William D. Summers, M.D.
Gynecology

52 Medical Park Drive East, Suite 215
Birmingham, Alabama 35235
Phone: 205-838-3740 Fax: 205-838-3845

PATIENT INFORMATION

Last Name ______________________ First ______________ Middle ______________

Area Code ________ Home Phone ________ Alternate Phone ____________ Age _____ Date of Birth ____________

Social Security Number ____________ _____ Drivers Lic No. ________________ Marital Status ____________

Address ____________________________ City ____________ State ____________ Zip ________

Spouse's Name ______________________ Children's Name(s) and Date of Birth ________________

Person to Contact In Case of Emergency Other than Spouse __________ Relationship ________ Phone No. ________

EMPLOYMENT INFORMATION

Employer ______________________ Phone Number ______________ Occupation ______________

Spouse's Employer ______________________________ Spouse's Daytime Phone ______________

RESPONSIBLE PARTY INFORMATION

Responsible Party __________________________ Relationship to Patient ______________________

Street Address __________________________ City, State, Zip Code __________________________

Responsible Party Employer ____________ Telephone Number ____________ Responsible Party Date of Birth ________

Responsible Party Social Security Number ______________________________________

INSURANCE

Name of Insured ____

Primary Insurance ____________ Primary Policy # ____________ Contact # ________ Group # ________ Co-pay 1 ________

Secondary Insurance ____________ Secondary Policy # ____________ Contact # ________ Group # ________ Co-pay 2 ________

Primary Doctor's name ________________ Referred By ☐ Physican ☐ Relative ☐ Friend ☐ Other ____________

ALLERGIES

Do you have any allergies? ____________ If so please list ______________________________

HOW DID YOU HEAR ABOUT OUR PRACTICE?

PHYSICAN, NEWSLETTER, WELCOME BOOKLET, OTHER, FRIEND ____________________

MAY WE HAVE THEIR NAME SO WE CAN SEND A THANK YOU? ____________________

CONSENT FOR TREATMENT – I CONSENT TO NECESSARY TREATMENT, INCLUDING DRUGS, MEDICINE, PERFORMANCE OF OPERATIONS AND CONDUCT OF X-RAY, OR OTHER STUDIES THAT MAY BE USED BY THE ATTENDING PHYSICIAN, HIS NURSE OR STAFF.

AUTHORIZATOIN FOR RELEASE OF INFORMATION – I AUTHORIZE DR WILLIAM SUMMERS, M.D. TO FURNISH ANY MEDICAL INFORMATION REQUESTED BY INSURANCE COMPANIES WITH WHOM I HAVE COVERAGE, ANY PUBLIC AGENCY WHICH MAY BE ASSISTING IN PAYMENT OF MY CARE, OR MY EMPLOYER WHO IS PROVIDING PAYMENT OF MY MEDICAL BILLS, DUE TO AN ON THE JOB INJURY.

ASSIGNMENT OF BENEFITS – I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DR. WILLIAM SUMMERS, M.D. OF BENEFITS OTHERWISE PAYABLE TO ME INCULDING MAJOR MEDICAL INSURANCE AND PAYMENT OF SURGIGCAL OR MEDICAL BENEFITS, BUT NOT TO EXCEED THE DR. WILLIAM SUMMERS, M.D. CHARGES FOR THESE SERVICES. I UNDERSTAND THAT I AM FINAICALLY RESPONSIBLE TO DR. WILLIAM SUMMERS, M.D. FOR CHARGES NOT COVERED BY THIS ASSIGNEMET. I AUTHORIZE THE REFUND OF OVERPAID INSURANCE BENEFITS WHERE MY COVERAGES ARE SUBJECT TO COORDINATION OF BENEFITS.

GURANTEE OF ACCOUNT – FOR SERVICES FURNISHED BY DR. WILLIAM D. SUMMERS, M.D. I HEREBY GUARNTEE THE PAYMENT OF ALL ACCOUNTS FOR SERVICES RENDERED. FOR PAYMENT OF SAID ACCOUNTS FOR SERVICES, I HEREBY WAIVE ALL CLAIMS OF EXEMPTION UNDER THAT STATE OF ALABAMA AND AGREE TO PAY, IN NECESSARY ALL COST OF COLLECTION, INCLUDING ATTORNEY'S FEE.

SIGNATURE______________________________ DATE____________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received a copy of the **William D. Summers, M.D., LLC** Notice of Privacy Practices. I understand that **William D. Summers, M.D., LLC** has the right to change its Notice of Privacy Practices from time to time and that I may contact **William D. Summers, M.D., LLC** at any time to obtain a current copy of the Notice of Privacy Practices.

Date ____________________

Patient Name (print) ____

Signature of patient ____
/Legal Representative

Relationship to Patient ____

<table>
<tr><th colspan="2">FOR OFFICE USE ONLY</th></tr>
<tr><td colspan="2">PRINT PLEASE

I have attempted to obtain the patient's signature on this form, but was not able to for the following reason:</td></tr>
<tr><td>Date:

Initials:</td><td>Please document the reasons you were unable to obtain the signature.</td></tr>
</table>

CONSENT AND ACKNOWLEDGEMENT
FOR DR. WILLIAM D. SUMMERS, M.D.

