Mark A. Gapinski, MD, SC
25 N. Winfield Road, Suite 511
Winfield, IL 60190
630-462-4963

Dear Patient,

Thank you for choosing Dr. Mark Gapinski's office for your gynecological care!

Please fill out the following forms as completely as possible. ***It is required that you return these forms to the office at least 48 hours prior to your scheduled appointment. If your forms are not received your appointment will be rescheduled.*** Your forms can be accepted by email, fax or USPS. If you have any questions about these forms please do not hesitate to contact our office. Please include a copy of your insurance card.

Your forms can be emailed to admin@4obgyne.com.

If you would prefer to fax your forms but do not have access to a fax machine the office recommends the free fax service through www.topfreefax.com. If you need help accessing or navigating this service please call the office for assistance. Our secure fax number is **630-462-0635**.

Our office is located within Central DuPage Hospital. The address is **25 N. Winfield Road, Suite 511, Winfield, IL 60190**.

You may want to plan to arrive early for your appointment to allow yourself some time to locate parking. There is open parking in Parking Lot 1 and Parking Lot 2 (the covered parking garage attached to the hospital), or free Valet Service in front of our building, the Out Patient Services Building, Entrance 1 off of Jewell Road.

Please be sure to arrive at least 10 minutes prior to your scheduled appointment time and bring your insurance card and a photo ID with you to your first appointment. It will be necessary for our office to scan these cards into our computer system. If you do not have proof of insurance for your office visits, the charges will be your responsibility (see Billing Policy on page 7). Please also be prepared to pay any copayments for your visit.

If you have any questions regarding the office or these forms, please feel free to call our office. Our phone number is 630-462-4963.

Thank you, we look forward to seeing you at your first visit!

Sincerely,

Staff of Dr. Mark Gapinski

PATIENT INFORMATION AND HEALTH QUESTIONAIRRE

Name: _____
Last First MI

Address: _____
Street APT# City State Zip Code

Home: (____) _____-_____ **Cell**: (____) _____-_____ **Work**: (_____) _____-_____ x ____
At which number do you prefer to be reached: ☐ Home ☐ Cell ☐ Work
***E-mail address:** _____ (*This will be used for communication via our Patient Portal)

Reason for visit: _____

_____

Primary Care Physician: _____

Who referred you to this office?
☐ I am a previous patient ☐ Primary Care Physician
☐ Internet: (Website) _____
☐ Insurance Company
☐ Other Physician: _____
☐ Friend/Family: _____
☐ Other: _____

Please provide us with your pharmacy Information for future prescriptions:
Name _____
Street _____
City _____
Phone _____

Date of Birth: _____/_____/_____ **Age:** _____ **Social Security Number:** _____-____-_____

Race: ☐ American Indian and Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ Other: _____
☐ Patient Refused
☐ White or Caucasian

Ethnicity: ☐ Hispanic
☐ Non Hispanic

Primary Language:
☐ English
☐ Other: _____

Employer Name: _____ **Occupation**: _____

Emergency Contact: Name: _____ Relation to yourself: _____
Phone #: (_____)_____-_____

Spouse Information:
Name: _____ Date of Birth: _____/_____/_____
Social Security Number: _____-____-_____ Employer: _____

Insurance Information:
Insurance Company: _____ Address: _____
(Provide address only if you do not have your insurance card with you today, or if the address is not indicated on the card. Please have card available for office to copy.)
Subscriber ID#: _____ Group/Case #: _____
Policyholder: _____ SSN: ___-___-_____ Relation to yourself: _____
(If you are not the policyholder)

Secondary Insurance Information:
Insurance Company: _____ Address: _____
(Provide address only if you do not have your insurance card with you today, or if the address is not indicated on the card. Please have card available for office to copy.)
Subscriber ID#: _____ Group/Case #: _____
Policyholder: _____ SSN: ___-___-_____ Relation to yourself: _____
(If you are not the policyholder)

