

Woman's Clinic, PA

Dedicated to women's health for over 50 years. Specializing in routine and high risk pregnancies, gynecologic surgery, laparoscopy, infertility, urinary incontinence, pelvic prolapse, and menopause.

Please complete entire form for our physicians.

Date: _____ Name: _____ Age: _____ Date of Birth: _____
 Reason for visit (Please Circle) Annual Visit Problem (Description if Problem) _____
 Referred by: _____ Primary Care Doctor: _____
 How did you hear of the Woman's Clinic, PA? Phone Book Friend Newspaper Ad Doctor Referral Other _____

CURRENT MEDICATIONS

Drug Name	Dosage	Reason for Medication	Prescribing Physician

What is your preferred Pharmacy? _____ Do you take any over-the-counter medications or herbs? _____
 Are you taking any Hormone Replacements? _____ Are you taking any Birth Control? _____
 Do you have any allergies? If yes, to what? _____
 Are you allergic to Latex? Yes No Are you allergic to Shellfish? Yes No Reaction: _____
 Do you want more children? Yes No Would you like to talk to the physician about permanent birth control? Yes No

GYNECOLOGIC HISTORY

Age at first period? _____ Date of your last period? _____ How many days does it last? _____
 How many days from the start of one period to the start of another? _____ Describe your flow: Light Medium Heavy
 Do you bleed between periods? Y N Do you pass clots? Y N Do you have pain with your period? Y N
 Do you miss school/work from pain? Y N Are you sexually active? Y N Do you have pain with sex? Y N
 Do you have any concerns with your sexual experience? Y N Do you have any STDs? Herpes, Chlamydia, HPV or other? Y N
 Have you had an abnormal pap smear? Y N Do you have pelvic pain? Y N Do you have a problem with infertility? Y N
 Have you had any procedures on your cervix? If yes, what type? _____

PREGNANCY HISTORY

(Please include: Miscarriages, Ectopic Pregnancies and Abortions)

#	Date of Birth	Length of Pregnancy	Labor Hours	Birth Weight	Sex of Child	Delivered Vaginally or C-sec?	Epidural, Spinal, IV meds for pain?	Early Labor (Yes/No)	Complications

MAJOR MEDICAL EVENTS

Procedure	Date	Procedure	Date	Procedure	Date

TESTS / IMMUNIZATIONS

	Date of last:	Result		Date of last:	Result
Pap Smear			Colonoscopy		
Mammogram			Pneumonia / Flu Vaccine		
Bone Density			Other Vaccines such as Gardasil and Tetanus		

YOUR PAST MEDICAL AND FAMILY HISTORY

Illness	You	Family Member	Illness	You	Family Member
Anemia			Heart Disease		
Anorexia			Heartburn		
Anxiety			Hepatitis		
Arthritis			High Blood Pressure		
Blood clots in veins			Irregular Heart Beat		
Blood Transfusion			Kidney Stone		
Breast Cancer			Lung Cancer		
Bulimia			Lupus		
Cervical Cancer			Osteopenia		
Cholesterol Elevation			Osteoporosis		
Colon Cancer			Ovarian Cancer		
Convulsions			Pneumonia		
Crohn's Disease			Rheumatic Fever		
Dementia			Sickle Cell Disease		
Depression			Stomach Cancer		
Diabetes			Stomach Ulcer		
Emphysema / COPD			Stroke		
Endometriosis			Thyroid Disease		
Irritable Bowel Syndrome			Tuberculosis		
Fibroids of Uterus			Ulcerative Colitis		
Fibrocystic Breast Disease			Urinary Leakage		
Headaches			Urinary Tract Infection		
Heart Attach			Uterine Cancer		

SOCIAL HISTORY

Marital Status: _____ Single _____ Married _____ Widowed _____ Divorced _____ Separated Occupation: _____
 Personal Habits: Do you smoke? Y N Packs per day _____ Are you interested in quitting? _____
 Do you use Alcohol? Y N Drinks per week? _____ Recreational Drug Use? Y N Type? _____
 Seat Belt Use? Y N Regular Exercise? Y N How often? _____
 Are you currently safe? Y N Has anyone close to you ever threatened to hurt you? Y N Are you afraid of your partner? Y N
 Has anyone ever hit, kicked, choked, or hurt you physically? Y N

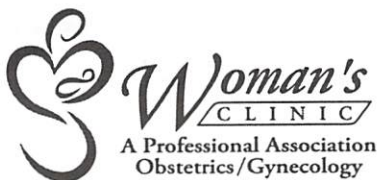
REVIEW OF SYMPTOMS (Please mark all that apply)