Patient Name ______________________________ Date of Birth: ______________________

Patient Address ____________________________ SSN ______________________________

____

I give Dr. William D. Summers, M.D. Office permission to release medical information to the following persons:

☐ None ______________________________ ☐ Spouse ______________________

☐ Parents ____________________________ ☐ Mother (only) __________________

☐ Father (only) ________________________ ☐ Guardian ______________________

☐ Other ______________________________

I wish to be contacted in the following manner by Dr. William D. Summers Office (please check 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 with detailed information
- ☐ Leave message with call back number only

☐ **Written Communication**

- ☐ O.K. to mail or Email to my home address
- ☐ O.K. to mail or Email to my work/office
- ☐ O.K. to fax to this number ______________

☐ **Email Address**

1. ______________________________
2. ______________________________

The Privacy Act generally requires healthcare providers to take responsible steps to limit the use of disclosure of and requests for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records or protected health information disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures for protected health information may be permitted without prior consent in an emergency.

ACKNOWLEDGEMENTS:

I acknowledge that I have received Dr. William D. Summers M.D. notice of Privacy Practices.

______________________________ ______________________________
Signature of Patient or Personal Representative — Date

______________________________ ______________________________
Relationship of Personal Representative to the Patient — Signature of Witness

____
Print Personal Representative's Name

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Name: ____________________ DOB ____________ Date: __________ pt ID# __________

Chief Complaint: Problem | BP ______ | wt ______ | ht ______
LMP ______ | Pap ______ | Mammo ______
Annual Exam | Bone Density __________ | Contraception __________

If there is a problem, please describe, including where it is, how severe it is and how long it has lasted:

____

____

OBSTETRICAL AND GYNECOLOGICAL HISTORY

1. How old were you when your menstral cycle began?
2. How many days does your cycle last?
3. Any recent changes in your menstral cycles?
4. Are your sexually active?
5. Have you ever had an abnormal pap smear?

	NUMBER		NUMBER		NUMBER
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTH: (<37 WEEKS)		LIVE BIRTHS		LIVING CHILDREN	

NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.	COMPLICATIONS?
1.						
2.						
3.						
4.						

CURRENT MEDICATIONS
(Including hormones, vitamins, herbs, non prescription medications)

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCRIBED

FAMILY HISTORY

MOTHER: ☐ LIVING ☐ DECEASED - CAUSE: AGE:	FATHER: ☐ LIVING ☐ DECEASED - CAUSE: AGE:

SIBLINGS: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):

CHILDREN: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):

ILLNESS	YES	WHICH RELATIVE(S) AND AGE OF ONSET		YES	WHICH RELATIVE(S) AND AGE OF ONSET
DIABETES	☐		BIRTH DEFECTS	☐	
STROKE	☐		DRINKING OR DRUG PROBLEMS	☐	
HEART DISEASE	☐		BREAST CANCER	☐	
BLOOD CLOTS IN LUNGS OR LEGS	☐		COLON CANCER	☐	
HIGH BLOOD PRESSURE	☐		OVARIAN CANCER	☐	
HIGH CHOLESTEROL	☐		UTERINE CANCER	☐	
OSTEOPOROSIS (WEAK BONES)	☐		MENTAL ILLNESS/DEPRESSION	☐	
HEPATITIS	☐		ALZHEIMER'S DISEASE	☐	
HIV/AIDS	☐		OTHER	☐	

PERSONAL PAST HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE
ASTHMA				CHICKENPOX			
PNEUMONIA/LUNG DISEASE				CANCER			
KIDNEY INFECTIONS/STONES				REFLUX/HIATAL HERNIA/ULCERS			
TUBERCULOSIS				DEPRESSION/ANXIETY			
SEXUALLY TRANSMITTED DISEASE				ANEMIA			
HIV/AIDS				BLOOD TRANSFUSIONS			
HEART ATTACK/PROBLEMS				SEIZURES/CONVULSIONS/EPILEPSY			
DIABETES				BOWEL PROBLEMS			
HIGH BLOOD PRESSURE				GLAUCOMA			
STROKE				CATARACTS			
RHEUMATIC FEVER				ARTHRITIS/JOINTPAIN/BACK PROBLEMS			
BLOOD CLOTS IN LUNGS OR LEGS				BROKEN BONES			
EATING DISORDERS				HEPATITIS/YELLOW JAUNDICE/LIVER DISEASE			
COLLAGEN VASCULAR DISEASE (LUPUS)				THYROID DISEASE			

OPERATIONS/HOSPITALIZATIONS

REASON	DATE	HOSPITAL

INJURIES/ILLNESSES

TYPE	DATE	TYPE	DATE

SOCIAL HISTORY

DO YOU SMOKE?	YES	NO	PHYSICIANS NOTES
EVER SMOKED? CURRENT SMOKING: PACKS PER DAY: YEARS:	☐	☐	
ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK:	☐	☐	
REGULAR EXERCISE: HOW LONG AND HOW OFTEN?	☐	☐	
DAIRY PRODUCT INTAKE/CALCIUM SUPPLEMENTS: QUANTITY	☐	☐	

