

# Patient Information

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_

City/ST/Zip code: \_\_\_\_\_

Home Phone : (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  Leave Message

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  Leave Message

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Sex: Male  Female

Marital Status: Married: \_\_\_\_ Divorced: \_\_\_\_ Single: \_\_\_\_  
Widowed: \_\_\_\_

Social Security: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (REQUIRED)

Driver's License #: \_\_\_\_\_ State \_\_\_\_\_

Race: American Indian or Alaska Native  Asian   
Native Hawaiian  Hispanic  African American   
White  Other Race

Ethnicity: Hispanic  Non-Hispanic

Email: \_\_\_\_\_@\_\_\_\_\_

Pharmacy where you want your prescriptions sent:

Pharmacy Name: \_\_\_\_\_

Address: \_\_\_\_\_

## How did you hear about us?

\_\_\_\_\_

### Primary Insurance Policyholder:

Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_-\_\_\_\_-\_\_\_\_

Group ID #: \_\_\_\_\_ Individual ID #: \_\_\_\_\_

### Secondary Insurance: \_\_\_\_\_

Policyholder

Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_-\_\_\_\_-\_\_\_\_

Group ID #: \_\_\_\_\_

Individual ID #: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

### Patient Consent for E-Prescribing (Electronic Prescribing):

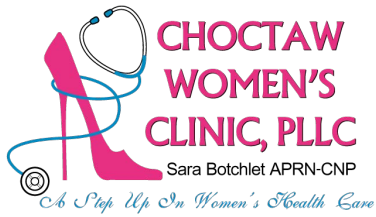
I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

Parent, Patient's Signature or Authorized Representative:

\_\_\_\_\_

Date: \_\_\_\_\_

Time: \_\_\_\_\_



# Patient Health History

## Personal Information

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Marital Status:  Married  Divorced  Single  Domestic Partner

Ethnicity: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*This form is to help us understand your health history. It will allow us to ensure your records are complete so we can provide the best care possible at the time of your visit. We understand that your answers are very personal, and we will maintain them in the strictest confidence, as is all of your medical information.*



## Health History

List any medical illnesses: \_\_\_\_\_ List any medications (Name, Dosage, How often it is taken): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List any drug allergies: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Tobacco use? \_\_\_\_\_

*If yes, how much?* \_\_\_\_\_

Alcohol use? \_\_\_\_\_

*If yes, how much?* \_\_\_\_\_

Do you use any illegal drugs? \_\_\_\_\_

Date of last mammogram: \_\_\_\_\_

Date of last DEXA Bone Scan: \_\_\_\_\_

Date of last Colonoscopy: \_\_\_\_\_

Are you currently pregnant? \_\_\_\_\_

How many pregnancies have you had? \_\_\_\_\_

How many living children do you have? \_\_\_\_\_

Have you had a miscarriage? \_\_\_\_\_

*If yes, how many?* \_\_\_\_\_

Have you had an abortion? \_\_\_\_\_

*If yes, how many?* \_\_\_\_\_

Have you had a C-Section? \_\_\_\_\_

*If yes, how many?* \_\_\_\_\_

List any SURGERIES and YEAR it was performed:

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First day of last menstrual period: \_\_\_\_\_

How often do you have a period? \_\_\_\_\_

Date of your last pap smear: \_\_\_\_\_

Have you ever had an abnormal pap smear? \_\_\_\_\_

*If yes, when?* \_\_\_\_\_

*Treated with:* \_\_\_\_\_

Have you ever had a sexually transmitted disease? \_\_\_\_\_

Age of first period: \_\_\_\_\_

How many days does your period last? \_\_\_\_\_

Are you currently sexually active? \_\_\_\_\_

Number of lifetime sexual partners: \_\_\_\_\_

Method of Birth Control: \_\_\_\_\_

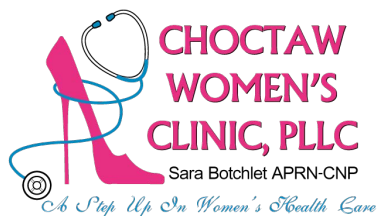
Have you ever used Gardasil? \_\_\_\_\_

Have you or your family members had any of the following?

- Heart Disease
- High Cholesterol
- High Blood Pressure
- Diabetes
- Thyroid Problems
- Hepatitis (*Type:* \_\_\_\_\_)
- Tuberculosis
- Anemia or Blood Disorder
- AIDS or HIV
- Birth Defects or Inherited Diseases

Have YOU ever had any of the following?

