Fax 731-422-2277

Woman's Clinic, P.A.

Dedicated to women's health for over 60 years. Specializing in routine and high risk pregnancies, gynecologic surgery, laparoscopy, infertility, urinary incontinence, pelvic prolapse, and menopause.

Please complete entire form for our providers.

Date: ___________________ Name: ____ Age: ____________ Date of Birth: _____________________

Reason for visit: ◯ Annual Visit, or ◯ Problem (Describe if problem visit) ____

Referred by: ____ Primary Care Doctor: ____

How did you hear of the Woman's Clinic, P.A.? ◯ Search engine ◯ Friend /Family ◯ Doctor Referral ◯ Other __________________________

CURRENT MEDICATIONS

Drug Name	Dosage	Reason for Medication	Prescribing Physician

YOUR PAST MEDICAL AND FAMILY HISTORY (List relationship)

Illness	You	Family Member	Illness	You	Family Member
Anemia			Hepatitis		
Anxiety / Depression			High Blood Pressure		
Arthritis			Irregular Heart Beat		
Blood clots in veins			Kidney Stone		
Blood transfusion			Lung Cancer		
Breast Cancer			Lupus		
Cervical Cancer			Osteopenia / Osteoporosis		
High Cholesterol			Ovarian Cancer		
Colon Cancer			Pneumonia		
Crohn's Disease			Sickle Cell Disease		
Diabetes			Stomach Cancer		
Emphysema / COPD			Stroke		
Endometriosis			Thyroid Disease		
Irritable Bowel Syndrome			Tuberculosis		
Fibrocystic Breast Disease			Ulcer		
Headaches			Ulcerative Colitis		
Heart Attack			Urinary Leakage		
Heart Disease			Uterine Cancer		
Heartburn					

What is your preferred Pharmacy? ________________________________ Do you take any over-the-counter medication or herbs? ◯ Yes ◯ No

Are you taking any Hormone Replacements? ◯ Yes ◯ No Are you taking any Birth Control? ◯ Yes ◯ No

Are you allergic to any medication? ____

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? ____________________ First day 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? ◯ Yes ◯ No Do you pass clots? ◯ Yes ◯ No Do you have pain with your period? ◯ Yes ◯ No

Do you miss school/work from pain? ◯ Yes ◯ No Are you sexually active? ◯ Yes ◯ No Do you have pain with sex? ◯ Yes ◯ No

Do you have any concerns with your sexual experience? ◯ Yes ◯ No Do you have any STDs? Herpes, Chlamydia, HPV or other? ◯ Yes ◯ No

Have you had an abnormal pap smear? ◯ Yes ◯ No Do you have pelvic pain? ◯ Yes ◯ No Do you have a problem with infertility? ◯ Yes ◯ No

Have you had any procedures on your cervix? If yes, what type? ◯ Colposcopy ◯ LEEP ◯ Cryo

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TESTS / IMMUNIZATIONS

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

PREGNANCY HISTORY
(Please Include: Miscarriages, Ectopic Pregnancies and Abortions)

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

LIST SURGERIES

Procedure	Date	Procedure	Date	Procedure	Date

SOCIAL HISTORY

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Engaged ◯ Widowed

Have you ever used any nicotine products? ◯ Yes ◯ No ◯ Cigarettes ◯ Vape ◯ Cigars ◯ Oral tobacco

Alcohol Use: ◯ Yes ◯ No Number of drinks per week:

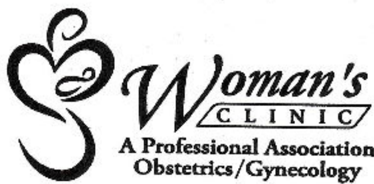
Recreational Drug Use: ◯ Yes ◯ No If yes, what type:

Have you ever been physically abused? ◯ Yes ◯ No Are you currently safe? ◯ Yes ◯ No

Do you exercise regularly? ◯ Yes ◯ No If yes, how often? Are you interested in Botox, Fillers or Laser? ◯ Yes ◯ No

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	
Headache		Lower Extremity Swelling		Urgency to Urinate		Anxiety / Depression	
Lightheadedness		Shortness of Breath		Urine Loss with Cough/Sneeze		Bleed Easily	
Vertigo		Blood in Stool		Memory Difficulties		Easy Bruising	
Breast Lumps		Constipation		Joint Pain		Enlarged Lymph Glands	
Breast Swelling		Heart Burn		Muscle Pain			



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:______________________Phone#____________________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.

(Please be advised that this will serve as acknowledgement that you understand THAT MOST TENNCARE PRODUCTS are accepted by the Woman's Clinic, P.A.)

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.

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.

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 for Woman's Clinic to View Medication History: ☐ Yes ☐ No

Woman's Clinic Physicians will only provide hospital services (i.e. deliveries and surgeries) at Jackson Madison County General Hospital Main Campus on Skyline Drive.