DAVID J. PATTON, M.D., Inc.

PATIENT REGISTRATION

1 Patient Information

Name: _____ _____ _____
Last First Middle

Date of Birth: _____ Social Security #: _____

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

Home Address: _____
(Street and/or PO Box)

City: _____ State: _____ Zip: _____

Home Telephone: _____ Mobile Telephone: _____

Emergency Contact Name: _____ Emergency Contact Telephone: _____

Primary Care Physician: _____ **Preferred Pharmacy:** _____

2 Insurance

PRIMARY INSURANCE
(Must provide copy of insurance card)

Insurance Company Name: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____ Subscriber's Social Security #: _____

Subscriber's Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

SECONDARY INSURANCE
(if applicable)

Insurance Company Name: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____ Subscriber's Social Security #: _____

Subscriber's Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

3 Assignment of Benefits

I hereby assign all medical and/or surgical benefits: to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurances, and any other health plans, to DAVID J. PATTON, M.D., INC.
This assignment will remain in effect until revoked by me in writing.

I understand that I am financially responsible for any balance and/or co-pay not covered by my insurance carrier(s) for services rendered.

I hereby authorize the release of any medical information necessary to process a claim with my insurance carrier(s) in securing payment of benefits.

Sign Here _____ _____
Insured or Authorized Person's Signature **Date**

PLEASE TURN OVER

David J. Patton, M.D., Inc.
108 W. Washington St. West
Charleston, WV 25302

DAVID J. PATTON, M.D., Inc.

(304) 345-4525
Fax: (304) 345-4527

HUMAN PAPILLOMAVIRUS (HPV) & DRUG TESTING CONSENT FORM

In accordance with the recommendations from the American College of Obstetrics and Gynecologists (ACOG) our providers are offering every woman over the age of 30 the opportunity for HPV testing in addition to your PAP Smear.

The HPV test, when combined with the annual screening Pap Smear, significantly improves the sensitivity of determining abnormalities of the cervix for women age 30 and older. Cervical cancer is associated with persistent HPV infection. A negative HPV performed in conjunction with the annual Pap Smear rules out most high grade abnormalities of the cervix. A routine Pap Smear alone could miss both low and high grade lesions compared to the low false negative rate of the combined testing.

HPV testing may also be of benefit for the following patients under the age of 30 who have undergone procedure abnormalities of the cervix. It is current standard of care to send all abnormal Pap Smears for HPV testing, this is called reflex testing. Our providers currently do reflex testing if possible on abnormal Pap Smear tests.

While most major carriers cover the cost of the screening, ***our office is not responsible for knowing the exact benefits of your insurance plan.*** PLEASE NOTE THAT IF YOU HAVE A DEDUCTIBLE, THE COST OF THE TEST MAY BE APPLIED BY YOUR INSURANCE COMPANY, RESULTING IN AN OUT OF POCKET EXPENSE. If you have any questions regarding your insurance coverage, please contact them BEFORE you elect to have the HPV test done.

_____ **I am requesting my physician to perform HPV testing.** I understand that this may result in an out of pocket expense. I understand that David J. Patton, M.D., Inc. is NOT responsible for any costs incurred as a result of electing to have HPV testing performed.

_____ **I DECLINE HPV testing despite the recommendation by ACOG.** I understand that my physician will perform reflex HPV testing if appropriate.

Sign Here _____ **Patient or Authorized Person's Signature** _____ **Date**

I hereby knowingly and voluntarily authorize and consent to the collection and testing of specimens of my urine by David J. Patton, M.D., Inc. or its designated agent for the purpose of drug testing.

I acknowledge that I may be drug tested at any point during my visit with David J. Paton, M.D., Inc., a refusal to authorize the collection and testing of my urine, or a refusal to authorize the above disclosure of the test results will be treated as a positive drug test.

In addition, I hereby knowingly and voluntarily release the Company and its designated agent authorized to provide the screening and their respective officers, directors, employees an agents from any and all claims, damages, losses, liabilities, costs and expenses, including attorney fees, arising from or relating to such collection and testing and any disclosure of the results thereof, including without limitation, the disclosure of any inaccurate or incomplete results, to the fullest extent permitted by law.

I have read and understood the above Authorization & Consent in its entirety, and I agree that a copy of this document is as valid as the original.

Sign Here _____ **Patient or Authorized Person's Signature** _____ **Date**

DAVID J. PATTON, M.D., Inc.

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rules 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 a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I also understand and agree to have my **digital photo** identification taken as part of my electronic health records.

