# Patient Information

Patient's Full Name:

_____
Last First Middle

SSN: _____ Date of Birth: _____

Mailing Address: _____
PO Box/Street City State/ ZIP

County:_____

Primary Phone:_____ Secondary Phone:_____

Email:_____ Language:_____

Marital Status [ ] M [ ] S [ ] D [ ] W Ethnicity: _____ Race:_____

Employment Status: [ ] Full time [ ] Part time [ ] Unemployed [ ] Retired Employer: _____

**Emergency Contact: _____ Relationship: _____Phone: _____**

Referring Physician: _____

Primary Care Physician: _____

**Responsible Party/ Guarantor (please print):**

Full Name: _____ Sex [ ] Female [ ] Male
Last First

DOB:_____ SSN:_____

Mailing Address:_____

Primary Phone :_____Secondary Phone:_____

Employment Status: [ ] Full time [ ] Part time [ ] Unemployed [ ] Retired Employer: _____

**Insurance (please print):_**

Primary Insurance:_____

Group #: _____

Subscriber ID: _____

Group Name:_____

Relationship to Insured:_____

Subscribers Name:_____

Sex: [ ] Female [ ] Male DOB:_____

SSN:_____

Address:_____

Secondary Insurance:_____

Group #:_____

Subscriber ID: _____

Group Name: _____

Relationship to Insured: _____

Subscribers Name: _____

Sex: [ ] Female [ ] Male DOB:_____

SSN:_____

Address:_____

# Health History Questionnaire

☐ *New Patient* ☐ *Return Patient*

A) **NAME**_____ Age_____
DOB_____

1. Marital status: ☐ Single ☐ Married ☐ Long-term relationship ☐ Divorced ☐ Widowed
2. Reason for this visit: _____Referring physician:_____
3. Occupation:_____
4. Preferred pharmacy (Store and Street/City): _____

B) **DRUG ALLERGIES** ☐ NONE ☐ YES: (please list): _____
_____

C) **CURRENT MEDICATIONS** (include dose/amount per day/medical reason for taking med)

| Medication | Dose | Frequency | Reason for medicine |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**D) GYNECOLOGIC HISTORY**

1. First day of Last Menstrual Period (LMP): _____
2. Age of first period: _____ years
3. Periods are ☐ regular, period start every _____ days
   ☐ irregular, periods start every ____ to _____ days (ex 12 to 60)
4. Duration of bleeding: _____ days
5. Periods are ☐ light ☐ medium ☐ heavy, changing a pad/tampon every ____ hour
6. Does bleeding or spotting occur between periods? ☐ Yes ☐ No
7. Is pain associated with periods? ☐ Yes ☐ No ☐ Occasionally
8. Have you gone through menopause? ☐ Yes ☐ No Year of Menopause: _____
   a. Taken hormone replacement? ☐ Yes ☐ No Medications:_____

**E) PAP SMEAR HISTORY**

1. Date of last pap smear: _____ ☐ Normal ☐ Abnormal
2. History of abnormal pap smears? ☐ Yes ☐ No
   If yes, what type of treatment have you had? (include year)
   ☐ Cryotherapy: _____ ☐ Cone biopsy (usually done in hospital): _____
   ☐ Laser: _____ ☐ Loop excision (LEEP- usually done in office): _____
3. Have you received the Gardasil (HPV) vaccination? ☐ Yes ☐ No

**F) SEXUAL HISTORY**

1. Are you sexually active? ☐ Yes ☐Not currently ☐ Never (virginal)
2. Current method of birth control: *(ex: condoms, pill, IUD)*_____
3. Problems with intercourse? ☐None ☐ Pain ☐ Bleeding ☐ Decreased libido

G) **OTHER PAST GYN HISTORY**: Check any that apply or ☐ None

☐ Genital Warts ☐ Herpes ☐ Syphilis ☐ Pelvic Inflammatory Dz (PID)
☐ Chlamydia ☐ Gonorrhea ☐ Trichomonas ☐ Recurrent vaginal infections (yeast or BV)
☐ Endometriosis ☐ Fibroids ☐ Ovarian cysts ☐ Other (specify)_____

H) **PAST MEDICAL HISTORY (Check any that apply)** ☐ None

☐ Arthritis ☐ Gallstones ☐ Respiratory problems (ex COPD)
☐ Diabetes ☐ Liver disease, includes hepatitis ☐ HIV
☐ gestational only ☐ Seizure disorder ☐ Thyroid disease
☐ High blood pressure ☐ Heart disease ☐ Depression/anxiety
☐ Kidney disease ☐ Asthma ☐ High cholesterol
☐ Breast cancer ☐ Blood clots legs/lungs ☐ Other _____

I) **PREGNANCY HISTORY** ☐ Never been pregnant

Obstetrics history including miscarriages, abortions, and ectopic (tubal) pregnancies

| Mo/ Year | Delivery Location | Duration of Pregnancy (# of weeks) | Delivery Type vaginal, cesarean, abortion, miscarriage | Delivering Physician | Complications Mother and/or Infant **Preeclampsia/ high blood pressure, diabetes, premature labor, other (specify)** | (Child) Sex | (Child) Birth Weight | (Child) Present Health |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

J) **SOCIAL HISTORY**: (Do you currently use…)