Patient Name: _____

Please list all medications you are currently taking:

Name of Medication	Dosage and Frequency	Date Started	Name of Prescribing Doctor

Personal Medical History:

Do you currently have, or have you ever, experienced any of the following:

YES	NO		YES	NO	
☐	☐	Asthma	☐	☐	Hypoglycemia
☐	☐	Cancer: type/location: _____	☐	☐	Thyroid Problems: If yes- ☐ hypothyroid
☐	☐	Chicken Pox	☐	☐	Kidney Problems ☐ hyperthyroid
☐	☐	Depression	☐	☐	Leakage of Urine ☐ thyroid nodule
☐	☐	Anxiety	☐	☐	Liver Problems
☐	☐	Diabetes	☐	☐	Ovarian Cysts requiring surgery
☐	☐	Emphysema	☐	☐	Polycystic Ovarian Syndrome
☐	☐	Uterine Fibroids	☐	☐	Rheumatic Fever
☐	☐	Endometriosis	☐	☐	Scarlet Fever
☐	☐	German measles	☐	☐	Seizures
☐	☐	Previously diagnosed migraines	☐	☐	Sinus Problems
☐	☐	Heart Disease	☐	☐	Stroke
☐	☐	High Cholesterol	☐	☐	Ulcers
☐	☐	Hypertension (High Blood Pressure)	☐		Other – Please Specify: _____

Allergies:

Drug Allergies: _____ Reaction: _____ ☐ None

Other Allergies: _____ ☐ Seasonal ☐ None

Surgical History:

List all past operations. ☐ None

Reason for Admission	Date	Procedure Performed	Doctor	Hospital

Hospital Admissions (other than surgeries listed above and births listed on page 5):

List serious illnesses which required hospitalization. ☐ None

Reason for Admission	Date	Procedure Performed	Doctor	Hospital

Patient Name: _____

Family Medical History:

Please indicate the following details regarding your family history:

Mother: ☐ Alive ☐ Deceased – Cause of death: _____

Father: ☐ Alive ☐ Deceased – Cause of death: _____

Siblings: ☐ Alive ☐ Deceased – Cause of death: _____

Maternal (Mother) Grandfather: ☐ Alive ☐ Deceased – Cause of death: _____

Maternal Grandmother: ☐ Alive ☐ Deceased – Cause of death: _____

Paternal (Father) Grandfather: ☐ Alive ☐ Deceased – Cause of death: _____

Paternal Grandmother: ☐ Alive ☐ Deceased – Cause of death: _____

Do your blood relatives have any of the following?

	YES	NO	Indicate family member's relationship to you: (i.e- "maternal aunt" or "paternal grandfather")
Cancer			Type:
Diabetes			
Heart Disease			
Breast Disease			
High Blood Pressure			
High Cholesterol			
Blood Disorders			
Sickle Cell Disease			
Down Syndrome			
Infants with Congenital Problems			

Social History:

Do you exercise? ☐ Yes ☐ No If yes, how many times per week? _____

Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes per day? ___ How long have you been smoking? _____

Have you smoked in the past? ☐ Yes ☐ No If yes, when did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____

Do you drink caffeine? ☐ Yes ☐ No If yes, how many cups per day? _____

In the past 6 months, have you used: Cocaine? ☐ Yes ☐ No Heroin? ☐ Yes ☐ No

Have you *ever* injected recreational drugs? ☐ Yes ☐ No

Menstrual History:

Age at first period: _____ Date of last period (1st day): _____

How many days does your period last? _____ How many days/weeks between your periods? _____

Do you have painful periods? ☐ Yes ☐ No If yes, please describe: _____

If you experience menstrual cramps, please describe whether mild, moderate, or severe: _____

Do you take medication for cramps? ☐ Yes ☐ No If yes, please describe: _____

Do you spot or bleed between periods? ☐ Yes ☐ No If yes, please describe: _____

Do you experience pain or bleeding during or after sexual activity? ☐ Yes ☐ No If so, please describe: _____

