Date: _____ Name: _____ Date of birth: _____

Nickname/prefer to be called: _____

Date that your last menstrual period began: _____

Reason for today's visit: _____

Allergies to medications/foods/substances? Yes No

If yes, what are you allergic to and what type of reaction/symptoms did you have?

_____

_____

_____

Medications used (include prescriptions, over-the-counter drugs, supplements, vitamins, inhalers, etc):

Name Strength Frequency

_____

_____

_____

_____

_____

Circle any of the following medical conditions that you have been diagnosed with:

Heart disease	High blood pressure	High cholesterol	Asthma
COPD/emphysema	Sleep apnea	Acid reflux disease	Stomach ulcers
Irritable bowel	Liver problems	Kidney stones	Low kidney function
Fibroid uterus	Endometriosis	Arthritis	Osteoporosis
Fibromyalgia	Diabetes	Thyroid disease	Migraine
Stroke	Blood clot (DVT/PE)	Allergies	Cancer

Please give details of above conditions and list any other significant medical diagnoses you have had:

_____

_____

_____

Gynecologic History:

Total number of pregnancies: _____ Births: _____ Miscarriages: _____ Pregnancy terminations: _____

What method are you using to prevent pregnancy at this time? _____

Number of sexual partners in the last year (circle): 0 1 More than one

Age at first menstrual period: _____ Age at menopause or hysterectomy:_____

Any abnormal pap smears? _____ If yes, details:_____

Any abnormal mammograms? _____ If yes, details:_____

Please list any specialists or other physicians whom you see for care:

_____

_____

_____

Preventive Care:

Please list the dates of your most recent:

Colonoscopy: _____ Bone density test: _____ Mammogram: _____

Pap smear: _____ Eye exam: _____ Flu shot: _____

Tetanus shot: _____ Pneumonia vaccine: _____ Shingles vaccine: _____

HPV vaccine: _____ Yearly physical or well woman exam: _____

Blood testing: _____

Surgical History:

Please list type of surgery and the approximate date (don't forget tonsillectomies or cosmetic surgeries):

_____

_____

_____

_____

_____

Family History:

Mother (circle): living or deceased ? If deceased, age and cause of death: _____

Father (circle): living or deceased ? If deceased, age and cause of death: _____

Check any of the following that run in your family **and** please note who had it and what age diagnosed:

	Mother	Father	Sister	Brother	Grandmother (mother's side)	Grandfather (mother's side)	Grandmother (father's side)	Grandfather (father's side)	Child	Other (aunts, uncles, cousins)	Age when diagnosed
Stroke											
Anxiety											
Depression											
Alcoholism or Drug Abuse											
Breast Cancer											
Colon Cancer											
Ovarian Cancer											
Melanoma											
Other Cancers (specify)											
Diabetes (type 1 or 2)											
Heart Disease											
Osteoporosis											
Rheumatoid Arthritis											
Thyroid Conditions											
Other (specify)											

Comments and specifications if applicable for above:

_____

_____

_____

Social History:

Occupation: _____ Employer: _____ Highest education level: _____

For students, name of your school and grade (or year of study): _____

Marital Status (circle): Single Married Separated Divorced Widowed Partnered/Living together

Number of children? _____ Genders and years of birth: _____

What do you like to do in your free time? _____

Do you exercise regularly? Yes No If yes, type and frequency? _____

Do you currently smoke cigarettes? Yes No If yes, how many packs per day? _____

If former smoker, quit date? _____ # of years smoked and usual # of packs daily? _____

Do you drink alcohol? Yes No If yes, # of days per week____ ? and # of drinks on those days_____?

