TAMILA SELITSKY, OB-GYN P.C.
660 92nd Street, 1st Floor
Brooklyn, New York 11228
Phone: (718) 680-4800 Fax: (718) 680-2400

PATIENT INORMATION

Last Name: _____ First Name: _____ Middle Initial: ___
Date of Birth: SS#: Gender: Female

Marital Status (Circle): Married Single Married Divorced Widowed Other

Sexual Orientation (Circle): Straight/Heterosexual Lesbian/Homosexual Bisexual

Home Address_____ Apt#: _____

City: _____State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

E-mail Address: _____

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician: _____Referring Physician: _____

How did you hear about us: Media Family Member Physician Website Friend

RESPONSIBLE PARTY (GUARANTOR) INFORMATiON

Relationship to Patient: Self Spouse Parent Other

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____

Home Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____ Phone #: _____

EMERGENCY CONTACT INFORMATION

Last Name: _____ First Name: _____

Phone Number : (_____)_____-_____ Relationship _____

PHARMACY

Name:_____ Phone: _____

Address: _____

Signature: _____

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STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Patient Name: _____
DOB: _____/_____/_____

This is a statement of our financial policy. You understand that you are obligated to ensure that our fees are paid in full. We will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You agree that you will pay any deductible and co-payment or co-insurance as determined by your insurance plan. Those payments will be made according to your insurance company statement. You will receive an invoice from our office with the amount of the outstanding balance.

For your convenience you may provide us with your credit/debit card information and your outstanding balance will be charged immediately. The receipt will be delivered by mail or e-mail.

Credit Card Information is OPTIONAL

Credit Card: ___Visa ___MasterCard ___Discover

Card Number: _____

Expiration Date: _____

ACKNOWLEDGEMENT:

I have read and understand the financial policy described above. I agree to pay, promptly and in full, any amounts due to the provider, including co-payments, deductibles, and co-insurance as determined by my insurance company.

Patient Signature(required): _____

Date: _____/_____/_____

Authorized Representative Signature: _____
If the patient is a minor

Date: ____/_____/_____

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NO SHOW POLICY

You will be charged $50.00 cancellation fee, if you fail to give us a 24-hour notice of cancellation.

Patient Name: _____

We ask you to show consideration by notifying our office at least 24 hours in advance, if you are unable to keep an appointment. We would like to have an option to offer that appointment to another patient, who needs to see the doctor.

Insurance company policy allows physicians to charge patients for missed appointment.

Thank you for your cooperation,

Dr. Tamila Selitsky & Staff

Signature: _____

Date: _____/_____/_____

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HIPPA PERMISSION QUESTIONNAIRE

Date: ____/_____/_____

Patient Name: _____

It is the policy of ***Tamila Selitsky, OBGYN, PC*** to make confirmation phone calls to patients 1-2 days before their appointment. Due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), it is necessary for us to get your authorization on certain items. Please see below and mark accordingly.

If you **do not** authorize any communication with anyone, initial here_____

I, _____ authorize the Staff of ***Tamila Selitsky, OBGYN, PC*** to leave a message on my **answering machine** regarding:

My Appointment	No	Yes
My Medical Care	No	Yes
My Patient Account/Billing	No	Yes

I, _____, authorize the Staff of ***Tamila Selitsky, OBGYN, and PC*** **to speak with** and release information to the following individual(s) regarding:

Name	Relationship	Phone	Appointments	Medical Records	Account/Billing
_____			___No ____Yes	___ No ___Yes	___ No ___Yes
_____			___No ____Yes	___ No ___Yes	___ No ___Yes
_____			___No ____Yes	___ No ___Yes	___ No ___Yes

I authorize the Staff of ***Tamila Selitsky, OBGYN, PC*** to use my email for medical and financial purposes: ___ No ___Yes _____ (email)

I understand that is it the policy of ***Tamila Selitsky, OBGYN, PC*** to take photo ID of each patient for their Medical Chart. I understand this release will remain valid and in place until revoked by me in writing.