REVIEW OF SYSTEMS

Please check (x) If any of the following symptoms apply to you now or since adulthood

	NOW	PAST	NOT SURE
2. EYES			
DOUBLE VISION	☐	☐	☐
SPOTS BEFORE EYES	☐	☐	☐
VISION CHANGES	☐	☐	☐
GLASSES/CONTACTS	☐	☐	☐
3. EAR, NOSE, AND THROAT			
EARACHES	☐	☐	☐
RINGING IN EARS	☐	☐	☐
HEARING PROBLEMS	☐	☐	☐
SINUS PROBLEMS	☐	☐	☐
SORE THROAT	☐	☐	☐
MOUTH SORES	☐	☐	☐
DENTAL PROBLEMS	☐	☐	☐
4. CARDIOVASCULAR			
PAINFUL BREATHING	☐	☐	☐
CHEST PAIN OR PRESSURE	☐	☐	☐
DIFFICULTY BREATHING ON EXERTION	☐	☐	☐
SWELLING OF LEGS	☐	☐	☐
RAPID OR IRREGULAR HEARTBEAT	☐	☐	☐
5. RESPIRATORY			
WHEEZING	☐	☐	☐
SPITTING UP BLOOD	☐	☐	☐
SHORTNESS OF BREATH	☐	☐	☐
CHRONIC COUGH	☐	☐	☐
6. GASTROINTESTINAL			
FREQUENT DIARRHEA	☐	☐	☐
BLOODY STOOL	☐	☐	☐
NAUSEA/VOMITING/INDIGESTION	☐	☐	☐
CONSTIPATION	☐	☐	☐
INVOLUNTARY LOSS OF GAS OR STOOL	☐	☐	☐
7. GENITOURINARY			
BLOOD IN URINE	☐	☐	☐
PAIN WITH URINATION	☐	☐	☐
STRONG URGENCY TO URINATE	☐	☐	☐
FREQUENT URINATION	☐	☐	☐
INCOMPLETE EMPTYING	☐	☐	☐
INVOLUNTARY/UNINTENDED URINE LOSS	☐	☐	☐
URINE LOSS WHEN COUGHING OR LIFTING	☐	☐	☐
ABNORMAL BLEEDING	☐	☐	☐
PAINFUL PERIODS	☐	☐	☐
PREMENSTRUAL SYNDROME (PMS)	☐	☐	☐
PAINFUL INTERCOURSE	☐	☐	☐
FIBROIDS	☐	☐	☐
INFERTILITY	☐	☐	☐
DES EXPOSURE	☐	☐	☐
ABNORMAL VAGINAL DISCHARGE	☐	☐	☐
8. MUSCULOSKELETAL			
MUSCLE WEAKNESS	☐	☐	☐

	NOW	PAST	NOT SURE
8. MUSCULOSKELETAL (Continued)			
MUSCLE OR JOINT PAIN	☐	☐	☐
9a. SKIN			
RASH	☐	☐	☐
SORES	☐	☐	☐
DRY SKIN	☐	☐	☐
MOLES	☐	☐	☐
9b. BREASTS			
PAIN IN BREAST	☐	☐	☐
NIPPLE DISCHARGE	☐	☐	☐
LUMPS	☐	☐	☐
10. NEUROLOGIC			
DIZZINESS	☐	☐	☐
SEIZURES	☐	☐	☐
NUMBNESS	☐	☐	☐
TROUBLE WALKING	☐	☐	☐
SEVERE MEMORY PROBLEMS	☐	☐	☐
FREQUENT OR SEVERE HEADACHES	☐	☐	☐
11. PSYCHIATRIC			
DEPRESSION OR FREQUENT CRYING	☐	☐	☐
SEVERE ANXIETY	☐	☐	☐
12. ENDOCRINE			
HAIR LOSS	☐	☐	☐
HEAT/COLD INTOLERANCE	☐	☐	☐
ABNORMAL THIRST	☐	☐	☐
HOT FLASHES	☐	☐	☐
13. HEMATOLOGIC/LYMPHATIC			
FREQUENT BRUISES	☐	☐	☐
CUTS DO NOT STOP BLEEDING	☐	☐	☐
ENLARGED LYMPH NODES (GLANDS)	☐	☐	☐
14. ALLERGIC/IMMUNOLOGIC			
MEDICATION ALLERGIES	☐	☐	☐
IF ANY, PLEASE LIST ALLERGY AND TYPE OF REACTION:			
OTHER ALLERGIES	☐	☐	☐
PLEASE LIST ALLERGY AND TYPE OF REACTION:			
15. CONSTITUTIONAL			
WEIGHT LOSS	☐	☐	☐
WEIGHT GAIN	☐	☐	☐
FEVER	☐	☐	☐
FATIGUE	☐	☐	☐
CHANGE IN HEIGHT	☐	☐	☐

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