Patient Information

Please print clearly

Patient Name: ________________________ Date of Birth:___/___/___ Age _________

Address: _______________________ City __________ State______ Zip____________

Phone (____) __________ Cell (____)__________ Marital Status__________________

Employer_____________________ Address________________________________

City____________ State_________ Zip______ Occupation_______________________

Work Phone (___) __________ Ext ______ Social Security________________________

Spouse/Parent Name______________________________ Phone (___)______________

Address: _______________________ City _____________State______ Zip__________

Primary Care Physician (full name) ____

Phone: _______________________

How were you referred? ____

Reason for today's visit? ____

Primary Insurance_______________________ Name on Policy_____________________

Policy Holder Date of Birth___/___/___ Policy Holders Employer___________________

Relationship to patient____________ ID#_______________ Group#_______________

Claims address_____________________ City______________ State_____ Zip________

Insurance Phone # ____________Do you have a copay? Yes No Amount____________

Secondary Insurance_____________________ Name of Policy Holder_______________

Policy Holder Date of Birth___/___/___ Policy Holders Employer___________________

Relationship to patient____________ ID#_____________ Group#__________________

Claims address_____________________ City____________ State_________ Zip______

Insurance Phone # ____________Do you have a copay? Yes No Amount____________

Authorization to pay insurance benefits to physician: I hereby authorize payment directly to Barry M. Littlejohn, M.D., S.C.; OR TO RELEASE INFORMATION: I hereby authorize Barry M. Littlejohn, M.D.,S.C. to release all medical information needed to process my insurance claim. I agree that his office may release records pertaining to my treatments to my insurance company or third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I hereby agree to pay for services rendered to the above mentioned patient as and when charges are incurred. In the event of default, I agree to pay any collection agency fees and/or attorney fees as may be required to collect for service rendered by this office.

SIGNATURE OF PATIENT__________________________ Date:___________________
(or responsible party)

Barry M. Littlejohn, M.D., S.C. Financial Policy

Thank you for choosing Dr. Barry M. Littlejohn as your woman's health care provider. Please carefully read and initial by each statement and sign below. This policy has been put in place to ensure that financial payments due axe recovered to allow us to continue to provide quality medical care to our patients. 11 is important that we work together to ensure that payment for services is as simple and straightforward as possible.

1. _______I understand that if I do not have my insurance card or co pay, that my appointment may be rescheduled until such time that I can provide the required documents or payments.

2. _______ I understand that if my account is not paid in full within 90 days, a $25.00 collection processing fee will be added to the outstanding balance and will be turned over to our collection agency for processing, No additional appointments will be made for delinquent amounts until they're brought current.

3. _______ I understand a $25.00 service fee will be added for any checks returned for any reason. I will be responsible for payments of this fee and the amount of the return check. NSF checks must be paid with certified funds (money order, Visa. Mastercard or cash.)

4. _______ I understand that if I am unable to make a scheduled appointment I need to contact Dr. Barry Littlejohn's office at least 24 hours before my scheduled appointment. This helps us in scheduling appropriately others in need of urgent care in a timely fashion. A $25.00 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST A 24 HOUR ADVANCED NOTICE.

5. _______It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is my responsibility to notify Dr. Barry Littlejohn's office if there is a change in my insurance coverage, residence or phone number, ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.

6. _______I have read and I understand the above Financial Policy and I agree by its terms.

Patient Name:____
(Please print)

Responsible Party Signature:____________________________________

Date:__________________

BARRY M. LITTLEJOHN, M.D.

Name ____ Date ___________________

Date of Birth __________________________________ Age _____________

Please complete the patient and family history. Pertinent family members include mother, father, sisters, brothers, grandparents, aunts and uncles.

Please circle **YES** if you or a family member has been treated for:

	PATIENT	**FAMILY**
Cancer…………………………………………………………………	YES	YES
Anxiety or depression………………………………………………	YES	YES
Problems with sleep…………………………………………………	YES	YES
Weight loss or gain more than 20lbs…………………………	YES	YES
Seizures………………………………………………………………	YES	YES
Tuberculosis…………………………………………………………	YES	YES
Asthma…………………………………………………………………	YES	YES
Thyroid problems……………………………………………………	YES	YES
Blood clot……………………………………………………………	YES	YES
Anemia…………………………………………………………………	YES	YES
Migraines………………………………………………………………	YES	YES
High Blood Pressure…………………………………………………	YES	YES
High Cholesterol……………………………………………………	YES	YES
Hepatitis………………………………………………………………	YES	YES
Gallbladder disease…………………………………………………	YES	YES
Bowel disorder………………………………………………………	YES	YES
Kidney disease………………………………………………………	YES	YES
Frequent urinary tract infections………………………………	YES	YES
Vaginal infections……………………………………………………	YES	YES
Urinary incontinence………………………………………………	YES	YES
Breast disease…………………………………………………………	YES	YES
Liver disease…………………………………………………………	YES	YES
Osteoporosis…………………………………………………………	YES	YES
Blood transfusion……………………………………………………	YES	YES

If you answered yes to any of the above, please explain.

____
____
____
____
____

Please list any other medical condition you have been treated for or diagnosed with that was not listed on the previous page: ____

____

Do you have any allergies to medications? _____________ If so, what medications? _______
____

List **all** medications and dosages you are currently taking including birth control, hormones over the counter medications and vitamins:____
____
____

List all surgical operations you have had: ____
____
____

Who is your primary care physician? ____

Menstrual History: Age at 1st period_______ First date of your last period_________________
Days between 1st day of period and next period_____ Duration of period ______days
Have you had a hysterectomy? ____________

How many times have you been pregnant? ______ Live births _______ miscarriages_______
ectopic pregnancies _______

Last pap smear ___________________ Were the results normal? ___________
Last mammogram ________________ Were the results normal? ____________

Do you smoke? __________ If so, how many per day? __________
Do you drink alcohol? _________ How often?___________
Do you drink caffeine? _________How much per day? ___________

Please list any additional concerns you would like to discuss at your visit today:
____
____
____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my *Protected Health Information (PHI).* I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been given an opportunity to receive and read a copy of this office's *Notice of Privacy Practices,* I understand that this that this office's *Notice of Privacy Practices* contains a more complete description of the uses and disclosure's of my *Protected Health Information (PHI).* I understand this organization has the right to chance its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address listed above to obtain a copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that this office restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand this office is not required to agree to my requested restrictions, but if they do agree then you are bound to abide by such restrictions.

Patient Name: ____

Relationship to Patient: ____

Signature: ____

Date: ____