Today's Date _____

Patient Information

Last Name _____
First Name _____
First Name Used _____
Middle Name _____
Former Last Name _____
Legal Sex _____
Gender Identity ☐ Male ☐ Female ☐ Transgender FTM ☐ Transgender MTF ☐ Gender non-conforming ☐ Choose not to disclose ☐ Other, Please specify:_____
Assigned Sex at Birth ☐ Male ☐ Female ☐ Choose not to disclose ☐ Unknown
Preferred Pronouns ☐ he/him ☐ she/her ☐ they/them
DOB _____
Address _____
Address 2 _____
City _____
State _____
Zip _____
Home phone _____
Mobile phone _____
Work phone _____
Contact preference HOME MOBILE WORK
May we text you? YES NO
Email (required) _____
Preferred Pharmacy _____

_____

_____

Preferred Lab _____
Preferred Radiology _____
Primary Care Physician _____

Marital Status _____
Homebound YES NO
Language _____
Race _____
Ethnicity _____

Guardian

Last Name _____
First Name _____
Middle name _____

Emergency Contact

Name _____
Relationship _____
Home phone _____
Mobile phone _____

Next of Kin

Name _____
Relationship _____
Phone _____

Employment

Employer name _____
Employer phone _____

How did you hear about us?
☐ Referred by Friend or Relative:_____
☐ Referred by Another Doctor:_____
☐ Privia Provider Online Directory
☐ Insurance company
☐ Advertisement
☐ Online Search
☐ Other, Please specify:_____

Primary Insurance Information

Insurance Plan Name _____
ID/Certification No. _____
Policy/Group No. _____

Secondary Insurance Information

Insurance Plan Name _____
ID/Certification No. _____
Policy/Group No. _____

Primary Policy Holder (if other than patient)

Patient's Relationship to policy holder: _____
Last Name _____
First Name _____
Middle Name _____
Address _____
Address (ctd) _____
City _____
State _____
Zip _____
Date of Birth _____
Policy Holder Sex _____
Employer Name _____

Secondary Policy Holder (if other than patient)

Patient's Relationship to policy holder: _____
Last Name _____
First Name _____
Middle Name _____
Address _____
Address (ctd) _____
City _____
State _____
Zip _____
Date of Birth _____
Policy Holder Sex _____
Employer Name _____

Guarantor Information

Last Name _____
First Name _____
Middle name _____
DOB _____
Address _____
Address 2 _____
City _____
State _____
Zip _____

Optional Information

Phone _____

Patient Signature: _____ **Date:** _____

Preferred Communication:
The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them. This could, for example, include sending correspondence to your office instead of your home. Please tell us your preferred place and manner of communication. **You may update or change this information at any time; please do so in writing.**

Patient Name: _____ Date of Birth: _____

I prefer to be contacted in the following manner (check all that apply):

☐ **Send all communication through my Patient Portal.**

☐ **Home Telephone:**_____ ☐ **Cell Phone:**_____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Work Telephone:**_____ ☐ **Written Communication:**_____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Please send all of my mail to my home address on file
- ☐ Please send all mail to THIS address:

_____

_____

☐ **Other:**_____

My Preferred Contacts:

We respect your right to tell us who you want involved in your treatment or to help you with payment issues. Our secure patient portal is our primary means of patient communication, such as to share your test results. **You** have the ability to control access to your patient portal.

Please indicate the person(s) with whom you prefer we share your information below.**Please update this information in writing promptly if your preferences change.**

Please note that in some situations, it may be necessary and appropriate for us to share your information with other individuals. This may include information about your general medical condition and diagnosis (including information about your care and treatment), billing and payment information, prescription information and scheduling appointments.

Note that we generally do not share your information via email; if you wish, you can give another individual access to your secure patient portal. You can set this up yourself through the portal or contact our Patient Experience team at 1-888-774-8428 - Monday – Friday 8 am – 6 pm ET.

- **Name:**_____**Telephone:**_____**Relationship:**_____

Email:_____

- **Name:**_____**Telephone:**_____**Relationship:**_____

Email:_____

- **Name:**_____**Telephone:**_____**Relationship:**_____

Email:_____

ACKNOWLEDGMENT: I understand that HIPAA may permit my provider to share my information with other persons **not** named on this form as needed for my care or treatment or to obtain payment for services provided.

Patient Signature: _____ Date: _____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

Chesapeake Women's Care, P.A.