Have you ever had a problem with alcohol abuse or alcohol addiction? Yes No

Do you use caffeine? (coffee/tea/soda/energy drinks/supplements) Yes No # of servings daily _____

Do you use marijuana? Yes No If yes, type and frequency? _____

Any current or significant prior use of cocaine/heroin/other "street" drugs? Yes No

Mental Health History (circle any conditions you have had/have):

Depression Anxiety OCD Bipolar disorder ADD/ADHD

Details of above (include any prior treatment or meds) or list any other mental health conditions:

_____

_____

_____

Infectious Disease History (circle any conditions you have had/have):

Tuberculosis Malaria Herpes Syphilis Hepatitis Gonorrhea

Chlamydia Cold sores Shingles Chickenpox HPV (human papilloma virus)

Review of systems (circle any symptoms that you are CURRENTLY experiencing or have had RECENTLY):

Fatigue	Weight gain	Weight loss	Change in vision
Change in hearing	Chest pain	Palpitations	Chronic cough
Shortness of breath	Abdominal pain	Blood in stool	Bowel changes
Painful periods	Irregular periods	Heavy periods	Vaginal discharge

Concern for exposure to sexually transmitted illness/desire to be tested for STI's

Abnormal moles	Breast lumps	Breast pain	Nipple discharge
Hot flashes	Night sweats	Anxiety symptoms	Depressive symptoms

CONSENT TO COMMUNICATE MEDICAL RESULTS

Patient's Name (Last) _____ (First)_____ (MI)_____Previous Name_____

Date of Birth MM_____/DD_____/YYYY_____ Social Security Number _____-_____-_____

Address _____City_____, State _____Zip _____

E-Mail Address _____Employer Name_____

List which phone numbers we may leave messages and test results on and circle preferred number

*Home Phone*_____ Can we leave messages? □ *yes* □ *no*

*Cell Phone*_____ Can we leave messages? □ *yes* □*no*

Work Phone _____ *Ext*_____ *Can we leave messages?* □ *yes* □ *no*

Preferred Pharmacy Name and Address _____ Pharmacy Phone _____

Race (***please circle one***) White, Black or African American, Native Hawaiian/Other Pacific Islander, Asian, Declined

Ethnicity (***please circle one***) Hispanic or Latino, Not Hispanic or Latino, Declined

Preferred Language: English Spanish Other: _____Translator Needed? Y or N

I, the undersigned, understand that medical results will be communicated directly to me unless I specifically identify individuals to whom information may be communicated.

In the event you are unavailable are we able to release the information to anyone else? □ yes □ no

If yes: Name _____ Relationship to Patient: _____

Emergency Contact: Last Name _____ First Name _____

Phone Number _____ Relationship to Patient _____

RESPONSIBLE PARTY INFORMATION

Responsible Party □ Self □ Spouse □ Parent □ Other □ **Check here if information is same as patient**

Responsible Party Name (Last) _____ (First) _____ (MI) ____

Date of Birth MM _____/DD_____/YYYY_____ Social Security Number _____ - _____ - _____

Telephone _____

Address Line_____

City_____, State _____ Zip _____

I am aware that the Women's Wellness Center is an Electronic Charts Office and all original documents are scanned into my file then destroyed. I agree that a facsimile will be honored as a legal document.

Signature _____ **Date**_____

(Must be a parent or guardian for children 17 and under)

WOMEN'S WELLNESS CENTER
POLICIES/PROCEDURES

Welcome to Women's Wellness Center. We are pleased that you have selected our practice for your medical care. To ensure the best possible experience at our office, **PLEASE READ THE FOLLOWING INFORMATION VERY CAREFULLY** and let us know if you have any questions concerns.

NO SHOW / CANCELLATION POLICY

All cancellations should be made no later than 24 hours prior to your scheduled appointment. "No-shows" or late cancellations will be subject to a $40.00 fee for a regular appointment, or $80.00 for a physical exam/well woman exam.

LATE ARRIVALS

If you are late for an appointment, you may be asked to reschedule. (yes, even though at times you might have to wait if the care of other patients has caused the provider to run behind schedule ☺)

PRESCRIPTION REFILLS

To limit prescription refill requests over the phone or from pharmacies, our providers will generally provide enough refills on prescriptions to last until you are due for your next appointment. Please watch your medications carefully and call to schedule an appointment BEFORE needing a refill. If you use a mail-in pharmacy you may need to schedule at least 2 weeks in advance to assure that you do not run out of medication. It is also very helpful for you to bring all of your current medication bottles with you to appointments so they can be reviewed.

