Dr. Clayton Young

Patient Registration Information

Date Referring Provider

Last name First name Middle name

Date of birth Age Sex Marital Status

Social Security # Phone # Alternate #

Address

Email address Pharmacy name and phone #

Emergency Contact name and phone #

Employer name and phone #

Primary Insurance Information

Insurance plan name Phone #

Address for claims

ID # Group # Patient relationship to policy holder

Policy Holder Name Sex Date of birth Social Security #

Policy Holder Address Employer

Secondary Insurance Information

Insurance plan name Phone #

Address for claims

ID # Group # Patient relationship to policy holder

Policy Holder Name Sex Date of birth Social Security #

Policy Holder Address Employer

Patient Record of Disclosures

The HIPAA Privacy Act gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications, or that of a communication of their PHI is made by alternative means, such as sending correspondence to the individual's work place instead of their home. The private rule generally requires Health Care Providers to take reasonable steps to limit the use or disclosure of and request for health information to the minimum to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Health Care Entities must keep records of PHI Disclosures. Information provided below, if it is completed properly, will constitute an adequate record.

Note: Uses and Disclosures for treatment, payment and health care operations may be permitted without prior consent in an emergency.

Patient Name _____ Date of Birth _____

Mother's Maiden Name _____ (This will be used for identification when contacting our office for personal and/or treatment information)

I wish to be contacted in the following manner (check all that apply)

Home Telephone _____

- ○ OK to leave message with detailed information
- ○ Leave message with call back number only

Work Telephone _____

- ○ OK to leave message with detailed information
- ○ Leave message with call back number only

Written Communications:

- ○ OK to mail to my Work
- ○ OK to mail to my Home
- ○ OK to email information
- ○ OK to fax to _____

Spouse/Significant other: Name _____

- ○ OK to leave message with detailed information
- ○ Leave message with call back number only

PCP or Referring Physician:

- ○ **OK** to disclose Health Information to my PCP or Referring Physician
- ○ **NOT OK** to disclose Health Information to my PCP or Referring Physician

Please list anyone else and their relationship to you that we may discuss information to: ***(please note that anyone requesting information on your behalf will need to know your mother's maiden name for identification).***

_____ _____

_____ _____

Patient Signature _____ Date of birth _____ Date _____

Authorization for release/request of protected health information

I, _____ authorize Conroe Physician Associates, Dr. Young's office to:

_____release to: _____ receive from:

Person or Organization Address

Phone Fax #

Information/Copies of the medical records on:

Patient Name date of birth social security #

Information to be released

This information is being released for the following purposes:

_____Continue Care _____Attorney/Litigation _____Insurance _____Disability Services _____Other

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this information in writing by contacting your office at the address that was notified to me, attention privacy officer.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be reported to HIPAA.
- Copies of all records including, but not limited to, progress notes, lab, x-ray, and ultrasound reports, records of hospitalizations, operative and procedure reports, as well as other data pertinent to my medical history.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific, written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose. (FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2).

Signature of patient or legally authorized representative relationship

Print name of legally authorized representative

Patient or legally authorized representative drivers license/ID/SS#

Witness-printed name/signature

Date signed Date Released

Consent for STD/HPV Testing

STD testing can be performed by either blood draw or cultures taken from vaginal secretions. The most common STD testing is for:

- Herpes
- Hepatitis Panel
- RPR (screening for Syphilis)
- Chlamydia and Gonorrhea
- HIV

[ ] I have read the above information and **I DO** consent to **[ ] ALL** or **[ ] JUST THE CIRCLED** screenings listed above.

[ ] I have read the above information and **I DO NOT** consent to the screenings listed above.

The American Society for Colposcopy and Cervical Pathology has now recommended routine screening for **high-risk Human Papilloma Virus (HPV)** to be performed along with your pap smear.

A few important things to know about HPV and cervical cancer screening:

- Most women will have HPV at some point during their lives but very few will develop cervical cancer.
- Cervical cancer develops if an HPV infection persists for many years.
- Knowing your HP status helps you and your provider determine how often you should be screened.
- Early detection of pre-cancerous cell changes is the key to preventing cervical cancer.
- Your HPV status is not a reliable indicator of our and your partner's sexual behavior. HPV can lie dormant in cervical cells for many years becoming an active infection.

[ ] I have read the above information and **AGREE** to have the HPV test performed with my pap smear. I also agree to pay for the HPV testing should my insurance carrier not cover the cost.

[ ] I have read the above information and **DO NOT** wish to have the HPV testing at this time.

Please note, these tests are considered screening tests and as such may not be covered by your insurance carrier. If you agree to have this testing performed, and any cost incurred due to insurance denial will become your responsibility.

