Paul Wexler, M.D. (New Patient Medical Form)

Patient Name:____ Date of Birth____________

Referred By:_____________________________________
Home Address____
Phone (h)___________________ Phone (b)__________________ Phone (Cell)_____________

Why are you here today?____

Do you have any allergies/problems with medications? YES NO
If yes, please list____

Are you currently taking any medications? YES NO
If yes, please list____

Do you use birth control? YES NO If yes, what type?________________________

What was the first day of your last menstrual period?__________________

When was your last pap smear?____________ Was it normal? YES NO

Have you ever had a mammogram? YES NO If yes, when?______________

History of Present Illness____

FAMILY HISTORY

Is your mother alive? YES NO If yes, her age & general health?_______________________
If no, cause and age at death?____

Is your father alive? YES NO If yes, his age & general health?_______________________
If no, cause and age at death?____

Do you have brothers? YES NO If yes, their ages and general health_________________

Do you have sisters? YES NO If yes, their ages and general health_________________

HAVE ANY OF THE WOMEN IN YOUR FAMILY HAD?:

Breast cancer YES NO If yes, who?_______________________________________

Cancer of the Ovary YES NO If yes, who?_______________________________________

Cancer of the Uterus YES NO If yes, who?_______________________________________

Cancer of the Cervix YES NO If yes, who?_______________________________________

Other significant illnesses in your family____

MENSTRUAL & PREGNANCY HISTORY

Are you still having periods? YES NO If no, your age at least period?_________________
Are your periods usually regular? YES NO
How many days between 1st day of period and 1st day of the next period?____________
How many days do you bleed?_________ Are your periods painful? YES NO
Have you ever been pregnant? YES NO If yes, how many times?_____________
Do you have any living children? YES NO If yes, how many?____________
Have you had any miscarriages? YES NO If yes, how many?____________
Have you had any stillbirths? YES NO If yes, how many?____________
Have you had any elective terminations of pregnancy? YES NO If yes, how many?____________
Have you had any complications in pregnancy or delivery? YES NO
If yes, please explain____
____

PERSONAL HISTORY

Surgical history (list operations and dates):____
____
____

HAVE YOU EVER HAD THE FOLLOWING:

Inflammation of the veins (phlebitis)	YES	NO
Migraine headaches	YES	NO
Gonorrhea/syphilis/Chlamydia (circle those that apply)	YES	NO
Herpes	YES	NO
AIDS	YES	NO
Hepatitis A, B or C	YES	NO
Warts on the Genitals	YES	NO
Abnormal Pap Smears	YES	NO
Uterine Infection	YES	NO

Do you smoke? YES NO If yes, how many packs per day?_________
Do you drink alcohol? YES NO If yes, how many per day (please circle)

1 drink or less/week Less than 1 drink/day
1-2 drinks/day More than 2 drinks/day

Other history that you want us to be aware of_____________________________________
____
____
____

Comments____
____

Patient's Age________
Patient Name___________________________________Patient's DOB_________

Address City State Zip
Home Phone________________
Email:_____________________________________ Day Phone________________

*****INSURANCE INFORMATION*****

Primary Insurance Name______________________________ Phone____________
Address____
City State Zip
Group/Plan #______________ Group Employer___________________
Policy Holder's Name___________________________ Date of Birth ___________
Policy Holder's SSN___________________________

SSN of the Patient_______________________________

Insurance Release Form

Reason for Today's Exam (e.g. gyn exam, pap smear)___________________________________

***PLEASE READ & SIGN THE FOLLOWING RELEASE FORM**
(This is required by your insurance)

I hereby authorize **GENASSIST/Dr. Paul Wexler** to release to

____
(Insurance Company)

any information including the diagnosis and records on myself. I also authorize and request that this insurance company pay directly to the above provider of my services the amount due for my care.

We do not bill secondary insurance. If you want an insurance claim form in order to bill your secondary insurance please contact the billing office. If I choose to bill my own insurance company myself for this visit, a completed insurance claim form will be mailed to me.

I understand that if I am here for a checkup without a specific problem or diagnosis the insurance company may not pay for my visit today. I understand that if my insurance company requires me to have a referral for my visit and I do not have one, I will be responsible for all charges. A service charge will be applied a rate of 1.5% per month to balances greater than 90 days past due.

Even if I have insurance, I understand that I am responsible for the entire cost of today's exam and will be billed accordingly.

Please acknowledge that you were informed of this by signing below, and we will keep this in your medical record.

Signature_________________________________ Date___________

(Paul Wexler, M.D. 8101 E Belleview Ave Suite J Denver, CO 80237)

Privacy Policy Statement Notice
For Paul Wexler, M.D./GENASSIST, Inc.
(HIPAA 2002)

At GENASSIST, Inc./Paul Wexler, M.D.'s office, we understand that privacy is important to you and we are committed to protecting the confidentiality of your medical information. The trust and confidence of our patients has always been our goal and that is why we have always taken steps to respect and protect your privacy.

Restricted Disclosure of Information:

GENASSIST, Inc./Paul Wexler, M.D. does **NOT** reveal information about your medical history to parties outside our office unless:

- You request or authorize it in writing.
- The disclosure is required or permitted by law (e.g. subpoena, investigation of fraudulent activity to comply with federal, state, or local laws).

Under HIPAA enacted on 10/16/02, we are unable to discuss any medical issues with anyone other than the patient without the patient's written authorization ahead of time.

Employee Obligations Regarding Confidentiality

We restrict access to medical information about you to those employees who have a business reason to know such information in order to provide medical services to you. The employees at GENASSIST, Inc./Paul Wexler, M.D's office, have been educated on the importance of privacy and confidentiality and are required to conform to our Privacy Policy requirements.

Security Procedures

GENASSIST, Inc./Paul Wexler, M.D.'s office uses established security procedures that conform to federal standards. We maintain physical, electronic and procedural safeguards to protect your medical information. We test and audit these procedures to ensure their integrity.

***Please certify that you have read this and understand the Privacy Policy Statement by signing and dating below:**

____ ____________
Patient Name Date

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