Karmel Women's Care
New Patient/ Annual Registration Information
(please read and complete all pages)

Name: _____ D.O.B: _____ Age: _____
Last First Middle

Address: _____ Apt # _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Employee/School: _____ Occupation: _____

Social Security: _____ Driver's License: _____

Emergency Contact Name: _____

Phone: _____ Relationship to the Patient: _____

Name of Primary Insurance: _____ Insurance Phone # _____

Group # _____ ID # _____

Subscriber/Policy Holder's Name: _____ D.O.B: _____

SSN: _____ Relationship to the Patient _____

Phone: _____ Employer: _____

Do you have secondary insurance coverage? ☐ Yes ☐ No

Primary Care Physician: _____

How did you hear about our office?

Pharmacy Name: _____ Zip Code: _____

Phone: _____ Fax: _____

Consent for Healthcare and Treatment:
I voluntarily consent to healthcare treatment from the physician and staff of Karmel Women's Care. I consent to any lab work (including HIV testing and drug testing), cultures, pathology, and medication administration that the physician(s) deem necessary. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of treatments of examination by my care gives

Name: _____ Date: _____

Signature: _____

Karmel Women's Care
Catherine Karmel, M.D

PATIENT E-MAIL AND TEXT MESSAGING REGISTRATION FORM

Due to the changing world of healthcare and technology, we now have the ability to provide our patients with certain types of information via e-mail and/or text messaging. If you wish to have the opportunity to receive information of this type, please complete the form below.

We believe strongly in protecting the privacy of our patients. When you provide this information to us, it is only used as a way to communicate with you. We do not share the names, e-mail addresses, and/or telephone number of patients with any other company, or with any other source.

Name:_____

E-Mail Address:_____

Cell Phone Number:_____

I hereby give you permission to send messages to me via email and/or text messaging as a means of communication regarding my healthcare.

Siganture:_____ Date:_____

Family Access

List the members of your family or personal care team with whom we may share your medical information with.

Name:_____ Relation to you:_____

Name:_____ Relation to you:_____

Name:_____ Relation to you:_____

Medication History

I give consent to download my medication history automatically for pharmacy benefit managers.

Signature:_____ Date:_____

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Catherine Karmel, M.D

PATIENT OUT-OF-NETWORK AGREEMENT

Name:_____

Date:_____

I _____ am aware that **Dr. Catherine Karmel** and **Karmel Women's Care** are an **Out of Network** provider for **all insurances**. I agree to be financially responsible for any services rendered by **Dr. Catherine Karmel** and **Karmel Women's Care** and I understand that payment is due at the time of service.

I understand that I may submit receipts for services to my insurance company and will be reimbursed according to my individual health insurance policy.

_____ _____
Patient Signature Date

_____ _____
Patient Signature Date

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Karmel Women's Care
Notice of Privacy Practices

Our office is required by law to maintain the privacy of your health information and to provide you with this notice. It describes how your health information can be used and disclosed and how you can access this information.

We will only use and share your health information for the purpose of providing treatment for you and your family or obtaining payment. Your health information will not be used for any other purpose unless we have asked for and been given your written permission.

We promise to use your health information within our office to provide you with the best possible care. This may include office procedures designed to optimize the coordination of the care between the doctors, the technicians, and office staff. In addition, we may share information with referring physicians, pharmacies, and other health care professionals providing your treatment. We may share information with a family member or friend who is involved in your medical care or payment for your care, provided that you agree to the disclosure, or we give you an opportunity to object to the disclosure.

Because we believe regular exams are crucial to maintaining your overall health, we will send out reminders when it's time to schedule an appointment. We may also contact you to follow up on your care and inform you of new treatments or services that may be of interest to you and your family. These communications are an important part of our commitment to provide the best care possible.

Under the new HIPPA (Health Insurance Portability and Accountability Act) laws, patients have certain rights related to your health information. You have the right to restrict the uses and disclosure of your information. You have the right to request that we only communicate with you privately. You have the right to read, review, and copy your information. If you would like a copy of the right to complain to our office or to the Secretary of Health and Human Services, or if you believe your privacy has been compromised by this office, please express your request or concerns to us in writing.

Other than the procedures stated above, or where required by Federal, state, or local law, we will not disclose your health information without your written authorization. You may revoke that authorization in writing at any time.

Acknowledgement of Privacy Practices

I acknowledge that I have read and understand the privacy practices of this office.

