Lynda J Wright M.D., LLC
4 River's Edge
Eliot, Maine 03903
Phone:(207)451-9440 Fax:(207)451-9421

Welcome to my practice! Enclosed you will find forms to be completed before your appointment. Please bring your insurance card and any co-payment that may be applicable. If your insurance requires a referral for this visit, please contact your Primary Care Physician. It is your responsibility to get this if it is required. If you have questions regarding this, please contact your insurance company before this appointment.

Any past gynecology records are very helpful in your care. Please forward the enclosed release form to any provider that would have pertinent records. Please have them sent prior to your appointment. They can be mailed to the address above or faxed to our records fax at (207)482-0201.

We ask that you bring these completed forms with you to your appointment and arrive 10-15 minutes prior to your appointment time.

I look forward to meeting you! If you should need to cancel or reschedule this appointment, please contact my office as soon as possible. Thank you!

Lynda J. Wright M.D.

Your appointment is scheduled on _____ @ _____.

DIRECTIONS TO OUR OFFICE

From Kittery @ Route 95 exits:

Rt.236 North for 4 miles.
Left onto Depot Road at 3rd set of lights.(Middle school on right)
Take immediate right onto Cedar Road. Continue 1 mile to end.
Turn left onto 103E, continue a few hundred feet and turn right onto Tidy Road.
**Continue 0.3 miles.*
At split in road, bear to left. Continue 0.1 mile to large green mailbox on left. Driveway sign reads "Private Road River's Edge."
House cannot be seen from the road. Please proceed with caution, as there may be oncoming cars.
Parking is on the right.

From South Berwick/Dover:

236S or 101E, Right onto 236S at light.
Right onto 103E, continue 1mile.
Turn right onto Tidy Road. (at end of curve to the right)
Follow directions above.*

From Eliot Center:

Continue on 103W(State Road) for 3 miles across Sturgeon Creek on small green bridge.
Turn left onto Tidy Road. (2/10th mile)
Follow directions above.*

NEW PATIENT FORM Page 1

Lynda J Wright M.D., LLC
4 Rivers Edge
Eliot, Maine 03903

Please print:

Name: _____

Mailing address: _____

_____

Home phone: _____ *Work phone:*_____ *Ext:*_____

Cell phone: _____ *Email:* _____

Date of Birth: _____

Primary Care Physician: _____

Emergency Contact: _____

Relationship: _____ *Phone:* _____

Insurance Info:

Primary Insurance Carrier: (Please furnish card)

*Name of Insurance:*_____

*Certificate #:*_____ *Group #:* _____

Subscriber: _____ *Relationship to Patient* _____

*Address if different:*_____

Date of birth: _____ *Employer:* _____

Secondary Insurance Carrier:

*Name of Insurance:*_____

*Certificate #:*_____ *Group #:* _____

*Subscriber:*_____ *Date of birth:*_____

*Address if different:*_____

NEW PATIENT FORM Page 2

Lynda J Wright M.D., LLC
4 Rivers Edge
Eliot, Maine 03903

Additional Information:

*Preferred Pharmacy:*_____

Preferred method of contact:

Appointment confirmation: email/phone

Test results: email/phone

Can we leave a message regarding medical care and test results? YES/NO

Race:

*__White __ Hispanic __ Other (please specify)*_____

__ American Indian or Alaska native __ Black or African American

__ Asian __ Native Hawaiian or Pacific Islander __ Decline to answer

Ethnicity:

__ Hispanic or Latino __ Not Hispanic or Latino __Decline to answer

Preferred Language: _____

*Occupation:*_____

I authorize medical treatment and understand I am responsible for any balance and/or services not covered by my insurance(s). I authorize the release of information requested by my insurance carrier(s) that is necessary to process unpaid claims and authorize payment "assigned" insurance benefits to Lynda J Wright MD.

I have reviewed a copy of Lynda J Wright, MD's privacy notice .____(initials)

*Signature:*_____ *Date:* _____

Lynda J. Wright MD, LLC
(207) 451-9440

Please complete the following questionnaire and bring it with you to your appointment. I feel this is the best way to consistently obtain a thorough medical history. The information given will be kept in the strictest confidence. I understand the highly personal nature of many of these questions and answers.

