

Name: _____

Chart: _____

DOB: _____

Date: _____

Age: _____

Kips Bay Gynecology
150 East 32nd Street
New York, NY 10016
Tel (212) 545-5400

Medical History

Name _____ Age _____ Today's Date: _____
Address _____ Apt. _____ City _____ St. _____ Zip _____
Home Phone _____ Work Phone _____ ext. _____ Cell _____

Please leave a phone # where we can leave personal messages () _____

Date of Birth _____ SSN _____ Referred by _____

Occupation _____ Marital Status: M S D W Email Address: _____

Please provide a Pharmacy #: _____

GYNECOLOGIC HISTORY:

Last menstrual period _____

Previous menstrual period _____

Menstrual interval _____ days

Duration of flow _____ days

Age of first menstruation _____

Cramps with periods (yes) (no) _____

Present Contraception _____

Past Contraception _____

Last Pap Smear _____

Past abnormal Pap Smear? (yes) (no) _____

Last mammogram _____

Are you sexually active? _____

Sexual preference _____

Do you have sexual difficulties? _____

Have you ever been sexually abused? _____

PREGNANCY HISTORY:

Total pregnancies _____ Live term births _____ Abortions _____

Premature births _____ Miscarriages _____ Stillbirths _____

Ectopic pregnancies _____ Previous C-section _____

ALLERGIES: _____

MEDICATIONS/VITAMINS/HERBAL SUPPLEMENTS: _____

MEDICAL HISTORY:

- () Heart Disease
- () Diabetes
- () Kidney disease
- () Anemia
- () Hypertension
- () Genetic disease
- () Seizure disorder
- () Lung disease
- () Mental illness
- () Smoking
- () Drug use
- () Alcohol use () occasional () regular
- () No problems

FAMILY HISTORY:

- () Heart Disease
- () Diabetes
- () Kidney disease
- () Anemia
- () High Blood Pressure
- () Genetic disease
- () Seizure disorder
- () Cancer
- () Mental retardation
- () Mental illness
- () Multiple pregnancy
- () Infertility
- () Other _____

FAMILY HISTORY

- () Blood Clots/Stroke

Please list all surgeries: _____

Practitioner Signature: _____

Notification and Acknowledgment of Non-Cancellation and Lab Fees

If you have an appointment scheduled with Kips Bay Gynecology LLC you must give cancellation notification of at least twenty-four hours between 9:00 a.m. and 5:00 p.m. on a day when there are regular office hours. There will be a no show cancellation fee of \$50 billed to you.

Please be aware that we **DO NOT** bill you for laboratory services. We use the lab that your insurance company requires us to use. Please be advised that your insurance company may deduct a co-pay from the lab payment; therefore the lab may bill you directly for its co-payment. If you have any questions regarding your lab bills, please call the phone number on your lab bill.

Patient Signature: _____ Date: _____

Notice of Privacy Practices Policies

Kips Bay Gynecology LLC is committed to protecting the privacy of its patients. It is the intent of Kips Bay Gynecology LLC to comply with the Privacy Rule promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and applicable New York State Law.

1. Kips Bay Gynecology LLC makes its Notice of Privacy Practices available upon request to any person.
2. Kips Bay Gynecology LLC provides the Notice of Privacy Practices Policies electronically or in person no later than the date of the first service delivery after April 14, 2004 [including service delivered electronically]
3. Kips Bay Gynecology LLC makes the Notice of Privacy Practices Policies available at its offices for the individuals to take with them upon request.
4. Kips Bay Gynecology LLC posts the Notice of Privacy Practices Policies in a clear prominent location where it is reasonable to expect individuals seeking service from Kips Bay Gynecology LLC to be able to read the Notice of Privacy Practices Policies. A copy is also available at www.kipsbaygyn.com

By signing below, I hereby acknowledge that the full privacy policy has been made available to me and will continue to be available upon request.

Patient Signature: _____ Date: _____