- Liver Disease
- Stomach, Bowel or Gallbladder Problems
- Asthma
- Syphilis (*Type:* \_\_\_\_\_)
- Herpes or HPV \_\_\_\_\_
- Cancer (*Type:* \_\_\_\_\_)
- Infertility
- Rheumatic Fever
- Allergies
- Kidney or Bladder Problems
- Sexual Abuse or Domestic Violence
- Chlamydia (*Type:* \_\_\_\_\_)
- Gonorrhea (*Type:* \_\_\_\_\_)
- Breast Problems
- Sexual Problems



# Important Information for our Patients Regarding Annual Well Woman Exams

The purpose of this handout is to inform our patients about the current coding practices for reporting medical services as dictated by Federal Law and your Insurance Carrier. The billing of Preventive and Screening Services can be complicated and confusing generating many questions from our patients.

An annual well-woman exam is a routine examination of a female who is, in general, not having any current health issues. These routine visits are scheduled separately from a visit to address specific problem health issues.

## The Annual Well Woman Exam for our clinic will include:

- Measure height
- Record weight
- Take blood pressure
- Update personal and family medical history
- Update surgical history
- Update current medications and medication history
- Update allergies
- Update reproductive history
- Update social history
- Physical exam including but not limited to:
  - Appearance (face, eyes, neck, skin)
  - Breast
  - Abdomen
  - Vagina, urethra, cervix, uterus, ovaries and lymph nodes
- General discussion regarding findings during exam and general counseling about health and well-being
- Pap smear (if needed)
- HPV testing (if applicable)
- Ordering of routine blood work (if applicable)
- Ordering of other routine testing such as bone density study (if needed)
- Refill of maintenance medications pertinent to gynecological care and/or change in medications or dosages

In addition to the above, discussions about problems and conditions you are being treated for, that are under control, are considered an integral part of the Well Woman exam and cannot be billed as a “sick visit” under Federal Compliance rules.

If a separate problem is identified, addressed or treated during the course of the Annual Exam, we are required to submit our claims based on the documentation in the medical record of the service provided to you. This may result in a second office visit charge and/or second co-pay.

If at the time of scheduling your Well Woman Exam, you are aware of problems you would like to discuss, we recommend scheduling a separate “problem appointment”. If you are scheduled for your Well Woman Exam today and are aware of problems you would like to discuss, please inform the nurse. In this event, your appointment may be converted to a “problem appointment” due to the time restraints and to avoid additional costs to you.

With the new health care laws regarding the coverage of preventive screening, we feel it is important to keep routine preventive screening separate from all other visits. This helps to ensure that accurate adjudication and payment from your insurance company for your routine well-woman visit is obtained and that you receive the full benefit of your plan allowances.

You as the insured will be responsible for payment as dictated by your insurance plan of all co-payments and deductibles at the time of service. Again, if an additional problem is treated or addressed during this exam, there may be an additional charge that you will be responsible for.

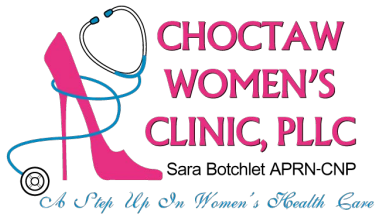
I understand the above information and agree to pay any charges incurred due to discussion/treatment of a problem during an Annual Well Woman Exam.

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_/\_\_\_\_/\_\_\_\_  
TODAY'S DATE

Note: Please be advised it is the patient's responsibility to inform staff if your insurance carrier requires the use of a specific laboratory.



# Female Symptom Checklist

Name: \_\_\_\_\_ E-Mail: \_\_\_\_\_ Date: \_\_\_\_\_

Symptoms (please check mark)	Never	Mild	Moderate	Severe
Fatigue				
Memory Loss				
Mental Confusion				
Decreased Sex Drive or Libido				
Sleep Problems				
Mood Changes or Irritability				
Tension				
Migraines or Severe Headaches				
Difficult to Climax Sexually				
Bloating				
Weight Gain				
Breast Tenderness				
Vaginal Dryness				
Hot Flashes				
Night Sweats				
Dry or Wrinkled Skin				
Hair Falling Out				
Cold All The Time				
Swelling All Over The Body				
Joint Pain				