Date _____
Full Name _____ Age _____
Name you prefer we use _____Relationship Status _____
Height _____ft. _____in. Current weight _____ lbs.
Weight one year ago _____lbs. Weight five years ago _____lbs.
pregnancies ____ #of full term deliveries ____ # of premature deliveries ____ # of living children _____
of miscarriages __ # of pregnancy terminations __ # of ectopic (tubal) pregnancies __ multiple births ___
What do you use for birth control? _____
What methods have you used in the past? _____
Partner vasectomy? Yes ___ No ___
First day of last menstrual period _____ Prior period _____
Date of menopause _____ Date of last Pap smear _____
For what reason did you make today's appointment?_____
_____
What is your occupation? _____

Please list all current prescription and non-prescription medication, with dose and frequency. (include vitamins and herbs): _____
_____
_____
_____

Please list all drug allergies and describe reactions: _____
_____

Please list all surgeries:
Year: _____ Procedure: _____
Year: _____ Procedure: _____
Year: _____ Procedure: _____
Year: _____ Procedure: _____
Anethesia problems: _____

Pregnancies: Please include dates of **all** pregnancies including miscarriages, ectopic pregnancies, abortions:

Date	Weeks of gestation	Vaginal or C-section	Sex	Birth weight	Complications,if any.

_____
_____
_____
_____
_____

How much sugar is in your diet?
____ Low (I do not add sugar to coffee or tea. I rarely eat desserts or sweet snacks. I do not consume alcohol on a regular basis.)
____ Moderate (I eat moderate amounts of the above but not on a daily basis.)
____ High (I consume the above on a daily basis.)

How much seafood is in your diet? (Seafood contains Omega-3 fatty acids which help reduce cholesterol levels)
____ Low (I occasionally eat fish and other seafood, but only rarely.)
____ Moderate (I eat at least 2 portions of seafood per week.)
____ High (I eat more than 2 portions of seafood per week.)

How much salt is in your diet?
____ Low (I do not eat any salty foods and never add salt while cooking or at the table.)
____ Minimal (I rarely eat salty foods and only add small amounts when cooking and at the table.)
____ Moderate (I do not watch my salt intake, but do not salt my food heavily.)
____ High (I consistently use large amounts of salt.)

How much cholesterol is in your diet?
____ Low (I never or rarely eat red meats, fished packed in oil, food made with fat,whole milk and dairy products. I **do not** eat red meat.)
____ Moderate (I eat moderate amounts of the above, but not on a daily basis.)
____ High (I eat much more red meat than chicken and fish and frequently eat other high cholesterol and processed food with partially hydrogenated fats.)

How much fiber is in your diet?
____ Low (I never or rarely eat whole grain cereals , whole wheat breads, fresh fruits and vegetables. I use highly refined grains, (such as white flour) and their products.)
____ Moderate (I eat moderate amounts of the above, but not on a daily basis.)
____ High (I consistently eat a high fiber diet and/or use a fiber supplement.)

Do you tolerate milk products? ____Yes ____ No

Are you a vegetarian? ____Yes ____No If yes, what type? _____

What type of exercise do you do? _____
How often? _____

What do you do to relieve stress? _____

Do you wear your seatbelt? _____ Helmet if biking? _____

Do you smoke now? ___ In the past? ___ How much? _____

How long have you/did you smoke? _____

If you have quit smoking, how long ago did you quit? _____

Do you drink alcoholic beverages? _____ Type _____ Weekly amount _____

Do you use street drugs? _____

Do you drink/eat caffeine? _____ Daily amount _____

Sexual History: (mark "X" if yes)

Risk Factors for AIDS
__ Have you ever tested positive for AIDS?

__ Has (any of) your sexual partner(s) ever had a positive test for AIDS?

Have you or your sexual partner(s)...

__ Used intravenous street drugs?
__ Received a blood transfusion prior to 1985?

__ Had more than 1 sexual partner in the last 5 years?
__ Ever had sexual relations with a bisexual?
__ Had sexual relations with a prostitute?
__ Been exposed to AIDS through your occupation?

Have you or any of your sexual partner(s) ever been treated for:

__ Gonorrhea?
__ Syphilis?
__ Chlamydia?
__ Venereal warts? (condyloma)
__ Herpes?

Medical History

Please circle illnesses or conditions you have had:

High blood pressure
Heart disease
Rheumatic fever
Heart murmur
Mitral valve prolapse
Blood transfusion

Phlebitis
Blood clot in vein or lungs
Alcoholism/drug use
Anemia
Bleeding tendencies
Asthma
Cancer
Eating disorder
Cerebral vascular accident (stroke)
Esophageal reflux (GERD)
Fibromyalgia
Chicken pox

Lyme disease
Migraines
Diabetes
Thyroid problems
Bowel problems
Epilepsy/seizure disorder

Anxiety
Depression
Fibrocystic breast change
Major accident
Hepatitis or liver disease
Kidney disease
Tuberculosis
Arthritis
Atrial fibrillation
High cholesterol
Emphysema (COPD)
Multiple sclerosis
Pelvic inflammatory disease