NAME_____ AGE_____ DATE _____

MEDICAL HISTORY

Medications currently taking: _____

Vitamins, Herbal Supplements: _____

Medical Illnesses: _____

_____

_____

Allergies: _____

Previous surgeries or hospital admissions *(List dates & reason)* _____

_____

COLPO: _____

LEEP: _____

Have you ever had a blood transfusion? NO☐ YES☐ When? _____

PERSONAL HISTORY:

Marital Status: _____ Smoke? _____ Packs per day _____

Alcohol Consumption: _____ Caffeine Consumption: _____

Recreational Drug use: _____

Have you ever been immunized against rubella (German Measles)? _____

GYN HISTORY:

Last menstrual period (1st day): _____ Normal? Previous period: _____

Age at 1st menstrual period: _____ How frequently do they come? _____

How many days do they last? _____ Flow: Heavy Medium Light Cramps: _____

Bleeding in between periods? _____ Vaginal discharge? _____

Date of last pap smear: _____ Method of contraception: _____

Have you ever had genital herpes or venereal warts? Any Abnormal PAPs? _____

Dates: _____ Treatments: _____

OBSTETRICAL HISTORY: *Please list dates* _____

Full term delilveries: _____

Stillbirths: _____ Premature Deliveries: _____

Abortions: Miscarriages:

Has any BLOOD relative ever had:	No	Yes	Who?
Breast CA	☐	☐	
Ovarian CA	☐	☐	
Other Cancer	☐	☐	
Diabetes	☐	☐	
High Blood Pressure	☐	☐	
Stroke	☐	☐	
Heart Disease	☐	☐	
Birth Defect	☐	☐	

Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information. I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification. In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses and attorney's fees incurred by my provider to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment. I voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being; however I may refuse any particular treatment or procedure.

If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time.

My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.

Consent to Call, Email & Text. I understand and agree that my provider may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my provider's staff, by visiting "My Profile" on my myPrivia Patient Portal, or by emailing the Privacy Officer at privacy@priviahealth.com.

HIPAA. I understand that my provider's Privacy Notice is available on my provider's website and at priviahealth.com/hipaa-privacy-notice/ and that I may request a paper copy at my provider's reception desk.

I hereby acknowledge that I have received my provider's Financial Policy as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy, the sharing of my information via HIE,* and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all Privia Health affiliated providers.

Printed Name of Patient: _____ **Email:** _____

Signature: _____ **Date:** _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent.

Name and Relationship of Person Signing, if not Patient:_____

***Note: If you do not want to participate in Health Information Exchange (HIE), it is your responsibility to follow the instructions outlined on the my provider HIE Opt-Out Request Form and/or contact the HIE directly.**

Patient's Name: _____ Date of Birth: _____

New Pregnancy Questionnaire

Please allow 20-30 minutes to complete this questionnaire prior to your first prenatal appointment.

Dating Information

What was the first day of your last period? _____

Due date _____

About

Height _____ft. _____in.

Pre-Pregnancy Weight . _____lb.

What is your occupation? _____

Is English your native language? **YES** **NO**

What is the name of your partner/spouse? _____

What is the phone number of your partner/spouse? _____

Is the father of the baby 40 or older? **YES** **NO**

Sensitive

Has your current partner ever threatened you, or made you feel afraid? **YES** **NO**

Have you ever been in an abusive relationship? **YES** **NO**

Do you feel unsafe in the neighborhood where you live? **YES** **NO**

Pregnancy History

Total Pregnancies	Full Term Deliveries (≥37wks)	Premature Deliveries (20-36wks)	Abortions Induced	Miscarriages (<20 wks)	Ectopic Pregnancies	Multiple Births	Living Children

Previous Pregnancy Details

Date of Delivery	Weeks Gestation	Type of Delivery	Place of Delivery	Birth Weight	Sex M/F	Preterm Labor?	Comments, complications, outcomes

Patient's Name: _____ Date of Birth: _____

Genetic Carrier Status

Have you ever had genetic carrier testing? (please circle)

Cystic Fibrosis **SMA** **Sickle Cell Trait/Carrier** **Other** **Unsure** **None**

Pregnancy History

Do you feel like you had a really stressful experience with any labor and delivery from any previous pregnancy?	**YES**	**NO**
Have you ever had a baby who was too small or growth restricted?	**YES**	**NO**
Have you had Gastrointestinal Diabetes with a previous pregnancy?	**YES**	**NO**
Did you have high blood pressure with any of your previous pregnancies?	**YES**	**NO**
Have you ever had preterm contractions that required hospitalization to stop them?	**YES**	**NO**
Have you ever had preterm delivery at less than 34 weeks that was NOT medically indicated?	**YES**	**NO**
Have you ever been diagnosed with a shortened cervix in a previous pregnancy?	**YES**	**NO**
Have you ever had your uterus rupture during pregnancy, or or delivery?	**YES**	**NO**
During previous delivery, did the baby's shoulder get stuck on the way out?	**YES**	**NO**
Have any of your babies been infected with Group B Strep?	**YES**	**NO**
Have you ever had a stillbirth after 20 weeks gestation?	**YES**	**NO**
Have you ever had a hemorrhage after delivery with a previous pregnancy?	**YES**	**NO**
Have you ever had a C-section?	**YES**	**NO**
Have you had postpartum depression after you delivered any of your babies?	**YES**	**NO**
Were you ever re-admitted to the hospital after a delivery?	**YES**	**NO**

