs	O Glaucoma
O High Blood Pressure	O Thyroid Over/Under Active	O Emotional Disorders
O Kidney Disease	O Bladder Problems	O Pulmonary Disorders
O Arthritis	O Sexually Transmitted Diseases	O Other: _____

History of Previous Surgeries: O Yes (list below) O No Previous Surgeries

1. _____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

Please provide your pharmacy's name/address/phone number:

_____

Family Medical History: O Yes (see list below) O No Family Medical History

O Diabetes O Hypertension O Heart Disease O Kidney Disease O Cancer (see below)

Family History of Cancer(s): (Any Ovarian, Uterine, Breast, Colon, Stomach, Kidney, Brain)

Relative:_____ Age:_____ Type:_____

Relative:_____ Age:_____ Type:_____

Relative:_____ Age:_____ Type:_____

Social History:

Smoking: O Yes O No Amount:_____ Alcohol: O Yes O No How Often:_____

Recreational Drugs: O Yes O No Sexual Orientation:_____

Sexual Dysfunction:_____ Sexual Problems:_____

Cervical Cancer Risk Assessment:

Age of First Intercourse:_____ Number of Sexual Partners:_____

Sexually Transmitted Diseases:_____

Menstrual History:

Age of Onset of Menses:_____ Duration:_____ Amount:_____

Days Intervening:_____ Date of Last Menses:_____

Total # of Pregnancies:_____ # Deliveries:_____ # Vaginal:_____ # C/S:_____

Abortions/Miscarriages:_____ Menopause (Year):_____

Date of Last Mammogram:_____ Date of Last Pap Smear:_____

Weight:_____ Height:_____

Review of Systems: (fill in all that apply that have occurred in the last 48 hours or apply to your reason for this visit)

Gynecological:
O none

O heavy periods O hot flashes O abnormal vaginal discharge
O infertility O painful intercourse O frequent yeast infections
O pelvic pain O vaginal dryness O postmenopausal bleeding

Constitutional:
O none

O weight gain/loss O fever O night sweats O insomnia
O fatigue

Eyes:
O none

O glasses/contacts O blurred vision O tunnel or double vision
O unusual sensitivity to light O excessive tearing or dry eyes
O cataracts O floater spots O halos O flashing lights

ENT:
O none

O hearing loss O dizziness O earaches O hoarseness
O infection or discharge O nose bleeding O loss of smell
O sinus problems O excessive dryness/salivation
O ulceration/bleeding in mouth O difficulty swallowing

Cardiovascular:
O none

O palpitations O chest pain O pressure or tightness
O swelling of limbs O difficulty breathing O feeling of suffocation
O heart murmur O varicose veins O cold hands or feet

Respiratory:
O none

O coughs with/without mucus O spitting blood O night sweats
O shortness of breath O wheezing O pain with breathing
O SOB upon exertion How many pillows do you sleep on?_____

Gastrointestinal:
O none

O changes in appetite O heartburn O excessive belching/gas
O nausea O vomiting O vomiting blood O sour stomach
O belly pain O change in bowel habits O constipation
O diarrhea O rectal bleeding O itching O tarry or bloody stools

---

Genitourinary:
O none

O excretion of large amounts of urine O frequent urination at night
O pain or burning upon urination O blood in urine
O difficulty urinating O incontinence

Review of Systems (continued):

Musculoskeletal:
O none

O joint pain O stiffness O backache O sciatica
O pain in calves when walking O weakness O warm or hot joints

---

Integumentary/Breast:
O none

O rashes O lumps O itching O dryness O hives
O changes in skin O changes in nails O new moles
O changes in moles O breast lumps O breast tenderness
O nipple discharge or bleeding O breast swelling

Neurological:
O none

O dizziness O drowsiness O confusion O numbness
O tingling O tremors O weakness O paralysis O fainting
O blackouts O seizures O headaches

Psychiatric:
O none

O nervousness O tension O mood swings O depression
O phobias O fear/panic O anxiety O dementia

Endocrine:
O none

O sensitivity to cold/heat O excessive sweating O excessive thirst
O excessive hunger O excessive urination O hot flashes
O missed periods O dry skin O infertility

Hematological/Lymphatic:
O none

O bruise easily O transfusion reactions O bleeding gums
O nose bleeds O swollen or tender lymph nodes

Allergy:
O none

O hay fever O sneezing O hives O itching
O multiple colds O slow healing O allergies to foods
O allergies to plants O allergies to dyes O allergies to tape

Gyn Cancer & Pelvic Surgery LLC

Practice limited to Gynecologic Oncology, Reconstructive Pelvic Surgery and Consultative Gynecology

THAD R. DENEHY, M.D., FACOG, FACS
BOARD CERTIFIED IN GYN ONCOLOGY & OB/GYN

PATIENT CONFIDENTIALITY AGREEMENT

Patient Name:_____ DOB: _____

SS#: _____

I agree that GCPS may disclose certain portions of my health information to a relative, friend, and/or caregiver because such person is involved with my healthcare or payment relating to my healthcare. Please list below the person(s) with whom GCPS has the permission to discuss such information with, GCPS will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

☐ I WISH TO MAKE NO DESIGNATION AT THIS TIME

NAME:_____ ☐ DISCUSS/LEAVE MESSAGE

RELATIONSHIP:_____ ☐ DO NOT DISCUSS

PHONE:_____

NAME:_____ ☐ DISCUSS/LEAVE MESSAGE

RELATIONSHIP:_____ ☐ DO NOT DISCUSS

PHONE:_____

NAME:_____ ☐ DISCUSS/LEAVE MESSAGE

RELATIONSHIP:_____ ☐ DO NOT DISCUSS

PHONE:_____

Signature of Patient:_____ Date: _____