_____

Gynecological History:

Please check if you *have, or have ever had*, a history of:

☐ Herpes ☐ Chlamydia ☐ Syphilis

☐ Trichomonas ☐ Gonorrhea ☐ Genital Warts (Condyloma)

Patient Name: _____

Current method of contraception: _____ If pills, please specify brand: _____

Date of your last pap smear: _____ Result: _____

Have you ever had an abnormal pap smear? ☐ Yes ☐ No If yes, when? _____

What treatment did you receive? _____

Date of last mammogram: _____ Result: _____

Have you ever had an abnormal mammogram? ☐ Yes ☐ No If yes, when? _____

What treatment did you receive? _____

Were you sexually active prior to the age of 16? ☐ Yes ☐ No

How many sexual partners have you had in the past? _____

Obstetrical History:

Do you have a history of infertility? ☐ Yes ☐ No If yes, please explain: _____

_____

_____

Specify number of: Pregnancies: _____ Miscarriages: _____ Abortions: _____

	Pregnancy # 1	Pregnancy # 2	Pregnancy # 3	Pregnancy # 4	Pregnancy # 5
Date of delivery:					
Vaginal or C-Section?					
Boy or Girl? (Baby's name)					
Baby's weight?					
Weeks gestation at delivery? (40 weeks is full term)					
Complications? If yes, please explain					
Pre-term labor?					
Epidural?					
Length of labor					
Length of pushing prior to delivery					
Induction? If so, reason?					
Doctor?					
Hospital?					

Patient Bill of Rights

1. The patient has the right to high-quality care delivered in a safe, timely, efficient and cost-effective manner and the right to be assured that the expected results can be reasonably anticipated.

2. The patient has the right to access medically indicated treatment and available accommodations, regardless of age, race, creed, gender, sexual orientation, marital status, national origin, disability, or source of payment for care.

3. The patient has the right to dignity, respect and consideration of legitimate concerns.

4. The patient has the right to privacy and confidentiality.

5. Patients are involved in all aspects of care. Informed consent, following a discussion of risk, benefits and alternatives, should be obtained. The patient has the right to information about the current diagnosis, treatment and prognosis. If it is not advisable to give such information to the patient for health reasons, the information should be available to a person designated by the patient or a legally authorized person.

6. The patient has the right to be advised of all reasonable options/alternatives for care and treatment and the potential advantages/disadvantages of each. Included in this should be a discussion of the advantages/disadvantages and alternatives to having the procedure performed in the office.

7. The patient has the right to refuse any diagnostic procedure or treatment, and to be advised of the likely medical consequences of such refusal.

8. The patient has the right to education to address his or her needs. The educational process should consider the patient's values, abilities, readiness to learn and family responsibilities in the care process.

9. The patient has the right to know who will be delivering the care and the qualifications of such individuals. In the case of student personnel (including residents/fellow), the patient has the right to know the extent to which the student personnel will be involved.

10. The patient has the right to change the practitioner if other qualified practitioners are available.

11. The patient has the right to inspect and obtain a copy of his or her medical records. In addition, the patient has the right to expect a reasonable and timely transfer of information from one practitioner to another when required. Charges for copies of medical records should not exceed the charges provided for by Section 17 of the Public Health Law.

12. The patient has the right to request and receive information concerning the bill for the services regardless of the source of payment.

13. The patient has the right to request and receive information about alternate sources of appropriate care.

14. The patient has the right to know about the expectations of the office-based practice with regard to his or her behavior and the consequences of failure comply with these expectations.

15. The patient has the right to express those spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of medical therapy for the patient.