Patient signature _____ Date _____

Witness signature _____

GYNECOLOGY INTAKE/MEDICAL HISTORY

Name Date of Birth Date of Visit

Please indicate (X) if any of the following applies to you NOW or in the PAST:

	CURRENT	PAST	NOTES
Constitutional			
• **Weight Gain**	_____	_____	
• **Weight Loss**	_____	_____	
• **Fatigue**	_____	_____	
Eyes			
• **Vision changes**	_____	_____	
• **Spots before eyes**	_____	_____	
• **Glaucoma/Cataracts**	_____	_____	
ENT/Mouth			
• **Ear Aches**	_____	_____	
• **Ringing in ears**	_____	_____	
• **Mouth sores**	_____	_____	
• **Sinus problems**	_____	_____	
• **Headaches**	_____	_____	
Cardiovascular			
• **Chest pains or pressure**	_____	_____	
• **Difficult/painful breathing**	_____	_____	
• **Difficult breathing with exertion**	_____	_____	
• **Heart trouble/attack**	_____	_____	
• **Heart palpitations**	_____	_____	
• **High blood pressure**	_____	_____	
• **Swelling in legs**	_____	_____	
Respiratory			
• **Wheezing**	_____	_____	
• **Shortness of breath**	_____	_____	
• **Spitting up blood**	_____	_____	
• **Cough**	_____	_____	
• **Chronic asthma**	_____	_____	
• **Pneumonia**	_____	_____	
• **Chronic lung disease**	_____	_____	
• **Tuberculosis**	_____	_____	
Gastrointestinal			
• **Diarrhea**	_____	_____	
• **Bloody stools**	_____	_____	
• **Constipation/gas**	_____	_____	
• **Stomach ulcers**	_____	_____	
• **Hepatitis/Jaundice**	_____	_____	
Genitourinary			
• **Blood in urine**	_____	_____	
• **Painful urination**	_____	_____	
• **Frequency or urgency**	_____	_____	
• **Incomplete emptying**	_____	_____	

• **Stress incontinence** • **Kidney infections/ stones** • **Abnormal periods** • **Abnormal pap smears** • **Painful intercourse** • **Venereal Disease**	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	
Musculoskeletal • **Muscle pain/weakness** • **Arthritis/joint pain** • **Fractures**	 _____ _____ _____	 _____ _____ _____	
Skin/Breast • **Pain/masses in breast** • **Breast discharge** • **Rash/ulcers**	 _____ _____ _____	 _____ _____ _____	
Neurological • **Dizziness/fainting** • **Seizures** • **Convulsions/epilepsy** • **Stroke** • **Numbness** • **Trouble walking**	 _____ _____ _____ _____ _____ _____	 _____ _____ _____ _____ _____ _____	
Psychiatric • **Depression/crying** • **Anxiety** • **Post-partum/depression**	 _____ _____ _____	 _____ _____ _____	
Endocrine • **Dry skin** • **Hot flashes** • **Abnormal thirst** • **Hypo/hyperthyroidism** • **diabetes**	 _____ _____ _____ _____ _____	 _____ _____ _____ _____ _____	
Hematologic/Lymphatic • **Unusual bruising/bleeding** • **Enlarged lymph nodes** • **Anemia** • **Blood transfusions**	 _____ _____ _____ _____	 _____ _____ _____ _____	
Allergic/Immunologic • **Drug/food allergies** • **Other allergies** • **HIV** • **Lupus/autoimmune disease**	 _____ _____ _____ _____	 _____ _____ _____ _____	
Cancer	_____	_____	

Operations/Hospitalizations

Reason	Date	Reason	Date

Obstetrical History

Births			
• Term_____	Date_____	Date_____	Number of Boys_____ Number of Girls_____
• Preterm_____	Date_____	Date_____	Number of Vaginal Deliveries_____ Number of Cesareans_____
	Date_____	Date_____	Number of Miscarriages_____ Number of Abortions_____

Obstetrical Complications

Injuries

Reason	Date	Reason	Date

Family History

Mother: Living_____ Deceased_____	**Cause_____**	**Age_____**
Father: Living_____ Deceased_____	**Cause_____**	**Age_____**
Siblings: Living_____ Deceased_____	**Cause_____**	**Age_____**

Illness	Relative
Diabetes: Yes_____ No_____	
Heart Disease: Yes_____ No_____	
High Cholesterol: Yes_____ No_____	
Hypertension: Yes_____ No_____	
Stroke: Yes_____ No_____	

Family History of Cancer

	You	Age	Siblings/ Children	Age	Maternal Side	Age	Paternal Side	Age
Breast								
Ovarian								
Bilateral Breast Cancer or Multiple Primaries								
Male Breast Cancer								
Are you Ashkenazi Jewish?								
Uterine (Endometrial) Cancer								
Colorectal Cancer								
Stomach, Kidney/Urinary tract, brain, or small bowel cancer								
10 or more colorectal polyps								
Other Cancers								

Social History

Tobacco Use: Yes_____ No_____	**Packs per day_____**	**Years Smoked_____**	**Quit?/When_____**
Alcohol Use: Yes_____ No_____	**Moderately_____**	**Daily Number of Drinks_____**	**Type Used_____**
Drug Use: Yes_____ No_____	**Type Used_____**	**Frequency_____**	**Quit?/When_____**
Domestic Violence: Yes_____ No_____			**Seat Belt Use: Yes_____ No_____**
Currently on a diet: Yes_____ No_____	**Regular Exercise Yes_____ No_____**		**Type:_____**

Patient Signature _____

Annual Review of History:

Date Reviewed_____ **Physician Signature_____**

Date Reviewed_____ **Physician Signature_____**

Date Reviewed_____ **Physician Signature_____**

Date Reviewed_____ **Physician Signature_____**

Date Reviewed_____ **Physician Signature_____**