UL Physicians

PATIENT INFORMATION FORM

Patient Information Name _____ Also Known As _____

SSN _____ Date of Birth _____ Sex ☐Male ☐Female

Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated Preferred Language _____

Special Needs ☐Adult Sitter/Guardian ☐Ambulates with Assistive Dev ☐Hearing Impaired ☐Sight Impaired ☐Multiple Birth ☐Speech Impaired ☐Wheelchair ☐Interpreter ☐Transportation Needs

Patient Race: Race – a human population considered distinct based on physical characteristics.	Ethnicity: Ethnicity a term which represents social groups with a shared history, sense of identity, geography and cultural roots which may occur despite racial difference.
☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander	☐ Hispanic or Latino ☐ Not Hispanic or Latino Religion _____

Home Address _____

City, St _____ County _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work/Other Phone _____

Employment Status _____ Email _____

Employer Name _____ Employer Phone Number _____

Employer Address _____

Employer City, St _____ Zip Code _____

Primary Physician _____ Primary Physician Phone _____

Referring Physician _____ Referring Physician Phone _____

Preferred Pharmacy _____ Pharmacy Phone _____

Pharmacy Address, City, St, Zip _____

Parent/Guardian(s) or Spouse Information Name _____

Relationship to Patient _____ SSN _____ Date of Birth _____

Address (If Different) _____ Zip Code _____

Employer _____ Employer Phone Number _____

Employer Address _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email _____

UofL Physicians

Patient Name: _____ Patient DOB_____2.

Emergency Contact (someone other than a parent and who does not live with the patient or a parent)

Name _____ Relationship _____ Phone _____

Parent/Guardian #2 Name_____

Relationship to Patient _____ SSN _____ Date of Birth _____

Address (If Different) _____ Zip Code_____

Employer _____ Employer Phone Number _____

Employer Address _____ Zip Code_____

Home Phone _____ Cell Phone _____ Email _____

Medical Insurance Info.	Primary Insurance	Secondary Insurance
Subscriber ID		
Group or Plan Number		
Plan/Program Code		
Insurance Co. Name		
Insurance Co. Phone Number		
Patient Relation to Subscriber		
Subscriber Name		
Subscriber Street Address		
Subscriber City and State		
Subscriber Zip Code		
Subscriber Date of Birth		
Subscriber Sex		
Subscriber Social Security #		
Subscriber Employer		
Co-pay Amount		

Injury Related Information ☐Work Related ☐Auto ☐Motorcycle ☐Other Date & Time of Injury _____

State Where Injury Occurred _____Contact Name _____ Phone _____

Claim # _____ Insurance Co. _____

Insurance Co. Address, City, St, Zip _____

_____ _____

Patient/Parent/Legal Guardian/Legal Authorized Representative Signature Date

If Parent/Legal Guardian/Legal Authorized Representative, Print Name _____

UofL Physicians

GENERAL CONSENT FORM

PATIENT NAME: _____ Date of Birth: _____

Payment. I authorize University of Louisville Physicians, Inc. (UofL Physicians) to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that UofL Physicians will direct payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. Patient Initials: _____

Consent for Treatment. I consent for UofL Physicians to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, as part of the care to be given a test may be performed for human immunodeficiency virus infection (HIV/AIDS), hepatitis, or other blood-borne infectious or communicable diseases if the doctor, APRN, or Physician Assistant orders the test for diagnostic purposes because of my/the patient's medical history, symptoms, or conditions. Patient Initials: _____

Electronic Prescription. I understand UofL Physicians utilizes electronic prescribing technology and participates with SureScripts. SureScripts operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient. Patient Initials: _____

Cell Phone Calls. As a service to our patients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

Involvement of Others in Care. I authorize UofL Physicians to provide and discuss my/the patient's care and medical needs with the following persons:

Name	Relationship	Phone

Patient Rights and Responsibilities

I acknowledge receipt of the Patient Rights and Responsibilities_____ Declined_____

Notice of Privacy Practices

I acknowledge receipt of the Notice of Privacy Practices_____ Declined_____

Minor Patient Photograph

I consent for UofL Physicians to photograph the patient for identification purposes only_____ Declined_____

_____ _____

Patient/Parent/Legal Guardian/Legal Authorized Representative Signature Date

If Parent/Legal Guardian/Legal Authorized Representative, Print Name _____

UofL Physicians
OB/GYN & WOMEN'S HEALTH

James Graham Brown Cancer Center
529 South Jackson Street
Louisville, KY 40202
(502) 561-7220

