Womens Health Center

PATIENT INFORMATION & AUTHORIZATION

This form is confidential. We appreciate your cooperation in completing this form thoroughly.

Patient Demographics

Patient's Name: _____ Date of Birth: _____

Address: _____ SS#: _____

City: _____ State: ____ Zip: _____ Occupation: _____

Email Address: _____ □ Home Phone: (_____) _____

Employer: _____ □ Cell Phone (_____) _____

Employer's Address: _____ □ Work Phone (_____) _____

City: _____ State: ____ Zip: _____ *Please check which phone you would prefer to receive calls.*

Referred by: _____ Okay to leave messages? Yes No

Spouse or Responsible Party

Name: _____ Relationship to Patient: _____

Address: _____ Date of Birth: _____

City: _____ State: ____ Zip: _____ SS#: _____

Employer: _____ Occupation: _____

Employer's Address: _____ Telephone (___) _____ Which type: _____

City: _____ State: ____ Zip: _____ Work Phone (____) _____

Emergency Contact

Telephone (____) _____

Name: _____

Circle one: Cell Home Work

Relationship to Patient: _____

Authorization

A. I authorize my physician to discuss all aspects of my medical condition and treatment with the following person(s). I understand that I can rescind this authorization at any time by submitting a written request.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature of Authorization _____

B. I authorize and consent to treatment of the minor child.

Signature of Parent or Guardian: _____ Relationship: _____

C. Co-payments are always due at the time services are rendered. We are happy to bill your insurance for services; however, the patient or the patient's responsible party is ultimately responsible for payment of any medical services rendered. **I authorize the payment of medical/surgical benefits to the physician. I acknowledge that I am responsible for payment of all charges.**

Signature: _____ Date: _____

Womens Health Center

PATIENT INFORMATION

Name: _____ Date of Birth:_____

Marital Status:

☐ Single ☐ Decline to Answer

☐ Married ☐ Separated

☐ Divorced ☐ Widowed

☐ Domestic Partner ☐ Other: _____

Religion: _____

Preferred Language: _____

Race:

☐ American Indian ☐ Pacific Islander

☐ Alaska Native ☐ Two or more races

☐ Asian ☐ White

☐ Black / African American ☐ Unknown

☐ Middle Eastern ☐ Decline to respond

☐ Native Hawaiian ☐ Other: _____

Ethnicity:

☐ Cambodian ☐ Mexican, Mexican American, Chicano/a ☐ Non-Hispanic

☐ Cuban ☐ Other Hispanic, Latino/a or Spanish origin ☐ Unknown

☐ Filipino ☐ Puerto Rican ☐ Decline to respond

☐ Other: _____

Womens Health Center

FINANCIAL POLICY

We are committed to providing you with the best possible care and are happy to discuss our professional fees and payment policies with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibilities.

Payment and Insurance

Together we can work collaboratively to keep healthcare costs down.

If you are enrolled in an HMO, you must provide the required prior authorization at your scheduled appointment. Should there be a remaining balance after the insurance payment, you will receive a statement. You are responsible for the timely payment of your account.

Insurance is a contract between you and the insurance company. As a party to your insurance contract, we will handle your claims according to our agreement with your insurance company. We will not get involved in disputes between you and your insurance company regarding deductibles, co-payments, non-covered services, secondary insurance, etc.

It is your responsibility to know the details of your health plan. Some insurance plans do not cover certain procedures. If you are in doubt as to whether a procedure, lab test, or x-ray is covered or unsure as to where it must be performed, please call your plan's member services department to clarify.

Full payment is due at the time of services, but if you are enrolled in a non-contracted insurance plan we will bill them as a courtesy for you if you provide us your current enrollment information. For patients paying cash, we require payment in full at the time of service.

- We accept cash, check, debit card, and all major credit cards.
- If your check is returned for non-sufficient funds (NSF), we will add a service charge to your account.

Financial Hardship

If you are having financial difficulty, our business office will be happy to work with you. If we establish a payment plan, we ask that payments be made as scheduled, each month and on time.

Tests and Surgery Charges

If your visits include laboratory tests, radiology, biopsies, pap smears, or cultures, you will receive separate billings from the company performing the processing and evaluation of those tests, e.g. Hoag Imaging, LabCorp, Quest, etc.

Prior to a surgery, we will obtain insurance coverage information and determine what portion, if any, of the fee will be your responsibility. You will be required to pay a percentage of that portion prior to surgery. If your insurance pays more than the balance due, we will refund your prepaid portion.

Cancellations & No-Shows

Please keep the appointments you have requested. We have reserved that time for you in order to take care of your healthcare needs. If you miss an appointment and do not reschedule, you run the risk that your physician will not be able to detect and treat a serious health condition. Please call us at least 24 hours prior to your appointment if you need to reschedule. This helps us fill your spot with another patient in need of an appointment. If you do not notify us you may be charged a $50 fee. This fee is not covered by insurance carriers and will be your responsibility. If you fail to call us to reschedule your appointment, you will be considered a no-show. You will be charged the $50 fee. If you have three no-shows, this may result in dismissal from our practice.