Endocrine History

Do you have an overactive thyroid, or Graves Disease?	**YES**	**NO**
Do you have an underactive thyroid,or Hashimoto's thyroiditis?	**YES**	**NO**
Do you have insulin dependent or juvenile (Type 1) diabetes?	**YES**	**NO**
Do you have adult-onset (Type 2) diabetes?	**YES**	**NO**

Patient's Name: _____ Date of Birth: _____

Cardiovascular History

Do you have high blood pressure?	**YES**	**NO**
Do you have ITP or a problem with low platelet count?	**YES**	**NO**
Have you or anyone in the family ever had a blood clot in the leg or lung?	**YES**	**NO**
Do you have a history of von Willebrand Disease?	**YES**	**NO**
Do you have a history of blood clots in your leg or lung, or a disorder that makes your blood clot more than usual?	**YES**	**NO**

Neurological History

Do you have any type of seizure disorder?	**YES**	**NO**
Have you ever been diagnosed with a stroke (CVA, TIA)?	**YES**	**NO**

Psychiatric History

Do you have problems with anxiety?	**YES**	**NO**
Have you had a problem with depression?	**YES**	**NO**
Have you been diagnosed with bipolar (manic-depressive) disorder?	**YES**	**NO**
Do you have schizophrenia?	**YES**	**NO**
Have you ever attempted suicide?	**YES**	**NO**
Have you ever been diagnosed with ADD (attention deficit disorder) or ADHD (attention deficit hyperactivity disorder)?	**YES**	**NO**

Respiratory History

Do you currently have asthma?	**IN PAST**	**YES**	**NO**

Surgical History

Have you ever had any complications with anesthesia?	**YES**	**NO**
Have you had weight loss/bariatric surgery?	**YES**	**NO**
Have you ever had a blood transfusion?	**YES**	**NO**
Have you ever had any surgery on your back?	**YES**	**NO**
Have you ever had any surgery on your abdomen?	**YES**	**NO**

Urologic History

Do you have any type of kidney disease?	**YES**	**NO**

Patient's Name: _____ Date of Birth: _____

General Medical History

Do you have antiphospholipid syndrome (APS)?	**YES**	**NO**
Do you have lupus?	**YES**	**NO**
Do you have rheumatoid arthritis?	**YES**	**NO**
Have you ever been diagnosed with or undergone treatment for a blood Disorder?	**YES**	**NO**
Have you ever been diagnosed with or undergone treatment for Cancer?	**YES**	**NO**

Gynecological History

Have you had 3 or more miscarriages?	**YES**	**NO**
Have you ever needed IVF or other treatment to get pregnant?	**YES**	**NO**
Have you ever had any surgery or procedures on your cervix?	**YES**	**NO**
- In a previous pregnancy, have you ever had your cervix sewn or taped closed due to a weak or incompitent cervix?	**YES**	**NO**
- Have you ever had a cold knife cone biopsy (conization) to remove tissue from your cervix?	**YES**	**NO**
- Have you ever had a LEEP (Loop Electrosurgical Excision Procedure) Performed to remove abnormal cells from your cervix?	**YES**	**NO**
- Have you ever had cervix cryosurgery to freeze and destroy abnormal tissue in your cervix?	**YES**	**NO**
Have you ever been diagnosed with a uterine anomaly such as bicornate, unicornate, arcuate, or septate uterus?	**YES**	**NO**
Do you have, or have you had fibroids of the uterus?	**YES**	**NO**
- Have you ever had an operation to remove a fibroid or growth from your uterus?	**YES**	**NO**

Gastrointestinal History

Do you have Ulcerative Colitis?	**YES**	**NO**
Do you have Crohn's disease?	**YES**	**NO**

Family History

Do you or your partner have an ethnic background of Cajun/French Canadian?	**YES**	**NO**
Do you or your partner have an ethnic background of Greek/Mediterranean/Italian?	**YES**	**NO**