_____ _____

Signature **Date**

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Karmel Women's Care
Catherine Karmel, M.D

Patient Name:_____ Date:_____

Reasons for today's visit: _____

Review of Systems

Please circle any concerning symptoms you are **currently** experiencing:

Constitutional	Weight gain/Weight loss, Fever
Dermatology	Rash or Easy Bruising
Endocrinology	Excessive fatigue, Hair loss, Too hot or cold, Hot flashes, Night sweats
CV/Respiratory	Chest pain, Shortness of breath, Cough
Neurology/Psych	Headache, Depressed mood, Mental or physical abuse
Gynecology	Breast changes, Abnormal vaginal discharge, Vaginal dryness, Pain with intercourse, Heavy bleeding, Bleeding between periods, Postmenopausal bleeding, Missed periods
Urogynecology	Leakage of urine, Urinary frequency, Blood in urine, Pain with urination
Gastroenterology	Abdominal pain, Blood in stool, Constipation, Diarrhea, Nausea/Vomiting

Any other concerns or issues you'd like to discuss with the doctor? _____

_____

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Name:_____

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Gynecologic History

What age did you have your first period:_____

How many days are there from start of your period to the start of next period. _____ days

How long does your period last? _____ days Flow: ☐ Light ☐ Medium ☐ Heavy

Date of Last Period: _____ Are you sure of the date? ☐ Yes ☐ No

Any recent changes in your period? ☐ Yes ☐ No
If yes, please explain:_____

Any signs of menopause? ☐ Yes ☐ No
If yes, please explain:_____

Are you currently sexually active? ☐ Yes ☐ No

If no, have you ever had sex? ☐ Yes ☐ No Number of lifetime sexual partners ____

My sexual partners are ☐ Men ☐ Women ☐ Both

Do you need birth control? ☐ Yes ☐ No

Current method of birth control, if applicable_____

Have you had the HPV vaccine? ☐ Yes ☐ No
Are you up to date with other vaccines? ☐ Yes ☐ No

When was your last PAP smear? _____ Results _____

Have you ever had an abnormal PAP smear? ☐ Yes ☐ No
If yes, please explain:_____
_____

Which of the following tests have you done?

Mammogram? ☐ Yes ☐ No Results _____

Any previous abnormal mammograms or biopsies? ☐ Yes ☐ No

Bone Density? ☐ Yes ☐ No Results _____

Colonoscopy/Sigmoidoscopy? ☐ Yes ☐ No Results _____

Skin cancer check? ☐ Yes ☐ No Results _____

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Name:_____

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Ethnic Background

If you or your partner are in the following categories, please respond.

(Please circle)

Black/Indian	-	Have you and/or your partner had sickle cell anemia carrier testing?	Yes ☐ No ☐
Mediterranean	-	Have you and/or your partner had thalassemia carrier testing?	Yes ☐ No ☐
Jewish/Cajun	-	Have you and/or your partner had Tay-Sachs carrier testing?	Yes ☐ No ☐
Non-Hispanic white	-	Have you and/or your partner had cystic fibrosis testing?	Yes ☐ No ☐

OBSTERIC HISTORY					
	Number		Number		Number
Total Pregnancies		Premature (< 37 Weeks)		Living Children	
Full Term (37-42 Weeks)		Abortions		Miscarriages	

Please List Each Pregnancy Below:

NO.	Date	Weight	Sex	Weeks Pregnant	Complications	Type of Delivery (Vag/C-Sec.)
1.						
2.						
3.						
4.						
5.						

Social History

Do you Exercise? ☐ None ☐ Less than 3 times per week ☐ More than 3 times per week

Smoking/Vaping ☐ Yes ☐ No ☐ Previously

Packs per day: _____ Number of Years: _____ Stopped _____ Years ago

Alcohol ☐ Yes ☐ No ☐ Previously

Drinks per day: _____ Drinks per week: _____

Recreational Drugs ☐ Yes ☐ No ☐ Previously

Kind: _____ Frequency: _____

Do you feel safe at home? ☐ Yes ☐ No

With whom do you live? _____

Have you been abused or threatened by anyone? _____

School Completed ☐ Junior High ☐ High School ☐ College ☐ Graduate ☐ Other

Marital Status ☐ Single ☐ Engaged ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Name:_____

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Personal Past Medical History