Symptom	Yes	Symptom	Yes	Symptom	Yes	Symptom	Yes
Change in Height		Breast Tenderness		Blood in Urine		Muscle Weakness	
Fatigue		Nipple Discharge		Difficulty with Urinating		Hair Loss	
Loss of Appetite		Chest Pain		Frequency of Urination		Heat/Cold Intolerance	
Weight Gain		Fainting		Incomplete Emptying of Bladder		Hot Flashes	
Weight Loss		Irregular Heart Beat		Painful Urination		Night Sweats	
Blurry Vision		Lower Extremity Swelling		Urgency to Urinate		Anxiety	
Dental Problems		Cough		Urine Loss with Coughing or Sneezing		Depression or Frequent Crying	
Double Vision		Shortness of Breath		Moles (New Growth or Changes)		Difficulty Sleeping	
Headache		Wheezing		Rash		Bleed Easily	
Lightheadedness		Blood in Stool		Memory Difficulties		Blood Transfusions	
Sore Throat		Constipation		Numbness		Easy Bruising	
Vertigo		Heart Burn		Joint Pain		Enlarged Lymph Glands	
Breast Lumps		Involuntary loss of gas or stool		Muscle Pain			
Breast Swelling		Nausea/Vomiting					

Form Completed By: _____ Patient _____ Office Nurse _____ Other: _____

Signature of Patient: _____

Date Reviewed with Patient: _____ Physician Signature: _____



NOTICE OF PRIVACY PRACTICES

We keep a record of the health care services we provide you. We will not disclose your record to others, unless you direct us to do so or unless the law authorizes or compels us to do so. You may get more information by contacting our Medical Records Department or Privacy Officer.

X SIGNATURE _____ DATE _____

AUTHORIZATION TO SHARE HEALTHCARE INFORMATION I permit you to share my healthcare information with

Name: _____ or FAX# _____ Relationship: _____

(please check all that apply)

- my healthcare information with exception to pregnancy testing, prenatal care, contraception and STD testing
- all information to include pregnancy testing, prenatal care, contraception and STD testing
- only information relating to _____

This authorization ends only upon my written request.

X SIGNATURE _____ DATE _____

FINANCIAL POLICY

Our office is committed to providing quality and cost-effective healthcare to our patients. It is essential that you understand what services are covered by your insurance plan and obtain all authorizations prior to your appointment. Your doctor may recommend services he/she feels are beneficial but may not be covered by insurance. It is your responsibility to understand the limit and restrictions affecting coverage for these services. ***If your insurance company requires you to use a specific lab, it is your responsibility to notify us of this.*** Insurance reimbursement is a contract between you and your insurance company. As a courtesy to you we file all claims for you. We will require a current copy of your insurance card in order to do this and will need to be informed of all changes in insurance status. You will be responsible for all co-pays, deductibles, co-insurance amounts along with the entire amount of any non-covered services. Payment for services is expected at the time of service. Patients who do not have insurance coverage (or proof of coverage) or who choose to pay for non-covered services are expected to pay in full at the time of service. If you cannot pay the full amount then you must make satisfactory payment arrangements with our business office prior to receiving services.

X SIGNATURE _____ DATE _____

(Please be advised that this will serve as acknowledgement that you understand TennCare is not routinely accepted by the Woman's Clinic, P.A. However, you understand that you may ask about an exception to this policy through the Woman's Clinic insurance department and agree to adhere to the qualification guidelines.)

X SIGNATURE _____ DATE _____

PREVENTATIVE CARE SERVICES

Your health plan may not provide benefits for preventative services. It is important you determine if your plan offers benefits for this service and their guidelines for it. We use industry standard codes and guidelines to submit insurance claims based on the encounter and documentation in the medical record. Current laws regarding fraud/abuse with billing procedures prohibit us from changing the procedure and/or diagnosis codes in order to get the claim paid by the insurance company.

X SIGNATURE _____ DATE _____

INSURANCE/BILLING INFORMATION

I authorize treatment and agree to pay all fees associated with such treatment. I authorize my insurance benefits to be paid directly to my physician. I authorize my physician to release any information required to obtain reimbursement. I agree that I am financially responsible for all service provided and should it be necessary to refer the account to a collection business associate, I will be responsible for all fees including but not limited to collection fees, attorney fees, and court costs involved with my account.

X SIGNATURE _____ DATE _____

NO SHOW POLICY (eff. 1-1-2014)

I am aware that if I fail to appear for scheduled appointments (and fail to cancel appointments) twice within a 6 month time-frame, my account will be assessed a \$25 fee for which I will be responsible for paying prior to scheduling another appointment. The Woman's Clinic hopes that this policy, in addition to the reminder service in place, will help to encourage our patients to cancel or reschedule any appointments they are unable to keep.

X SIGNATURE _____ DATE _____

Permission to View Medication History: Yes No