Patient's Name: _____ Date of Birth: _____

Do you or your partner have an Ashkenazi/Eastern European Jewish background?	**YES**	**NO**
Has anyone in you or your partner's family had a baby with anencephaly?	**YES**	**NO**
Do you, or anyone in your family, have any birth defects?	**YES**	**NO**
Has anyone in your family had Canavan Disease?	**YES**	**NO**
Does anyone in your family have an intellectual disability?	**YES**	**NO**
Do you or your partner have any children with special needs?	**YES**	**NO**
Have you, or anyone in your family, had a chromosomal defect?	**YES**	**NO**
Has anyone in your family had familial dysautonomia (FD)?	**YES**	**NO**
Have you, or anyone in your family, had a heart defect?	**YES**	**NO**
Do you, or anyone in your family, have sickle cell anemia?	**YES**	**NO**
Has anyone in you or your partner's family had sickle cell trait (SCT)?	**YES**	**NO**
Has anyone in you or your partner's family had a child with down syndrome?	**YES**	**NO**
Has anyone in you or your partner's family had hemophilia?	**YES**	**NO**
Has anyone in you or your partner's family had Muscular Dystrophy?	**YES**	**NO**
Has anyone in you or your partner's family had Cystic Fibrosis?	**YES**	**NO**
Has anyone in you or your partner's family had Huntington's Chorea?	**YES**	**NO**
Has anyone in you or your partner's family had Fragile X?	**YES**	**NO**
Has anyone in you or your partner's family had spinal muscular atrophy (SMA)?	**YES**	**NO**
Has anyone in you or your partner's family has von Willebrand Disease?	**YES**	**NO**
Has anyone in the family had pre-eclampsia?	**YES**	**NO**
Do you have any close relatives (parent, child, sibling) with diabetes?	**YES**	**NO**

Infection History

Do you live with someone who has tuberculosis or have you been exposed to someone with tuberculosis?	**YES**	**NO**
Have you had a rash or viral illness since your last menstrual period?	**YES**	**NO**
Have you ever been diagnosed with MRSA?	**YES**	**NO**
Have you ever been diagnosed with Hepatitis A, Hepatitis B, or Hepatitis C?	**YES**	**NO**
- Have you had Hepatitis A?	**YES**	**NO**
- Have you had Hepatitis B?	**YES**	**NO**
- Have you had Hepatitis C?	**YES**	**NO**
Are you HIV positive?	**YES**	**NO**
Have you ever had a genital herpes breakout?	**YES**	**NO**
Does your partner have a history of genital herpes?	**YES**	**NO**

Patient's Name: _____ Date of Birth: _____

Vaccination History

Have you ever had chickenpox or been vaccinated for it? **YES** **NO**

Social History

Do you have any objections to blood transfusions? **YES** **NO**

Do you have an outdoor cat? **YES** **NO**

Do you have exposure to chemicals or radiation? **YES** **NO**

When was the last time you used any alcohol?

Never **Years Ago** **Weeks Ago** **Not Since Pregnant** **Current**

When was the last time you smoked, vaped, or used any tobacco/nicotine products?

Never **Years Ago** **Weeks Ago** **Not Since Pregnant** **Current**

- Do you vape or use e-cigarettes?

Never **Years Ago** **Weeks Ago** **Not Since Pregnant** **Current**

- When was the last time you smoked a cigarette?

Never **Years Ago** **Weeks Ago** **Not Since Pregnant** **Current**

When was the last time you used marijuana, cocaine, meth, benzos, and/or opioids?

Never **Years Ago** **Weeks Ago** **Not Since Pregnant** **Current**

- When was the last time you used any marijuana?

Never **Years Ago** **Weeks Ago** **Not Since Pregnant** **Current**

- When was the last time you used any cocaine?

Never **Years Ago** **Weeks Ago** **Not Since Pregnant** **Current**

- When was the last time you used any methamphetamines?

Never **Years Ago** **Weeks Ago** **Not Since Pregnant** **Current**

- When was the last time you used any benzos (such as Valium, Xanax, or Ativan)?

Never **Years Ago** **Weeks Ago** **Not Since Pregnant** **Current**

- When was the last time you used any opioids?

Never **Years Ago** **Weeks Ago** **Not Since Pregnant** **Current**

Are you exposed to second-hand tobacco smoke? **No** **Current**

Social Determinants of Health

Do you need a pregnancy confirmation letter (for work, to access services like WIC, etc.?) **YES** **NO**

Do you ever need help reading or making sense of materials you get from your doctor, clinic, or other hospital? **YES** **NO**

Have you felt you had a health care visit that made you feel uncomfortable for one reason or another, or that the care you received was affected by your race, gender expression or other factors? **YES** **NO**

Patient's Name: _____ Date of Birth: _____

Counseling

Do you have any questions about your options of abortion, adoption, or continuing the pregnancy? **YES** **NO**

Pap History

Date of last pap _____

Any history of abnormal pap or HPV? **YES** **NO**

Any history of gonorrhea, chlamydia, syphilis, HIV, genital herpes, hepatitis, or other sexually transmitted disease? **YES** **NO**

Pregnancy Symptoms

Indicate any symptoms you have experienced since becoming pregnant (circle all that apply)

Abdominal pain/cramping **Breast tenderness** **Swelling/edema** **Fever** **Nausea** **Vomiting** **Headache** **Urinary complaints** **Vaginal discharge/odor** **Vaginal bleeding** **Constipation**

Other: _____

Other information, history, or concerns you would like your provider to know:

_____

_____

_____

_____

_____