____ Have you ever had or been advised to have any surgery?
____ biopsy of cervix
____ biopsy, other (please describe) _____
____ tubal ligation (tubes tied)
____ cryosurgery
____ cone biopsy
____ laser surgery
____ D&C
____ hysteroscopy
____ removal of one or both tubes/ovaries (please describe): _____
____ bladder repair (anterior repair)
____ rectal repair (posterior repair)
____ breast biopsy ____ breast lumpectomy ____ mastectomy
____ laparoscopy
____ hysterectomy (removal of uterus or womb)
__ abdominal incision
__ removal through vagina

What was the reason for your surgery? _____

Review of Systems - please check if you **currently have** any of the following symptoms"

Problems unique to women:
____ Do you have any symptoms of vaginal/vulvar problems?
____ Vaginal discharge ____ itching

____ unpleasant odor
____ vulvar(skin) irritation
____ vaginal dryness
____ difficulty lubricating with intercourse

____ Do you have or have you recently had abnormal bleeding? When? _____
____ bleeding between periods
____ more than 1 period per month
____ bleeding after menopause
____ excessively long periods
____ bleeding with intercourse

____ Do you have any pelvic or low abdominal pain?
Pain with menstrual periods? __ mild __moderate __severe
Does the pain start __ before your period __ at the same time __after you start

____ Do you have pain with intercourse?
____ at the entrance to the vagina
____ when your partner goes in deep
____ at other times (please describe) _____

____ Have you ever had a colposcopy of your cervix?

____ Did your mother take DES while pregnant with you?

____ Have you been attempting to get pregnant for more than 1 year without success?
How long? _____
What fertility testing have you had and what were the results? _____
_____
_____

____ Do you have any symptoms possibly related to premenstrual syndrome?
Symptoms are on a regular cyclic basis, either before, during and/or after menses.
How long do they start before your period? _____ days
____ cyclic(monthly) weight gain
____ bloating or swelling
____ mood swings
____ headaches
____ vision changes
____ breast tenderness
____ tiredness
____ food cravings
____ are these symptoms severe enough for you to desire therapy to reduce or eliminate them?

____ Do you have any problems or questions regarding your sexual function?
____ decreased sex drive
____ difficulty reaching orgasm or climax
____ history of sexual abuse
____ other _____

____ Do you or have you had urinary tract problems?
____ bladder infection? If so, how many and when was last one. _____
____ kidney infection? How many _____
____ other urinary tract disease? If so, what? _____
____ burning or pain on urination?
____ frequency of urination?
____ need to urinate during the night? If so, how many times? _____
____ loss of urine with coughing,sneezing, running, lifting or straining? Is this a significant problem? ___
____ pass urine in small amounts
____ feeling of incomplete emptying
____ need to use pantyliner or pads
____ other urinary problems _____

____ Do you have any breast problems?
____discharge from your breasts?
____ lumps in your breasts?
____ back/neck pain from large breasts?
____ shoulder indentations from bra straps?

Have you been taught to perform a breast self-examination? ____
Do you examine your breasts monthly? ___
Have you had a mammogram? ____ When _____ Where _____

Do you understand that very tiny breast cancers may not be felt by your doctor and that is why repeat examinations to mammograms are necessary? ____

Do you understand that repeat exams and/or mammograms are very helpful, but that not all breast cancers can be seen on mammogram? _____

____ Do you have gastrointestinal problems?
____ constipation
____ rectal pain or pressure
____ rectal itching
____ rectal bleeding or blood in the stool
____ difficulty having a bowel movement
____ need to manually assist a bowel movement
____ diarrhea
____ constipation and diarrhea
____ hemorrhoids
____ heartburn/esophageal reflux
____ other? Please describe _____

____ Do you have constitutional symptoms?
____ fever or chills
____ hot flashes __ at all hours __ At night only
____ fatigue
____ difficulty getting to sleep
____ waking up in the middle of the night
____ weight gain ____# in ____ month(s). ____ weight loss ____ in ____ month(s).

____ Do you have skin and/or hair problems?
____ complexion problems
____ recent change in size or color of nevus(mole) If so, where_____
____ increased hair growth(chin, lip, etc.) Does this run in your family ___
____ sensitive skin
____ hair loss or thinning

____ Do you have any other medical problems that are not covered in this questionnaire? If so, please list:
_____
_____

Family History:

Have any family members had and if so, whom:
____ breast cancer _____
____ ovarian cancer _____
____ uterine cancer _____
____ colon cancer _____
____ pancreatic cancer _____
____ high blood pressure _____
____ heart disease _____
____ stroke _____
____ osteoporosis _____
____ diabetes _____
____ AIDS _____

