Juneau
OBSTETRICS & GYNECOLOGY

Nell A. Wagoner, MD
Nicholas D. Newbury, DO
Deana Darnall, ANP

3268 Hospital Dr, Suite B
Juneau, AK 99801
P: (907) 586-1717
F: (907) 586-2677

Dear Valued Patient,

Thank you for taking the time to complete this packet prior to your appointment. We value your time and therefore want to be as efficient as possible with it. By filling out this paperwork prior to your appointment, you will allow us to expedite the check-in process. We kindly ask the following of you:

- Arrive 15 minutes prior to your scheduled appointment time.
- Allow a minimum 24 hours advanced notice if you are unable to make an appointment or need to reschedule *(we reserve the right to charge a $75 administrative fee if timely notice is not given).*
- Bring your most current insurance card(s) and photo ID with you.
- Notify the staff if there has been any change to your personal information including legal name, mailing address or phone number.
- Please let us know if there is something we can do better or if there is a service that you think would make your office visit a better experience. If you would like to make an anonymous recommendation or comment please send us a letter, ATTN: Dr. Newbury.

Thank you, and we look forward to working with you.

Regards,

The Juneau OB/Gyn team

Patient Demographic Information

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Name _____ Maiden/Previous Names _____

Contact Information

Home Phone ( ) _____ Cell Phone ( ) _____ Work Phone ( ) _____

Mailing Address _____ **Physical** Address _____

☐ *same as mailing*

_____ _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Personal Information

Social Security # _____ Birthdate _____ Marital Status: ☐ Single ☐ Married ☐ Sep. ☐ Div. ☐ Wid.

Employer _____ Occupation _____

Name of Spouse/Partner _____ Their Employer _____

Responsible Party (If different than above)

Name _____ Address _____

Phone ( ) _____ _____

Employer _____ Phone ( ) _____ City _____ State _____ Zip _____

Emergency Contact

Name _____ Phone ( ) _____

Relationship _____

Insurance

	Insurance #1	Insurance #2
Insurance Company		
Subscriber Name		
Subscriber SSN		
Subscriber Birthdate		
ID Number		
Group Number		

All private Insurance holders are responsible for calling their insurance company and knowing when second opinions and preauthorization for surgery and/or admission to the hospital is necessary. If payment is refused because of non-compliance with insurance requirements regarding these issues, the patient will be responsible for payment.

Release of Benefits and Information: I authorize my insurance benefits to be paid directly to the doctor. I understand that I am financially responsible for the charges that are not covered by insurance and agree to pay the balance due. I authorize the doctor or insurance company to release any information required for processing claims associated with the services rendered.

Patient Signature _____ Date _____

How did you hear about us? _____

Health History Questionnaire

Juneau OBSTETRICS & GYNECOLOGY

We ask that all new and established patients (if it has been several years since your last visit) fill this form out. Periodically your health history, that may not seem pertinent to your visit today, can change. It is important that we are aware of your total health picture. Also, if a family member has been diagnosed with a cancer or illness since your last visit, the care you are offered may change to reflect such information.

Preferred Contact Number:_____ May we leave a message with test results? ☐ Yes ☐ No

Name: _____ Age: _____ DOB: _____ Date: _____

Reason for today's visit: _____

Primary care doctor: _____

Gynecologic History

First day of last period _____ How many days between cycles? _____ Are they regular? ☐ Yes ☐ No

How many days do you bleed _____ **Flow**: Heavy / Moderate / light **Pain**: Mild / Moderate / Severe

Date of last mammogram _____ Was it normal? ☐ Yes ☐ No Age of 1st period: _____

Date of last pap smear _____ Was it normal? ☐ Yes ☐ No

Birth control method _____ Comments: _____

Medicare Risk Screening Questions

Have you ever been treated for ☐ Vaginosis ☐ Trichomonas ☐ Genital Warts ☐ Gonorrhea ☐ Chlamydia ☐ Syphilis

	YES	NO	
Have you ever had an abnormal pap smear?	☐	☐	If yes, when _____
Were you sexually active before the age of 16?	☐	☐	
Have you had more than 5 sexual partners in your life time?	☐	☐	
Have you ever tested positive for HIV?	☐	☐	
Did your mother take the medication DES when she was pregnant with you?	☐	☐	