Authorization to discuss your medical information:

☐ Patient only **OR**

You may disclose my medical information to:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

I wish to be contacted in the following manner (fill out all that apply):

Home Telephone _____

☐ O.K. to leave message with detailed information

☐ Leave message with call-back number only

Work Telephone _____

☐ O.K. to leave message with detailed information

☐ Leave message with call-back number only

Written Communication

☐ O.K. to mail to my home address

☐ O.K. to mail to my work/office address

Other _____

Sign Here _____ **Patient or Authorized Person's Signature** _____ **Date**

_____ **Print Patient or Authorized Person's Name** _____ **Birthdate**

David J. Patton, M.D., Inc.
108 W. Washington St. West
Charleston, WV 25302

DAVID J. PATTON, M.D., Inc.

(304) 345-4525
Fax: (304) 345-4527

PERMISSION FOR RELEASE OF INFORMATION

Patient's Name: _____
Last First Middle Maiden/Other

Date of Birth: _____ **Social Security No.:** _____ **Phone:** _____

Address: _____
Street City State/Zip

Authorize David Patton, M.D. to OBTAIN INFORMATION FROM:

_____
Name of Provider/Facility

_____
Address

_____
City, State, Zip

_____
Phone Fax

Authorize David Patton, M.D. to RELEASE INFORMATION TO:

_____
Name of Provider/Facility

_____
Address

_____
City, State, Zip

_____
Phone Fax

Dates From: _____ To: _____

Please initial all that apply:

_____ All Records
_____ Obstetric Records _____ HIV/AIDS related info
_____ Lab Reports _____ Genetic testing info
_____ Shot Records Only _____ Dental X-rays
_____ STD/Communicable disease information
_____ Other _____

Information is being released for the following purpose(s):

Please check

☐ Changing Healthcare Provider
☐ School
☐ Specialists, Hospital Care, Nursing Home
☐ Other: (Must Specify) _____

I understand the following:

- This permission will expire 90 days after I have signed this form.
- I may cancel this permission at any time by contacting David Patton, M.D., Inc. in writing.
- If I cancel my permission, David Patton, M.D. will no longer release my information. I understand that David Patton, M.D. may have released information before I canceled my permission.
- Any of my health information that was shared after I gave my permission and before I canceled it is no longer protected by Federal Privacy regulations.

ACKNOWLEDGEMENT: I have reviewed the contents of this permission. I understand the risks and benefits of sharing this information. By signing below, I agree with the statements made in this form and to the release of my protected health information.

PLEASE PRINT YOUR NAME HERE _____

Sign Here _____ _____
Patient/Legal Guardian/Authorized Person's Signature **Date**

HEREDITARY CANCER FAMILY HISTORY INFORMATION

Patient/Physician Information

Patient's name: _____ Date of birth: _____

Physician's name: _____ Date: _____

Instructions: Please indicate your family's history of cancer in the table below. Check Yes for the cancer(s) that apply to you and/or your blood relatives. Please list the relative, side of family, and age of diagnosis for each cancer type.

Blood relatives to consider: parents, children, siblings, half-siblings, aunts, uncles, cousins, nieces, nephews, and grandparents.

Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No

Patient/Family Cancer History

Please fill in as completely as possible

		Your Age at Diagnosis	Family Member	Side of the Family Mother's or Father's	Age at Diagnosis
Example - Breast	☑ Yes ☐ No	53	Mother Grandmother Aunt	 Mother's Father's	65 62 55
Breast (one breast)	☐ Yes ☐ No				
Breast (both breasts or multiple primary breast cancers)	☐ Yes ☐ No				
Was the breast cancer triple negative?	☐ Yes ☐ No ☐ Unknown		**Who:**		
Ovarian (Fallopian Tube, Peritoneal)	☐ Yes ☐ No				
Pancreatic	☐ Yes ☐ No				
Prostate	☐ Yes ☐ No				
Uterine (endometrial)	☐ Yes ☐ No				
Colorectal	☐ Yes ☐ No				
Stomach	☐ Yes ☐ No				
Other *Please specify:* *Examples of other cancers: melanoma, kidney/urinary tract, brain, or small bowel)*	☐ Yes ☐ No				

Have you or any of your family members had genetic testing for any hereditary risk of cancer? ☐ Yes ☐ No

If yes, please explain: _____

_____

Sign Here _____ _____

Patient/Legal Guardian/Authorized Person's Signature (Required) **Date**

For office use only

Patient appropriate for further risk assessment or genetic testing? ☐ Yes ☐ No

☐ Patient offered genetic testing? ☐ Accepted ☐ Declined

☐ Patient offered genetic counseling? ☐ Accepted ☐ Declined

Physician's signature: _____ **Date:** _____