PHONE CALLS/EMERGENCIES

In case of a true emergency, call 911 or go to the nearest emergency room. Urgent calls after hours will be forwarded to our provider-on-call. Please reserve use of this service for truly urgent matters that cannot wait until regular business hours (not med refills or non-acute issues). If you do not hear back from a provider within 30-60 minutes, please feel free to call back. Phone calls will be charged based on complexity of issues addressed, duration of the call, and whether or not prescriptions are required. During office hours, if you urgently need to speak to a provider we recommend coming in for an appointment. If you can't come in for an appointment, phone calls with providers during office hours may be charged based on complexity and duration.

FORM COMPLETION

Many forms will need to be completed during an office visit so accurate and complete information can be obtained. If you drop off or fax a form, you will be contacted to schedule an appointment. If the provider decides a form can be completed outside an office visit, you will be billed a fee for completion of the form, and the amount will be based on the type of form.

TIMELINESS OF CARE

In an attempt to keep providers on schedule as well as allow sufficient time to address everyone's concerns, we ask that you please let the scheduler know everything that you want to address when scheduling, and again at the beginning of the visit. There may not be time to address everything within the time allotted, so please be understanding if you are asked to schedule a separate appointment. Additional requests that you think should only take a minute or two often take much longer and can throw the schedule off by an hour or more by the end of the day.

FORMULARIES

It is very helpful to bring a copy of your insurance company's medication formulary with you at the time of your visit. This is a list of preferred medications for your particular plan. This will allow your provider to select medications that will be most cost beneficial to you. Also, let your provider know at the time of your visit if you will need prescriptions for a mail-in pharmacy. We recommend checking with your insurance company whether this is an available option as it can save you quite a bit of money with chronic medications.

BLOOD DRAWS

Blood draws may be done by the Quest phlebotomist here in the office or you may take your orders to another lab if you prefer. Quest has a facility here as a courtesy only and is in no way affiliated with Women's Wellness Center. Issues with lab billing will need to be addressed directly with Quest.

LABS/TEST RESULTS

We do our best to notify you of the results of any tests ordered or performed in our office in a timely fashion. If you do not receive results within 2 weeks, please call the office. **No news does not necessarily mean good news!**

INSURANCE BILLING ISSUES

Insurances are billed as a courtesy only. You are ultimately responsible for any unpaid balances. If you have a high deductible plan, you will be required to pay a deposit prior to being seen. You will be financially responsible for all outstanding charges. There will be a minimum monthly billing charge of $10.00 or interest at the rate of 1.75% per month (whichever is greater) on any balance not paid within 30 days of the date of service. In addition, should your account become delinquent and assigned to a collection agency, you will be charged an additional collection charge of 35% of the outstanding balance or a minimum of $40.00 whichever is greater to offset in part the collection agencies fee charged to this practice. Should legal action be initiated by the collection agency, you will be charged a collection fee of 50% of the outstanding balance as well as all costs and reasonable attorney fees incurred in such collection efforts by this office or our assignee.

CODING OF OFFICE VISITS

Our providers do their best to code office visits as accurately as possible—this includes both preventive and problem based visits. We encourage you to understand your insurance benefits prior to services being performed, as we cannot change codes retrospectively after your visit.

ASSIGNMENT OF BENEFITS

I hereby authorize Women's Wellness Center to file a claim with my insurance carrier and I authorize payment for medical services to Women's Wellness Center.

HIPAA

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), Women's Wellness Center may not disclose your personal health information without your authorization.

The HIPAA Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. ***An original copy of this detailed policy is available in the office by request if you would like to review it***.

Thanks again for choosing us for your medical care, and thank you for your help!

Sincerely,

The Providers and Staff of Women's Wellness Center

I acknowledge that I have read and understand the above policies and procedures:

Signature_____Date_____

Printed Name_____

WITNESS_____