Tobacco: ☐ Never ☐ Yes, Packs/Day: _____ ☐ Former ☐ Cigarettes ☐ Chew tobacco
Years smoked: _____ ☐ VAP
Alcohol: ☐ Never ☐ Former ☐ Yes, Drinks/week:_____ Type:_____
Illicit Drugs: ☐ Never ☐ Former ☐ Yes, Type:_____
How many caffeinated drinks per day? _____ drinks/day
Lifestyle: Are you on a specific diet? ☐ Yes ☐ No If yes, which type of diet: _____
Do you exercise regularly? ☐ Yes ☐ No Days/Week:_____ Hours/Day:_____
History physical/sexual/emotional abuse? ☐ Yes ☐ No Do you currently feel safe? ☐ Yes ☐ No

K) **PAST SURGICAL HISTORY** (List all surgeries & year) ☐ None

| Surgery | Mo/Year | Complications |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

L) **FAMILY HISTORY** ☐ None

| | Yes | **Relatives** (mother, father, **maternal/paternal** grandparents etc) **Diagnosis age** |
|---|---|---|
| Diabetes | ☐ | _____ |
| Heart disease/ High BP | ☐ | _____ |
| High cholesterol | ☐ | _____ |
| Breast cancer | ☐ | _____ |
| Ovarian/uterine cancer | ☐ | _____ |
| Colon/prostate ca | ☐ | _____ |
| Other/specify | ☐ | _____ |

# Receipt of Privacy Practice Information

Patient's Full Name: _____

[ ] Yes [ ] No I have read and have access to the notice of privacy and acknowledgment used by Highlands Center for Women.

[ ] Yes [ ] No I authorize the release of my medical information to my insurance company should it be required for payment of my claim.

[ ] Yes [ ] No I authorized detailed messages regarding my treatment, laboratory results etc to be left at the following phone numbers:

Home: _____ Cell: _____ Work:_____

[ ] Yes [ ] No In the event of an emergency, I authorize Highlands Center for Women to leave messages regarding my treatment, laboratory results etc to the following individuals:

Name_____ Relationship:_____ Phone:_____

Name_____ Relationship:_____ Phone:_____

Name_____ Relationship:_____ Phone:_____

**Appointment Reminders:**

Highlands Center for Women will send a general reminder message prior to appointments.

[ ] Yes [ ] No I authorize Highlands Center for women to send annual appointment reminders via email to the following email address: _____

[ ] Yes [ ] No I authorize appointment reminders via text message

Phone number: _____

**I UNDERSTAND THAT THESE AUTHORIZATIONS ARE IN EFFECT UNTIL REVOKED BY ME IN WRITING**

Signature: _____ Date:_____

# Financial Policy for Patient Care Services

Thank you for choosing Highlands Center for Women for your gynecologic and obstetric needs. We are dedicated to providing the best possible care for you and want you to completely understand our financial policy.

- Every patient (parent or guardian if the patient is a minor) is responsible for the payment of any and all services provided by Highlands Center for Women, P.A.
- Our policy is to file your insurance as a courtesy to you. The balance due is your responsibility and is expected from you if we have not received payment from the insurance carrier within 30 days of filing your claim. If we receive duplicate payment from the insurance company, we will then send you a full refund for any overpayment.
- Please note that failure to show up for scheduled appointments or cancellations without a 24 hour notice, will precipitate a $20 charge to your account.
- Copayment, Co-insurance, and/or any deductible amount that has not been met will be due at the time of service.
- If you do not have insurance and are considered a "Self-Pay" patient, we require payment in full at the time of service when you check out after each visit.
- Additional forms: copies of medical records (separate authorization required), disability, or FLMA forms are available at an additional cost and payable at time of pickup.
- For returned checks, a $35 collection fee will be added to your account.
- Prescription requests made outside of an office visit will be charged a $15 fee.
- **Annual Exams- Please check your insurance policy to make sure you have yearly preventative coverage or women's health coverage for a PAP/Pelvic/Breast Exam. If covered, most insurance companies allow for only one annual exam per 12 month period. Please note: An annual exam visit does not include discussion of new problems or detailed review of chronic conditions. If you have a new health problem when you come in for your annual exam, your provider will determine if he/she can address your concerns at this time or if you need to schedule another appointment. It will be at the discretion of the physician if there is enough time to do both. <u>If the physician does address your other health concerns during your annual, you will be billed for an office visit and an annual (according to the correct coding guidelines set forth by your insurance).</u>**

Highlands Center for Women is a participating provider with many managed care organizations; however, we do not participate with all companies.

- It is the responsibility of every patient to verify our participation with their plan. It is also their responsibility to make payment in full should Highlands Center for Women or its physicians not be listed as a preferred provider (s). Further, it is up to the patient to notify Highlands Center for Women if a specific lab is required by their insurance coverage.

We ask that you read this policy and assist us in keeping costs down by ensuring that we are able to be reimbursed for our services on a timely basis. We welcome the opportunity to discuss any aspect of our financial policy. To help us in this policy we ask that you assist us by:

1. Providing us with the most current and updated information for yourself, your insurance company, and your insurance coverage. Please advise us of any changes since your last visit.
2. Make payment at the time of service for the entire balance if you are a "Self-Pay" patient or for the amount of the deductible, co-pay or co-insurance if you have insurance.
3. Please do not discuss the financial aspect of your care with the physician(s). It is important for them to be allowed to practice medicine and provide patient care. Please work with our Financial Counselor, check-out staff, or business personnel regarding account questions or problems you may have.

I have read the above Financial Policy, I understand and agree to my Financial responsibilities.

_____ _____

Signature Date