Check if you have or have ever had:	**YES**		**YES**
Anemia		Heart Problems	
Anxiety		Hepatitis / Jaundice	
Arthritis / Joint Paint		Herpes / HSV	
Asthma		Condyloma / Genital Warts / HPV	
Autoimmune Disease		High Blood Pressure	
Blood Clots in legs or lungs		High Cholesterol	
Blood Transfusions		HIV / AIDS	
Bowel Problem		Kidney Infections / Urinary Tract Infection	
Breast Cancer		Kidney Stones	
Cancer (please specify)		Pneumonia	
Chlamydia		Osteoporosis / Osteopenia	
Chronic Lung Disease		Mood Disorder	
Depression		Stroke	
Diabetes (please specify)		Seizure	
Eating Disorder (please specify)		Syphilis	
Fractures		Tuberculosis – TB	
Gastrointestinal Problems (please specify)		Thyroid Disease (please specify)	
Glaucoma		Urinary Incontinence	
Gonorrhea / GC		Other:	

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Name:_____

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PLEASE LIST ANY OPERATIONS, HOSPITALIZATION, MAJOR INJURIES YOU HAVE HAD:			
Surgery/Hospitalization/ Reason	**Date**	**Surgery/Hospitalization/ Reason**	**Date**
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

PLEASE LIST THE MEDICATION THAT YOU ARE CURRENTLY TAKING:					
Drug Name	**Dosage**	**Physician**	**Drug Name**	**Dosage**	**Physician**
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		
ALLERGIES TO MEDICATIONS / SUBSTANCES (LATEX GLOVES, ETC?)		List:			

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Name: _____

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Family Medical History

CIRCLE AND CHECK IF YOUR BLOOD RELATIVES HAVE HAD:			
MAJOR ILLNESSES	**YES**	**NO**	**WHAT BLOOD RELATIVE?**
Alcohol/Drug Addiction			
Anemia			
Arthritis/Joint Pain			
Asthma			
Birth Defect			
Bowel Trouble/Ulcers			
Breast Cancer			
Other Cancer			
Chronic Lung Disease			
Depression/Anxiety/Mood Disorders			
Diabetes			
Glaucoma			
Heart Trouble/Murmur			
Hepatitis/Liver Disease			
High Blood Pressure			
High Cholesterol			
Kidney Infection/Stones			
Stroke			
Thyroid Disease			
Tuberculosis - TB			
Obesity			
Osteoporosis			
Other:			

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Name: _____

Date of Birth (MM/DD/YY): _____

Hereditary Cancer Risk Assessment Questionnaire – General Instructions

Please answer the following questions about your personal and family history to the best of your knowledge. This will help your provider understand if there could be patterns of hereditary cancer in your family. For personal history, enter the types of cancer you have had and your age at diagnosis. For family members who are blood relatives, enter the types of cancer they had and their approximate age at diagnosis. Family members include parents, siblings, children, uncles, aunts, grandparents, great-grandparents, grandchildren, great-grandchildren, great-uncles, great-aunts, nieces, nephews, or half-sibling.

Family History of Cancer

Type of Cancer	Personal / Family History	Personal – age at diagnosis	Parent/sibling/child - list age at diagnosis	Family members on mother's side – list sex and age at diagnosis	Family members on father's side – list sec and age at diagnosis
Example: Breast Cancer	☑ Yes ☐ No	40	Mom, F, 47 Sister, F, 55	Aunt, F, 50	Niece, F, 36
Breast	☐ Yes ☐ No				
Ovarian	☐ Yes ☐ No				
Prostate	☐ Yes ☐ No				
Pancreatic	☐ Yes ☐ No				
Colorectal	☐ Yes ☐ No				
Uterine	☐ Yes ☐ No				
Gastric	☐ Yes ☐ No				
Melanoma	☐ Yes ☐ No				
Other (please fill in):	☐ Yes ☐ No				
Other (please fill in):	☐ Yes ☐ No				

Please complete the following check all that apply:

☐ Personal or family history of cancer at age 50 or younger

☐ Personal or family history of ovarian or pancreatic cancer

☐ Personal or family history of one or more of the following conditions: Male Breast Cancer / Triple Negative Breast cancer / 10 or more colorectal polyps

☐ Two relatives with cancer on the same side of your family

☐ Ashkenazi Jewish descent

☐ You have had hereditary cancer genetic testing (if yes, please attach the report to the Empower Requisition Form)

☐ Family member that has had hereditary cancer genetic testing. If yes, list gene mutation found; if any _____

☐ Concerned about personal and/or family history of cancer

Signature

_____ _____ _____
Patient's Name **Patient Signature** **Date**

_____ _____ _____
Provider's Name **Provider's Signature** **Date**

For office use only

Patient offered hereditary cancer testing (check all that apply)

☐ Yes ☐ No ☐ Patient accepted ☐ Patient declined

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