Pregnancy History

Total number of pregnancies _____ Number of vaginal deliveries _____ Number of miscarriages _____

Number living children _____ Number of cesarean sections _____ Number of terminations _____

Review of Symptoms by System (leave blank if answer is no)

	Current	Past	Notes
1. Constitutional			
Weight loss	☐	☐	
Weight gain	☐	☐	
Fever	☐	☐	
Fatigue	☐	☐	
2. Eyes			
Double vision	☐	☐	
Spots in vision	☐	☐	
Vision changes	☐	☐	
3. Ears, Nose, Throat			
Hearing loss	☐	☐	
Ringing in ears	☐	☐	
Sinus problems	☐	☐	
Mouth soars	☐	☐	
4. Cardiovascular			
Painful breathing	☐	☐	
Chest pain	☐	☐	
Heart palpitations	☐	☐	
Leg swelling	☐	☐	
5. Respiratory			
Wheezing/short of breath	☐	☐	
Chronic cough	☐	☐	
6. Musculoskeletal			
Numbness or weakness	☐	☐	
7. Psychiatric			
Depression/anxiety	☐	☐	

	Current	Past	Notes
8. Gastrointestinal			
Diarrhea	☐	☐	
Constipation	☐	☐	
Bloody stool	☐	☐	
Nausea/vomiting	☐	☐	
9. Genitourinary			
Blood/pain with urination	☐	☐	
Urgency/frequency	☐	☐	
Incontinence	☐	☐	
Painful intercourse	☐	☐	
10. Skin/Breast			
Breast pain/mass	☐	☐	
Nipple discharge	☐	☐	
Ulcers/ rash	☐	☐	
11. Neurologic			
Dizziness	☐	☐	
Seizures	☐	☐	
Trouble walking	☐	☐	
12. Endocrine			
Dry skin/hot flashes	☐	☐	
Abnormal thirst	☐	☐	
13. Hematologic			
Easy bruising	☐	☐	
Cuts that don't stop bleeding	☐	☐	
14. Immunologic			
Allergies	☐	☐	

(over)

Personal and Family Medical History (Presently treated for or in the past)

MAJOR ILLNESSES	SELF	FAMILY MEMBER:	MAJOR ILLNESSES	SELF	FAMILY MEMBER:	MAJOR ILLNESSES	SELF	FAMILY MEMBER:
Asthma	☐	☐	Cancer	☐	☐	Bowel disease	☐	☐
Pneumonia	☐	☐	Ulcers	☐	☐	Glaucoma	☐	☐
Lung disease	☐	☐	Depression/anxiety	☐	☐	Arthritis	☐	☐
Kidney disease	☐	☐	Anemia	☐	☐	Hepatitis	☐	☐
Tuberculosis	☐	☐	Seizures/epilepsy	☐	☐	Thyroid disease	☐	☐
Heart disease	☐	☐	Rheumatic fever	☐	☐	Blood clot/DVT	☐	☐
Diabetes	☐	☐	Stroke	☐	☐			
High blood pressure	☐	☐	Bleeding disorder	☐	☐			

List your other conditions:

Surgical History

Surgery	YES	NO	Date
Dilation and Curettage?	☐	☐	
Cervical cone, LEEP, Cryo?	☐	☐	
Endometrial Ablation?	☐	☐	

Other Surgeries (include date and hospital)

Medications (include dose)

Allergies (include reaction)

Hospitalization or Injury (include hospital and date)

Last Immunization/Test

Tetanus _____ Pneumonia _____ Colonoscopy _____

Flu Shot _____ TB Test _____

date date date

Social History

HABIT	YES	NO				
Smoking	☐	☐	Packs per day		Years:	
Alcohol	☐	☐	Drinks per day		Per week:	
Drug use	☐	☐	Type			
Regular Exercise	☐	☐	Type of exercise		Minutes/week:	
Seat Belt Use	☐	☐				

Marital Status Married ☐ Single ☐ Widowed ☐ Divorced ☐ # In household: _____

Education Level High School ☐ College ☐ Graduate School ☐ Other ☐ Occupation: _____

Personal Safety	YES	NO
Has anyone close to you ever threatened to hurt you?	☐	☐
Has anyone ever hit, kicked, choked, or hurt you physically?	☐	☐
Has anyone, including your partner, ever forced you to have sex?	☐	☐
Are you ever afraid of your partner?	☐	☐