Medical Insurance Information

Patient Name: _____ Responsible Party: _____

Signature: _____ Date: _____

Womens Health Center

NOTICE OF PRIVACY PRACTICES

The Practice reserves the right to modify the privacy practices outlined in this notice.
I am aware of NOTICE OF PRIVACY PRACTICE posted at entrance.

I understand that if I wish to keep a copy, I will receive one upon request with front office.

_____
Name of Patient

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if patient is a minor or an adult who is unable to sign.)

_____
Relationship of Representative

Documentation of Attempt to Obtain Acknowledgement of Receipt of Privacy Practices

An attempt was made to obtain an acknowledgement of the Notice of Privacy Practices on _____.

The Acknowledgement was not obtained because:

☐ The patient was undergoing emergency treatment.

☐ The patient declined to sign the acknowledgement.

☐ Other _____

Name of Patient: _____

Name of Staff Member: _____

Signature of Staff Member: _____ Date: _____

Womens Health Center

HEALTH QUESTIONNAIRE

Today's Date: _____

Date of Last Menstrual Period: _____

Patient Demographics

Name: _____ Date of Birth: _____

Referred by: _____

Reason for visit: _____

Current Medications- Including supplements, vitamins, herbal products, and over-the-counter medication

EXACT NAME OF DRUG	DOSAGE & FREQUENCY	PRESCRIBING PHYSICIAN	EXACT NAME OF DRUG	DOSAGE & FREQUENCY	PRESCRIBING PHYSICIAN

Please list additional medications on the back of this paper or attach a separate sheet.

Preferred Pharmacy

Address: _____ City: _____ Cross Streets: _____

Mail Order: _____

Allergies

DRUG/SUBSTANCE	REACTION	DRUG/SUBSTANCE	REACTION

If you are uncomfortable answering any questions, please leave them blank; you can discuss them with your doctor or nurse

Social History

Tobacco Use:

Current Every day Smoker **Current Some Day Smoker** **Former Smoker** **Passive Smoker** **Never Smoker**

Type: **Cigarettes** **Pipe** **Cigars** **Snuff** **Chew**

Pack(s)/day: _____ Years: _____ Quit Date: _____

Do you drink alcohol? **Yes** **No** How many drinks per week? _____

Do you use drugs socially? **No** **Yes** Use/week: _____

Type: **IV** **Inhalant** **Pills** **Topical** **Marijuana** **Cocaine** **Meth** **Heroine** **Other:** _____

Patient Name: Date of Birth:

Are you sexually active? **Yes** **Not Currently** **No** Sexual partners: **Men** **Women** **Both**
What method of contraception are you currently using? _____
What methods of contraception have you previously used (please include name of pills):
_____

Activities of Daily Living

Are you on a special diet? **Yes** **No** If 'yes,' please explain: _____
Do you exercise regularly? **Yes** **No** How many times per week? _____
Do you do self-breast exams? **Yes** **No** How often? _____

Socioeconomic

Occupation: _____ Employer: _____
Spouse/Partner's Name: _____ # of children: _____
(Include step and adopted children)
Education: **High School** **Some college** **AA Degree** **Bachelor's Degree** **Graduate Degree** **Other: _____**

Relevant Dates

Date of last Pap Smear: _____ Was it normal? **Yes** **No** If 'no,' please explain: _____
Date of last mammogram: _____ Was it normal? **Yes** **No** If 'no,' please explain: _____
Have you had a bone density study? **Yes** **No** Date: _____ Result: _____
Have you had a colonoscopy? **Yes** **No** Date: _____ Result: _____

Past Medical History

ILLNESS	YES (DATE)	NO	NOTES
Asthma			
Pneumonia/Lung Disease			
Kidney Infections/Stones			
Tuberculosis			
Fibroids			
Hypertension			
Elevated Cholesterol			
Eating Disorder			
Autoimmune Disease (Lupus)			
Chickenpox			
Cancer			
Reflux/Hiatal Hernia/Ulcers			
Migraine Headaches			
Hepatitis			

ILLNESS	YES (DATE)	NO	NOTES
Anemia			
Blood Transfusions			
Heart Disease			
Bowel Problems			
Seizures/Convulsions/Epilepsy			
Depression/Anxiety			
Glaucoma			
Bladder Problems			
Bleeding Disorders			
Diabetes			
Arthritis/Fibromyalgia			
Thyroid Problems			
Other:			

Do you accept blood transfusions? **Yes** **No**

Operations and Medical Procedures *Include colonoscopies*

REASON	DATE	RESULTS

Patient Name: Date of Birth:

Family History

Are you adopted? **Yes** **No**
Does anyone related to you have a history of the following illnesses?

