Thompson GYN, LLC
DR. DENISE THOMPSON
Board Certified Gynecologist
thompsongyn.com
Comprehensive and Compassionate Care for Women
765-274-5100
Fax: 765-274-5103
2705 Enterprise Drive, suite 267
Anderson, IN 46013

New Patient Paperwork

Today's Date: _____

Name:_____ Date of Birth: _____

Occupation: _____

Please indicate each of your chronic medical problems by marking the appropriate box below:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Anemia
- ☐ Diabetes
- ☐ Asthma
- ☐ Arthritis
- ☐ Heart Disease
- ☐ Lung Disease
- ☐ Stroke
- ☐ Migraine headaches
- ☐ Thyroid Problems
- ☐ Kidney Problems
- ☐ Cancer: type_____
- ☐ Blood Clots
- ☐ Osteoporosis
- ☐ PCOS-Insulin Resistance
- ☐ Abnormal Pap Smear
- ☐ Endometriosis

Please list any other medical conditions: _____
_____
_____

Allergies: **(Medications, Latex and Type of reaction).**
_____
_____
_____

Current Medications: **(Please list all prescribed and over the counter with dose and frequency).**
_____
_____
_____
_____
_____

Surgical History: **Please list all surgeries- month, year and where they were performed:**
_____
_____
_____
_____
_____

Are you under the care of any other doctors for any medical problems? Y or N

If so, whom and for what medical problems?_____

Who is your Family Doctor? _____

Pharmacy preference: _____

Menstrual History:

Date of last menstrual period: _____
Are cycles regular? Y or N
Are cycles painful? Y or N

Age of first period: _____
Number of days of flow: _____

Are you menopausal? Y or N
Age at menopause: _____

Sexual History:

Are you currently sexually active? Y or N
Number of LIfetime partners? _____
Age at first intercourse? _____
Partners: Male Female Both

History of STI? **(Please circle all that apply.)**

Chlamydia Gonorrhea HPV Herpes Syphilis Trichomonas

Pregnancy History:

# of Pregnancies _____ # of Deliveries _____ # of Miscarriages _____ # of Abortions_____
# of Live Births _____

Please list all pregnancies: (Include day/year, Vaginal/C-section, Gender, Weight, Complications.)

_____
_____
_____

Birth Control:

Are you currently using birth control? Y or N
If Yes, what method are you using?_____ Do you want to continue this method? Y or N

Marital Status:

Single: _____
Divorced: _____
Married: (Spouses name) _____
Widowed: _____

Have you ever been a victim of abuse? _____

Do you have a safe place to live? Y or N

Date of last:

Pap smear: _____ Mammogram: _____
Bone Density Scan: _____ Colonoscopy/Cologuard: _____

Social History:

Tobacco: ____ Yes ____ No ____ Former
Packs per day:_____ # of years:_____ Year quit:_____
Alcohol: ____ Yes ____ No ____ Former Number of drinks per week:_____ Year quit:____
Illegal drug use: ___Yes ___No ____ Former Type of drug: _____
Exercise: ____ Yes ____ No If yes, Type:_____ Times per week: _____
Caffeine intake: None Occasional Moderate

Family History:

If any blood relative has suffered from the following conditions, check the box and indicate which relative. M=Mother, F=Father, MGM=Maternal Grandmother, MGF=Maternal Grandfather, PGM=Paternal Grandmother, PGF=Paternal Grandfather, S=Sister, B=Brother, C=Child, A=Aunt, U=Uncle

☐ High Blood Pressure	M / F / MGM / MGF / PGM / PGF / S / B / C / A / U
☐ Asthma	M / F / MGM / MGF / PGM / PGF / S / B / C / A / U
☐ Arthritis	M / F / MGM / MGF / PGM / PGF / S / B / C / A / U
☐ Heart Disease	M / F / MGM / MGF / PGM / PGF / S / B / C / A / U
☐ Lung Disease	M / F / MGM / MGF / PGM / PGF / S / B / C / A / U
☐ Diabetes	M / F / MGM / MGF / PGM / PGF / S / B / C / A / U
☐ Kidney Problems	M / F / MGM / MGF / PGM / PGF / S / B / C / A / U
☐ Stroke	M / F / MGM / MGF / PGM / PGF / S / B / C / A / U
☐ Anemia	M / F / MGM / MGF / PGM / PGF / S / B / C / A / U
☐ High Cholesterol	M / F / MGM / MGF / PGM / PGF / S / B / C / A / U
☐ Thyroid Problems	M / F / MGM / MGF / PGM / PGF / S / B / C / A / U
☐ Cancer-type_____	M / F / MGM / MGF / PGM / PGF / S / B / C / A / U

Any other pertinent information we should know about you or you want to address in your visit?

_____
_____
_____
_____
_____

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Consent to Treat & Financial Agreement

I, _____ (printed patient name) give permission for Thompson GYN to give me medical treatment.

☐ I acknowledge that Thompson GYN may bill my insurance company for services provided to me.

☐ I agree to pay for services that are not covered or covered charges not paid in full including but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.

☐ I understand that Thompson GYN has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Thompson, GYN, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

☐ I certify that any information I provide, if any, in applying for payment under "Medicare", "Medicaid" or other insurances of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Thompson GYN by the Medicare, Medicaid, or other insurance programs.

☐ I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Printed Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Patient Representative Printed Name: _____

Patient Representative Signature: _____

Relationship to Patient:

☐ Spouse ☐ Healthcare Power of Attorney ☐ Guarantor
☐ Legal Guardian ☐ Parent ☐ Other _____

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HIPAA Disclosure Form:

This acknowledgement of notice and consent authorizes Thompson GYN to use health information about you for treatment, payment, and health care purposes. You may review our current notice prior to signing this acknowledgement and consent.

If you would like to receive a personal copy of the Privacy Notice, we can print the notice at the time of your appointment.

I hereby acknowledge that I have been offered to receive a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the reception area.

Printed Patient Name: _____

Date of Birth: _____

Patient Signature: _____

Date: _____

Patient Signature (if Patient is under age 18):_____

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REQUEST FOR HEALTH INFORMATION FROM ANOTHER FACILITY/OFFICE

Requesting medical records from the following facility/office:

_____

Fax: _____ Phone: _____

Medical records will be released to:

Thompson GYN
2705 Enterprise Drive
Suite 250
Anderson, IN 46013
Phone: 765-274-5100 Fax: 765-274-5103

Patient Information:

Patient Name (Please Print):

_____

Patient Address:_____
Date of Birth: _____
Last 4 of Social Security # _____
Telephone: _____
Covering the period(s) of treatment:_____

PURPOSE OF DISCLOSURE: **CONTINUITY OF CARE**

INFORMATION BEING REQUESTED:_____

We are requesting this information for the continuity of care for the patient listed above. This request is in compliance with 45 CFR 164.506 of the Health Insurance Portability and Accountability Act (HIPAA) which allows the release of information without explicit patient consent for treatment purposes.

SIGNATURE OF PATIENT: _____
DATE/TIME: _____