17. The patient has a right to voice complaints about the office or the care it provides.

BILLING POLICY

- Payment is due at the time services are rendered. All copayments will be collected upon arrival to your appointment. Please be prepared to pay any outstanding balances at your visits.
- If you are uninsured, or cannot provide proof of insurance at the time of service, payment will be due in full at time of service.
- Accounts over 30 days past due will incur a $10 rebilling fee.
- After 3 statements, or any account with balances over 90 days past due, will be turned over for further collection management. These accounts will incur a $10 non-negotiable charge.
- There will be a $25 charge for returned checks.
- There will be a $25 charge for no-show appointments. Please allow 24 hours' notice if you must cancel or reschedule an appointment.
- There will be a charge for transferring medical records. Please contact the office to discuss these charges.
- Phone calls or electronic encounters unrelated to an office visit or care that is provided outside of the office setting may incur a charge. These charges will be submitted to the insurance on file with Dr. Gapinski's office but may ultimately be applied to your deductible, out-of-pocket maximum or may be non-covered and become your responsibility in full.
- Dr. Gapinski reserves the right to collect pre-payment for services. It is not uncommon for patients to be required to pre-pay for estimated costs of delivery and/or surgical services, based on insurance benefits and Dr. Gapinski's insurance contracts.
- There will be a $25 charge for any FMLA and Short Term Disability paperwork that needs to be filled out, due upon completion. Please allow up to 7 days for these forms to be completed. The office will gladly mail or fax these on your behalf, if desired.
- Some accounts may be eligible for payment plan arrangements. A non-negotiable $20 service fee will be charged at the time of payment arrangements. Please contact the office directly to discuss payment plan arrangements, if needed.

Dr. Gapinski accepts Visa, DISCOVER, MasterCard, AmericanExpress & Check for payment.
Sorry, cash is not accepted.

Assignment of Benefits

I hereby authorize direct payment of surgical/medical benefits to Dr. Mark Gapinski for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization to Release Information

I hereby authorize Dr. Mark Gapinski to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

Medicare/Medicaid

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of the authorized benefits be made on my behalf.

Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that I may ask Dr. Gapinski's office for a copy of his Notice of Privacy Practices at any time. Please initial below whether you desire a copy at your first visit:

_____ I am requesting a copy of Notice of Privacy Practices
_____ I am declining a copy of Notice of Privacy Practices

A photocopy of these assignments shall be valid as the original.

PATIENT NAME (please print) _____ PARENT/GAURDIAN _____

SIGNATURE _____ Date _____

Mark A. Gapinski, MD, FACOG
25 N. Winfield Road, Suite 511
Winfield, IL 60190
P) 630-462-4963 F) 630-462-0635

COMMUNICATION CHOICES

Patient Name _____ Date of Birth _____

By completing and signing this form I authorize Dr. Mark Gapinski and his office to leave detailed messages containing medical information at the following phone numbers. I understand this document will be valid until I revoke it in writing. **If you do not desire detailed messages to be left then do not write any phone numbers below.**

On my home voice mail/answering machine: #_____

On my cell phone voice mail: # _____

On my work voice mail/answering machine: # _____

In the space below, if desired, please indicate any personal representatives/individuals who are permitted to receive or know information concerning your healthcare for the time period that this form is valid:

Name _____ Relationship: _____

Phone # _____

Name _____ Relationship: _____

Phone # _____

Name _____ Relationship: _____

Phone # _____

Signature _____ Date _____

AUTHORIZATION

Patient Name _____ DOB _____

I authorize Dr. Mark Gapinski & Staff to disclose highly confidential health information including HIV/AIDS related health information, behavioral or mental health information, drug/alcohol diagnosis treatment and referral information and Genetic Testing information/records to my primary care physician in order to provide continuation of care when necessary.

Please list your Primary Care Physian: _____

I also authorize Dr. Mark Gapinski & Staff to access my external prescription records when necessary.

I understand written revocation must be sent to Dr. Mark Gapinski's office in order to reverse these authorizations.

Patient Signature _____ Date _____