ILLNESS	YES	RELATIVE (Ex. Maternal Aunt)	AGE OF ONSET	ILLNESS	YES	RELATIVE (Ex. Maternal Aunt)	AGE OF ONSET
Alcohol/ Drug				Elevated Lipids			
Anesthesia Problems				Genetic			
Arthritis				Gastrointestinal			
Birth Defects				Heart			
Blood clots in lungs/legs				Hypertension			
Blood Disorder				Osteoporosis			
Cancer:				Psychiatry/Mental Illness/Depression			
Breast				Pulmonary			
Colon				Renal			
Ovarian				Stroke			
Uterine				Tuberculosis			
Diabetes				Thyroid			
Other:							

Hereditary Cancer Risk Questionnaire

Please check all that apply:

□ Personal history of breast cancer diagnosed less than 50 years old

□ Family history of more than 3 cancers on the same side of the family

□ Personal and/or family history of ovarian, male breast, metastatic prostate, or pancreatic cancer

□ Ashkenazi Jewish ancestry and history of breast cancer

Obstetrical History

Pregnancy History: **Never been pregnant** **Currently pregnant** **# of times you have been pregnant before? _____**

Number of: **Vaginal deliveries: _____** **C-sections: _____** **Miscarriages: _____** **Ectopic pregnancies: _____**

Elective abortions: _____ **Premature births: _____** **Stillbirths: _____**

Date of Delivery	Gest. Age	Labor Length	Wt.	Sex	Delivery Type (Vaginal, C-section)	Anesth. Type (Epidural, Spinal)	Name	Location	MD

Any pregnancy complications? **Yes** **No** If 'Yes,' please explain: _____

Any history of depression before or after pregnancy? **Yes** **No** How was it treated? _____

Patient Name: Date of Birth:

Menstrual History

Age periods began: _____ Menstrual periods come every _____ days and last for _____days.

Period pattern is: **Regular** **Irregular** Menstrual flow is: **Light** **Moderate** **Heavy**

Do you have pain with periods? **No pain** **Mild** **Moderate** **Severe**

Pain symptoms: **Cramping** **Throbbing** **Nausea** **Diarrhea** **Headache** **Other:** _____

Do you have premenstrual symptoms (PMS)? **Yes** **No** _____

Gynecological History

Have you ever had an abnormal Pap? **Yes** **No** If 'yes,' explain: _____

Have you ever had a sexually transmitted disease? **Yes** **No** _____

Have you been treated for infertility? **Yes** **No** _____

Do you have any urinary problems? **No** **Loss of urine** **Frequent urination** **Other:** _____

Do you have pain with sexual relations? **Yes** **No** _____

Do you have recurrent vaginal infections? **Yes** **No** _____

IF Menopausal:

When did you stop having periods? _____

Have you used/taken hormone replacement? **Yes** **No** If 'yes,' what type, dose, and when? _____

_____

Have you had any vaginal bleeding since menopause? **Yes** **No** When and how much? _____

Do you have...

Hot flashes?	**Yes**	**No**	Decreased libido?	**Yes**	**No**
Night sweats?	**Yes**	**No**	Anxiety?	**Yes**	**No**
Trouble sleeping?	**Yes**	**No**	Depression?	**Yes**	**No**
Decreased memory?	**Yes**	**No**	Vaginal Dryness?	**Yes**	**No**

Optional

Have you been physically or mentally abused by your spouse or partner? **Yes** **No**

Have you ever been sexually abused or raped? **Yes** **No**

Do you have any other questions or concerns?

_____

_____

_____

Patient Name: Date of Birth:

Please circle any symptoms you have experienced in the last month.

CONSTITUTIONAL
Unexplained weight loss
Unexplained weight gain
Fever
Fatigue

EYES
Double vision
Spots before eyes
Vision changes

EAR / NOSE / THROAT / MOUTH
Ear aches
Ringing in ears
Sinus problems
Sore throat

RESPIRATORY
Wheezing
Shortness of breath
Chronic cough

CARDIOVASCULAR
Chest pain
Difficulty breathing on exertion
Heart palpitations

GASTROINTESTINAL
Frequent diarrhea
Blood in stool
Nausea / vomiting
Constipation
Black / tarry stool

GENITOURINARY
Blood in urine
Pain w/ urination
Leaky urine
Urgency
Frequency of urination
Vaginal discharge
Heavy periods
Painful periods
Irregular vaginal bleeding
Painful intercourse
Vaginal itching / irritation

BREASTS / SKIN
Pain in breasts
Nipple discharge
Breast mass
Skin rash or lesion

HEMATOLOGICAL/ LYMPHATIC
Frequent bruises
Cuts do not stop bleeding
Enlarged lymph nodes

MUSCULOSKELETAL
Muscle weakness
Joint pain

NEUROLOGICAL
Dizziness
Frequent headaches
Significant memory problems

PSYCHIATRIC
Depression
Frequent crying
Anxiety

ENDOCRINE
Dry skin
Abnormal thirst
Hot flashes

ALLERGIC/IMMUNOLOGIC
Environmental allergies
Hives

The Patient Health Questionnaire-2 (PHQ-2)

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half The Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

COSMETIC SERVICES

Circle if any apply.

Facial vein / redness
Loose skin
Abdominal contouring
Facial contouring
Sun/age spots, freckles
Vulvar / vaginal/ laxity
Muscle toning
Aging hands
Overall complexion / skin texture
Unwanted hair
Acne/ scarring
Micro needling
Excessive sweating