_____
Signature (required)

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MEDICAL HISTORY

Patient Name: _____

Reason for visit: Annual Problem _____

Allergies to medications: YES NO Latex Allergy: YES NO

If yes, to what medicine _____

Current Medication(s): _____

_____

_____

Last Menstrual Period: ___/___/___ Menopause: ___/___/___

Last Pap Smear: ___/___/___

Last Mammogram: ___/___/___

Last Bone Density: ___/___/___

# of Pregnancies: _____ # of Children: _____

# of Vaginal Deliveries: ____ Date: ___/___/___ Date: ___/___/___ Date: ___/___/___

# of C-sections deliveries: _____ Date: ___/___/___ Date: ___/___/___ Date: ___/___/___

# of Miscarriages: _____ # of Abortions: _____ # of Ectopic: _____

GYN HISTORY:

Are your periods regular, once a month? YES NO

At what age did your period start? _____

How many days does your cycle last? _____

Do you have excessive cramping with your periods? YES NO

Do you have bleeding in between your periods? YES NO

Do you have excessively heavy periods? YES NO

Do you want to do something about your heavy periods? YES NO

Do you have pain during intercourse? YES NO

Do you have leakage of urine? YES NO

Do you have an overactive bladder? YES NO

Do you have history of any of the following?

Fibroids? YES NO Ovarian Cysts? YES NO

Endometriosis? YES NO Breast Disease? YES NO

Have you ever been sexually active? YES NO Virgin: YES NO

Are you currently sexually active? YES NO

What is your method of contraception? None Condoms Pills Patch

IUD Depo-Provera Nuva-Ring Tubal Ligation

HAVE YOU EVER BEEN TREATED FOR?

Bacterial Vaginal Infection? YES NO

Trichomonas? YES NO

Genital Warts (HPV)? YES NO

Gonorrhea? YES NO

Chlamydia? YES NO

Syphillis? YES NO

Herpes? YES NO

Hepatitis? YES NO

HIV? YES NO

Have you ever had an Abnormal Pap Smear? YES NO If yes, when ____/____/____

What method of treatment did you have? Colposcopy LEEP

SURGICAL HISTORY:

			When:				When:
Hysterecomy?	YES	NO	____/____/____	Uterine Fibroid Removal?	YES	NO	____/____/____
Laparoscopy?	YES	NO	____/____/____	Uterine Ablation?	YES	NO	____/____/____
Hysteroscopy?	YES	NO	____/____/____	Ovarian Surgery?	YES	NO	____/____/____
Tubal Ligation?	YES	NO	____/____/____	Bladder/Prolapse?	YES	NO	____/____/____
Appendectomy?	YES	NO	____/____/____	Gall Bladder?	YES	NO	____/____/____
Breast?	YES	NO	____/____/____	Thyroidectomy?	YES	NO	____/____/____
Tonsillectomy?	YES	NO	____/____/____	Myomectomy?	YES	NO	____/____/____

YOUR MEDICAL HISTORY:

Hypertension:	YES	NO	Migraines:	YES	NO	Osteoporosis:	YES	NO
Diabetes:	YES	NO	Heartburn:	YES	NO	Cancer:	YES	NO
High Cholesterol:	YES	NO	Anemia:	YES	NO	Type:_____		
Heart Condition:	YES	NO	Seizures/Epilepsy:	YES	NO			
Stroke:	YES	NO	Bowel Problems:	YES	NO			
Thyroid Problem:	YES	NO	Anxiety:	YES	NO			
Asthma:	YES	NO	Depression:	YES	NO			
Kidney Stones:	YES	NO	Autoimmune Disease:	YES	NO	Type:_____		
Arthritis:	YES	NO	Hot Flashes:	YES	NO			
Breast Pain:	YES	NO	Breast Lump:	YES	NO			

FAMILY HISTORY:

Breast Cancer: YES NO Who:_____

Ovarian Cancer: YES NO Who:_____

Uterine Cancer: YES NO Who:_____

Colon Cancer: YES NO Who:_____

Heart Attack: YES NO Who:_____

Diabetes: YES NO Who:_____

Stroke: YES NO Who:_____

Hypertension: YES NO Who:_____

Osteoporosis: YES NO Who:_____

Blood Clots/DVT: YES NO Who:_____

High Cholesterol: YES NO Who:_____

Asthma: YES NO Who:_____

Thyroid Disease: YES NO Who:_____

Other: _____

SOCIAL HISTORY:

Do you smoke? YES NO

Do you drink Alcohol? YES NO Avg. # of drinks _____ # per week _____

Do you do recreational drugs? YES NO Type:_____

I have carefully reviewed the questionnaire and completed it to the best of my knowledge.

Patient Signature: _____ Date: ____/_____/_____