NAME: _____ DATE: _____

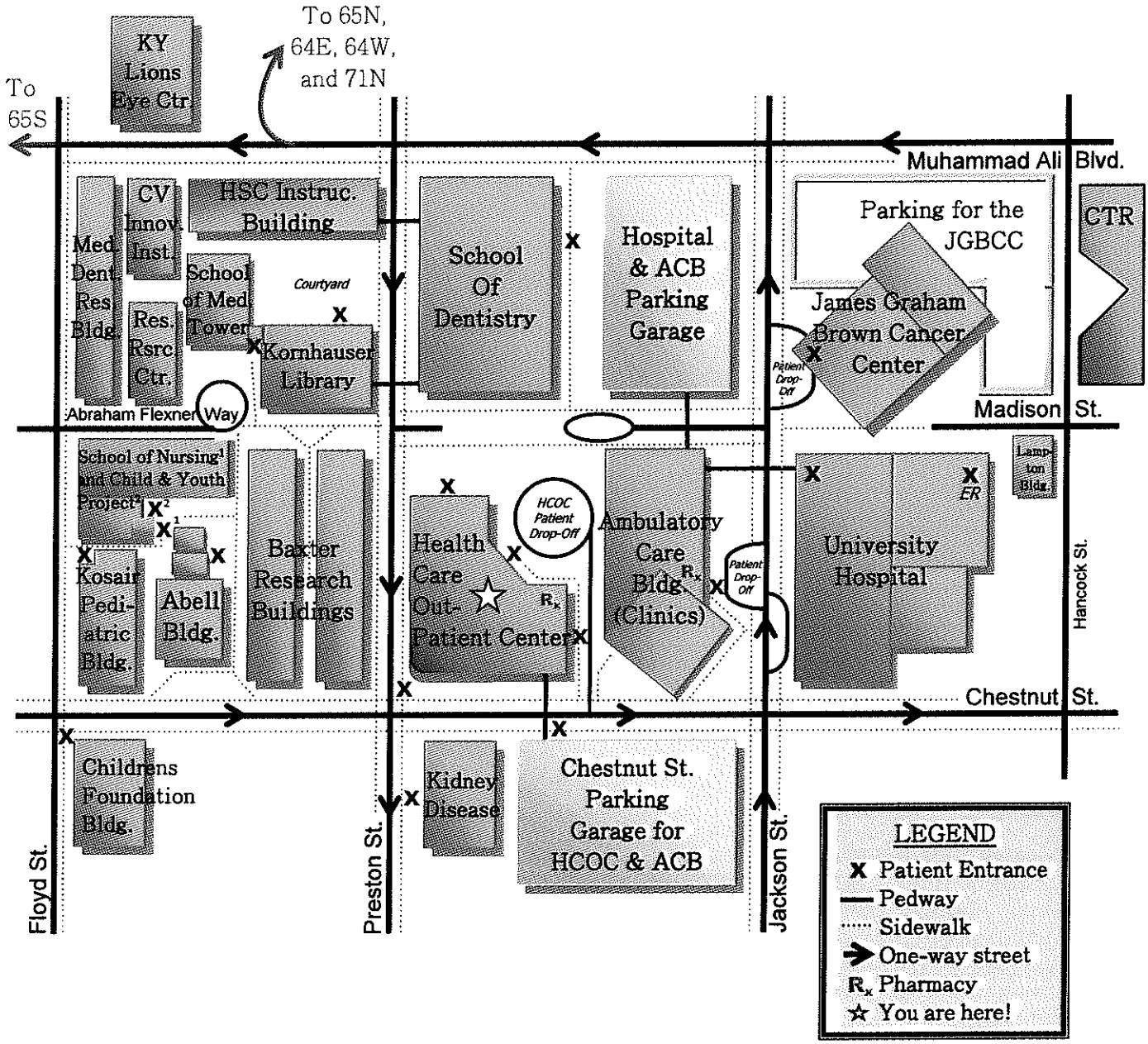
Who referred you to us? _____

1. Have you ever had a serious illness (diabetes, cancer, high blood pressure, etc.)?
2. If cancer, specify type and treatment received.

   _____
3. Any other illness or medical problems (kidney, colon, gall bladder, etc.)?
4. Have you ever had any surgery? If so, state what type of surgery, name of your doctor, date surgery performed and where. _____
5. Are there any serious illnesses that run in your immediate family? _____
6. Are you on any medication? _____
7. Are you allergic to any medication? _____
8. Do you use tobacco products? _____ What type? _____ How often? _____
9. Do you drink alcohol? _____ How often? _____
10. Do you use any drugs? _____How often? _____
11. Have you ever had a sexually transmitted disease? _____What type? _____
12. What contraceptives have you used in your lifetime? _____
13. How old were you when you first started your menstrual cycle? _____
14. How many days apart are your periods (every 28 days)? _____
15. How many days do your periods last? _____
16. How many pads or tampax do you use on your heaviest days? _____
17. Menstrual cycle cramping: _____Mild_____Moderate_____Severe_____
18. When was the first day of your last period? _____
19. How many times have you been pregnant? _____
20. How many living children do you have? _____
21. How old is your youngest child? _____ Oldest child? _____
22. Have you had a mammogram? _____If yes, when? _____
23. When was the date of your last pap smear and the name of your doctor?

    _____
24. What is the reason for your visit today?_____

UofL Medical Complex Map



UL Physicians

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OB/GYN & WOMEN'S HEALTH

James Graham Brown Cancer Center
529 South Jackson Street
Louisville, KY 40202
(502) 561-7220

On behalf of our physicians, nurses, and staff, welcome to UofL Physicians OB/GYN & Women's Health. We are located in the James Graham Brown Cancer Center located at 529 South Jackson Street, 3rd Floor, Gynecologic Oncology suite. Free parking is available in the Brown Cancer Center parking lot, or directly across the street in the UofL parking garage on South Jackson Street. We will validate your parking ticket for the UofL garage.

For your first visit to our office, please arrive at least 20 minutes prior to your scheduled appointment time. Please bring with you a current picture ID, Insurance Card and a list of all medications you are currently taking along with the following completed forms:

- Patient Information Form page 1 and 2
- General Consent Form
- Medical History Form

Completing all paperwork prior to your arrive enables us to begin your care quickly and better serve your medical needs. Please have your referring physician fax your medical records to (502) 588-9529 prior to your appointment date. If you have insurance coverage, you will need to present your insurance card(s) at the time of your appointment. If your coverage is through Passport, please obtain a referral prior to your visit from the physician assigned to you on your card. Co-pays and deductibles are also due at this time. If your insurance company required pre-authorization or a referral from your primary care physician, please obtain this prior to your appointment.

The team at UofL Physicians OB/GYN & Women's Health is dedicated to providing you with the best care available. If you have any questions or concerns prior to your visit, please do not hesitate to call us at (502) 561-7220. We look forward to meeting you.

UofL Physicians OB/GYN & Women's Health