Patient Signature: _____ Date: _____

Physician Signature: _____ Date reviewed with patient: _____

Annual Review History:

Date Reviewed: _____ Physician Signature: _____

Date Reviewed: _____ Physician Signature: _____

Date Reviewed: _____ Physician Signature: _____

Date Reviewed: _____ Physician Signature: _____

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Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: _____ Physician Name: _____

Date of Birth: _____ Today's Date _____

Instructions: This is a screening tool for the common features of hereditary cancer syndromes. If you circle Y (yes) for any statement below, you may be appropriate for hereditary cancer testing. When you circle Y, please provide the family member's relationship to you, the site of their cancer and their age when they were diagnosed with cancer.

1st Degree Relatives = Mother/Father/Sister/Brother/Children
2nd Degree Relatives = Aunt/Uncle/Grandparent/Niece/Nephew
3rd Degree Relatives = Cousin/Great Grandparent

Have you or any of your relatives been tested for hereditary cancer (HBOC/BRACAnalysis or Lynch/COLARIS)? YES NO

Have you ever been diagnosed with cancer? What site: What age:

		COLON AND UTERINE CANCER	SELF	FAMILY MEMBER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	**THREE (3)** relatives on the same side of the family with Uterine (Endometrial) and/or Colorectal cancer at any age				
Y	N	**TWO (2)** relatives on the same side of the family with Uterine (Endometrial) and/or Colorectal cancer under age 50				
Y	N	**ONE (1)** Uterine (Endometrial) and/or Colorectal cancer under age 50 in self				

		BREAST AND OVARIAN CANCER	SELF	FAMILY MEMBER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	ONE (1) Breast cancer at age 45 or younger (in self, first or second degree family members)				
Y	N	ONE (1) Ovarian cancer at any age (in self, first or second degree family members)				
Y	N	TWO (2) relatives on the same side of the family with breast cancer, one of whom was diagnosed at age 50 or younger (in self, first or second degree)				
Y	N	THREE (3) relatives on the same side of the family with breast and/or ovarian cancer at any age				
Y	N	ONE (1) Triple negative breast cancer age 60 or younger - receptor status negative for ER, PR and HER2 (in self, first or second degree family members)				
Y	N	ONE (1) Male breast cancer at any age (in self, first or second degree family members)				
Y	N	ONE (1) Breast or ovarian cancer in Ashkenazi Jewish family members				
Y	N	ONE (1) Pancreatic cancer with 2 or more breast and/or ovarian cancers on the same side of the family				
Y	N	A family member with a known BRCA mutation				

Are you of Jewish descent? YES NO

Is there any other cancer in you or any family members not listed above? If yes, please provide the family member's relationship to you, the site of their cancer and their age when they were diagnosed with cancer:

_____

Patient's Signature: _____ Today's Date: _____

FOR OFFICE USE ONLY

- ☐ Patient does not meet criteria for further risk assessment and/or genetic testing
- ☐ Patient is appropriate for further risk assessment and/or genetic testing
- ☐ Information given to patient for review
- ☐ Follow-up appointment scheduled on: _____

- ☐ Patient offered genetic testing: Accepted OR Declined HCP Signature:

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I understand that Juneau Obstetrics and Gynecology may share my health information for treatment, billing and healthcare operations. I have been given a copy of the organization's notice of privacy practices that describes how my health information is used and shared. I understand that Juneau Obstetrics and Gynecology has the right to change this notice at any time. I understand that I may obtain a current copy by contacting the office.

My signature below constitutes my acknowledgement that I have been provided with a copy of the notice of privacy practices and that I agree to the terms of the document.

_____
Name of Patient (please print)

_____ _____
Signature of Patient or Legal Guardian Date

_____
Relationship to patient

HIPAA Notice of Privacy Practices

Effective Date: November 16, 2016

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Nicholas Newbury, DO.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, **Treatment Alternatives** and **Health Related Benefits and Services**. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the

crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Nicholas Newbury, DO. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Nicholas Newbury, DO.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Nicholas Newbury, DO.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Nicholas Newbury, DO. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Nicholas Newbury, DO. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.juneauobgyn.com.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Nicholas Newbury, DO. All complaints must be made in writing. You will not be penalized for filing a complaint.