____ intellectual disability _____
____ epilepsy _____
____ neural spine defect (including spinal bifida) _____
____ Down's syndrome _____
____ Tay Sach's _____
____ Sickle Cell _____
____ Muscular Dystrophy _____
____ Huntington's Chorea _____
____ hemophilia _____
____ Cystic Fibrosis _____
____ birth defects _____
____ short stature _____
____ multiple pregnancy losses _____
____ Multiple pregnancies (twins) _____
____ Tuberculosis _____
____ mental illness _____
____ alcohol or drug abuse _____
____ other problems? _____

	Living	Age or age at death	Present health or cause of death
Mother	__yes __ no	_____	_____
Father	__ yes __ no	_____	_____
Sister	__ yes __ no	_____	_____
Sister	__ yes __ no	_____	_____
Sister	__ yes __ no	_____	_____
Sister	__ yes __ no	_____	_____
Brother	__ yes __ no	_____	_____
Brother	__ yes __ no	_____	_____
Brother	__ yes __ no	_____	_____
Brother	__ yes __ no	_____	_____

Religious or ethnic backround: _____

I have noted or listed all medical problems or conditions of which I am aware in the above questionnaire. I have provided complete information concerning medical problems or conditions of which I am aware.

Signature _____ Date _____

Lynda J Wright, MD,LLC

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practice, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14,2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain,including health information we created or received before we made the changes. Before we make significant change in our privacy practices, we will change this notice and make the new notice available upon request. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact the Office Coordinator.

Uses and disclosures of Health information
We use and disclose health information about you for treatment, payment and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use or disclose your health information to obtain payment for services we provide you.
Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization , we cannot use or disclose your health information for any reason except those described in this notice,
To your family and friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons involved in care: We may use or disclose health information o notify, or assist in the notification of (including identifying or locating) a family member,your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you an opportunity to object to such uses or disclosures.
In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up prescription s, medical supplies or other similar forms of health information.
Marketing Health-Related services: We will not use your health information for marketing communications without your written authorization.
Required by law: We may use or disclose your health information when we are required by law.
Abuse or neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are the possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.
We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment reminders: We may use or disclose your health information to provide you with appointment reminders, such as voice mail messages,emails, or letters.

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (you must make a request in writing to obtain access to your healthcare information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time to locate and copy your health information, and postage if want the copies mailed to you. If you want an alternative format, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.)

D**isclosure Accounting**:You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment,payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14,2003. If you request this accounting more than once in a 12month period, we may charge a reasonable, cost-based fee for responding to these additional requests.

Restrictions:You have the right to request that we place additional restrictions on our use or disclosure of yur health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communications:You have the the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payment will be handled under the alternative means or location you request.

Amendments: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS:

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S Department of Health and Human Services.

Contact

Lynda J Wright MD LLC
4 Rivers Edge
Eliot, Maine 03903
(207) 451-9440

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue S.W.
Washington, D.C.20201
(877)696-6775

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION AND RECORDS

I hereby request and authorize

to release any and all health information regarding treatment rendered to me, and to discuss any informatiom or options regarding the same, to:

Lynda J Wright MD
74 State Rd Suite 105
Kittery, Maine 03904
Phone (207)451-9440
Fax (207)482-0201

Other information to be disclosed: _____
Information I refuse to disclose: _____

The purpose of this release is to: _____

I understand that my medical records contain information relating to my diagnosis and treatment and I authorize the release of all such information listed above, except those items that I have specified. I undestand that I may review my records and refuse authorization to disclose all of the above health care information.I further understand that I may revoke this authorization by written notice to the above healthcare provider at any time, except where the healthcare provider has already acted upon the authorization.I further understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient. This authorization is valid for a period of 30 months from the date of signing, unless an earlier date is assigned: _____.

If I have been disgnosed or treated for any of the following, I understand that my healthcare provider(s) need my specific consent to disclose related information.

1.Substance Abuse records: I (_Do/_Do Not) authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse. Such information may not be disclosed by the recipient without my specific written consent.
2.Mental Health records:
A) I (_Do/_Do Not) authorize disclosure of information which refers to treatment or diagnosis of mental health. Such information may not be redisclosed without my specific written consent.
B) I (_Do/Do Not) want to review such information before it is released. I understand that this review must be supervised.
3.HIV records: I (_Do/_Do not) authorize disclosure of information which refers to HIV test results, infection status or treatment information. Such information may not be redisclosed by the recipient without my specific written consent.

I understand that I am entitled to a copy of this authorization.
A photocopy of this authorization shall be considered as effective and valid as the original.

By: _____ _____
Patient *Date of birth*
or _____ _____ _____
Authorized representative if applicable *Relationship* *Date*