4605 Country Club Road, Winston-Salem, NC 27104
(336) 768-3632 FAX (336) 768-4473

Please fill out these forms completely before arriving for your appointment and bring them with you to your appointment.

Failure to fill the forms out completely will result in a longer wait time, and your appointment may need to be completely rescheduled.

Thank you for your cooperation.

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ACKNOWLEDGEMENT — NOTICE OF PRIVACY PRACTICES

I have been given an opportunity to read Hawthorne Obstetrics & Gynecology *Notice of Privacy Practices.* I have been given a copy if I requested one.

Patient (print name) ______________________________

Patient (signature) ______________________________

Date ______________________________

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Patient Information Sheet

Name:____________________________ Date of Birth:___________ Date of scheduled visit: ___________

***The following questionnaire allows our office to update your medical record. Please fill this form out and bring it with you to your appointment.**

Chief complaint or reason for your visit:

____

- List of Current medications you are taking. Include any over the counter medications/supplements: **Include dosages.**

List any allergies to medications, foods or latex. Include reaction to each.

- List any surgeries that you have had, including dates:

Family History: List any major family health disease, (include cancers, diabetes, heart disease, thyroid problems, respiratory, Breast cancer, Ovarian cancer, Colon cancer, Uterine cancer, etc).

Mother: ____

Father: ____

Brother(s): ____

Sister(s): ____

Maternal Grandmother: ____

Maternal Grandfather: ____

Paternal Grandmother: ____

Paternal Grandfather: ____

Other Family: ____

Social History: Please circle answer or fill in response

- Do you drink alcohol? None, Occasional, Moderate, Heavy
- How much caffeine do you. consume in a day? None, Occasional, Moderate, Heavy
- Do you take any illicit drugs (marijuana, cocaine, etc.)? None, Occasional, Moderate, Heavy
  When did you last use drugs and what did you use? ___________________________
- Do you smoke?: Never smoked, Occasional smoker, Everyday smoker, Former smoker
- If you quit smoking, when did you quit? ___________________________

Obstetrical History:

As of today, how many times have you ever been pregnant? __________

Number of Miscarriages ______ Dates of Miscarriages __________, __________, __________

Number of abortions ______ Dates of abortions ______________, ______________

Number of Stillborns ______ Dates of deliveries ______________, ______________

Number of Live births ______ Dates of deliveries ______________, ______________,

______________, ______________, ______________, ______________

Medical History:

When was the first day of your last menstrual period? ___________________________

List any medical problems that you have (example: High blood pressure, depression, diabetes, thyroid issues, heart issues, etc.) ___________________________

____

*Who is your Primary Care Physician/phone number? ___________________________

*Have you ever had the Gardasil HPV (Human Papilloma Virus) vaccine? Yes or NO

*If yes, have you had all 3 injections? Yes or NO If no, how many did you get and when was the date of your last injection? ______________

*When was the date of your last:

Pap Smear ______________, was it normal Yes or NO Explain______________

Mammogram ______________, was it normal Yes or NO Explain______________

Colonoscopy ______________, was it normal Yes or NO Explain______________

Bone Density ______________, was it normal Yes or NO Explain______________

Pharmacy Information:

Name of your pharmacy ______________________ Phone: ______________

Address, City, State: ___________________________

Permission to Communicate with Family and Friends Form/Voicemail

So that we may serve you better, you have the option of providing us with a list of family and friends with whom we may discuss your health information. You are **not required** to provide a list or to sign this form.

By signing this form I give consent to Hawthorne Obstetrics & Gynecology to discuss health information with the people listed below who assist with my care. **If I do not want certain information discussed, I have listed it below.** I understand that sensitive information, like HIV and pregnancy test results, mental health or substance abuse will not be shared.

Name	Phone Number	Relationship
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________

Do not discuss information about ______________________________

☐	I give Hawthorne Obstetrics & Gynecology Permission to leave **Normal** Lab/Test results on my answering machine/voice mail.
☐	I **Do Not** give Hawthorne Obstetrics & Gynecology Permission to leave any Lab/Test results on my answering machine/voice mail.
☐	Allow release of information to the American Red Cross for communications with family members of the U.S. military, such as notifying service members of family illness or death, including verifying such illnesses for emergency leave requests. The following information may be provided: Physician Name, Diagnosis, Prognosis, Current Condition, Life Expectancy, and a recommendation for leave.

____

Patient/Patient Representative Signature Date/Time Print Name

EMAIL:

____

Date of Birth

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted ______________________________ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

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DATE ____________ CHART NUMBER ____________

PATIENT'S FULL NAME ____________
LAST NAME FIRST NAME MI

SEX _____ BIRTHDATE __________ SOC. SEC. NUMBER ____________

ADDRESS ____________

CITY STATE ZIP CODE

HOME PHONE ____________ CELL PHONE ____________ TEXT REMINDER ❑ Yes ❑ No

PATIENT'S EMPLOYER ____________ OCCUPATION ____________

MARITAL STATUS ________ SPOUSE'S FULL NAME ____________
LAST NAME FIRST NAME MI

SPOUSE'S EMPLOYER ____________ SPOUSE'S WORK PHONE ____________

PERSON RESPONSIBLE FOR THE BILL ____________
(IF DIFFERENT FROM PATIENT) LAST NAME FIRST NAME MI

EMERGENCY CONTACT/ RELATIONSHIP ____________ PHONE ____________

PRIMARY PHYSICIAN: ____________ PHARMACY & LOCATION: ____________

PLEASE BRING YOUR INSURANCE CARD WITH YOU TO YOUR APPOINTMENT SO THAT WE CAN COPY IT FOR OUR RECORDS.

PRIMARY INSURANCE COMPANY NAME: ____________

NAME OF THE INSURED ____________
LAST NAME FIRST NAME MI

INSURED'S SEX ________ INSURED'S DATE OF BIRTH ____________

INSURED'S SOCIAL SECURITY NUMBER ____________

INSURED'S PLACE OF EMPLOYMENT ____________

PATIENT'S RELATIONSHIP TO THE INSURED SELF SPOUSE CHILD OTHER
(CIRCLE ONE OF THE ABOVE)

SECONDARY INSURANCE COMPANY NAME: ____________

NAME OF THE INSURED ____________
LAST NAME FIRST NAME MI

INSURED'S SEX ________ INSURED'S DATE OF BIRTH ____________

INSURED'S SOCIAL SECURITY NUMBER ____________

INSURED'S PLACE OF EMPLOYMENT ____________

PATIENT'S RELATIONSHIP TO THE INSURED SELF SPOUSE CHILD OTHER
(CIRCLE ONE OF THE ABOVE)

ADDITIONAL INFORMATION MAY BE PLACED ON THE BACK OF THIS FORM

Dear Patient,

The staff at Hawthorne Obstetrics & Gynecology is trying to get a better sense of the overall diversity of our patient population so that we have a better understanding of our practice and patient needs. This confidential information is for quality monitoring purposes only and will never affect the quality of care you receive at Hawthorne Obstetrics & Gynecology. Thank You!

**Please note: Primary Language is required. If you choose not to answer Race or Ethnicity, please check "Prefer not to answer."

Your Name: ____

Today's Date: ________________________

Your Primary Language: ______________________________

Please place a check mark to the left of the option that applies to you:

Race:

____ American Indian or Alaska Native ____ Asian ____ Black or African American

____ More than one race ____ Native Hawaiian ____ Other Pacific Islander

____ White ____ Prefer not to answer

Ethnicity:

____ Hispanic or Latino ____ Not Hispanic or Latino ____ Prefer not to answer

If you are a new patient to our practice, how did you hear about us? ____________________________

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