History of Breast Cancer: Self (Y/N): \_\_\_\_\_ Family Member: \_\_\_\_\_

Have You Ever Had Any Issues With Anesthesia (Y/N): \_\_\_\_\_ Explain: \_\_\_\_\_

Current Hormone Replacement Therapy: \_\_\_\_\_

Past Hormone Replacement Therapy: \_\_\_\_\_

Nutritional Supplements or Vitamins: \_\_\_\_\_

Last Menstrual Period (estimate year if known): \_\_\_\_\_

Birth Control Method: \_\_\_\_\_

Date of Last Mammogram: \_\_\_\_\_

Date of Last Pap Smear: \_\_\_\_\_

Want to Be Sexually Active (Y/N): \_\_\_\_\_

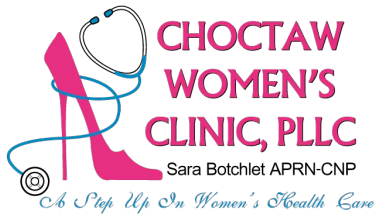
I Have Completed My Family (Y/N): \_\_\_\_\_

History of Heart Disease (Y/N): \_\_\_\_\_

History of Diabetes (Y/N): \_\_\_\_\_

History of Osteoporosis (Y/N): \_\_\_\_\_

History of Alzheimer's Disease (Y/N): \_\_\_\_\_



# Laboratory

We ask that each patient know his/her insurance benefits, including your lab benefits, prior to your scheduled appointment time.

You will need to know how much your individual lab policy covers and which lab your insurance prefers you go to (DLO or Lab Corp). You have the option to send your lab through your insurance or you can choose to do self-pay through us. If you choose to send through your insurance you will be responsible for any co-insurance or deductible that applies. You will not receive a bill for lab work from Choctaw Women's Clinic for your lab work, it will come from the lab itself.

If you choose self-pay, you pay us at date of service and you will not receive a bill from the labs.

**Circle one: Insurance or Self-pay**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**Choctaw Women's Clinic No Show and/or Cancellation Policy**

Failure to CANCEL within a 24-hour time prior to your appointment time will result in a \$35 fee.

Failure to NOT SHOW for an appointment will result in a \$35 no show fee.

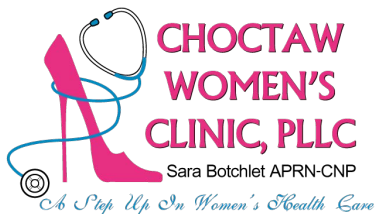
**Choctaw Women's Clinic No Show and/or Cancellation Policy for Consultation or a Pellet Procedure**  
**Failure to CANCEL** a consultation or pellet procedure within a 24-hour time prior to your appointment time will result in a \$50 fee.

Failure to NOT SHOW for a consultation or pellet procedure will result in a \$50 no show fee.

I understand the above cancellation and no-show policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## Medical Release Form

I, \_\_\_\_\_ hereby authorize the physician and staff of CWC permission to release information concerning my health and well-being to the following:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Leave message on answering machine - Phone Number: \_\_\_\_\_

I DECLINE to authorize the release of information concerning my health and wellbeing.

The following information may be given to the above individuals: (please check all you agree to):

Any other information (No limitation) includes all communication.

Appointment Time     Test/Lab Results

Procedures     Medications

The following items may be picked up on my behalf by the above individuals: (please check all you agree to):

Written Prescriptions     Copy of Medical Records

Radiology Films     Laboratory Results

Any other information regarding my health

I understand I may revoke this consent at any time by giving written notice to the person or organization making the disclosure. I understand that this organization originates and maintains health records describing my health history, symptoms, diagnoses, examinations, past/current/future treatments and test results as well as financial information pertaining to my account. I acknowledge that I have been provided with Full Disclosure of their Notice of Privacy Practices and I consent to the use and disclosure of my own or persons form whom I am responsible (i.e. minors) Financial and Health Information for any reason that Choctaw Womens Clinic may require to carry out Health care operations to or for me and/or for persons whom I am responsible.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Parent/Guardian Signature if patient is a minor.)

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this form is not filled out and/or signed by the patient or legal guardian, no information can be given regarding your medical care to any individual including spouse and/or family members. This includes copies of medical records, radiology films or prescriptions on your behalf. If you have any questions regarding this authorization, please ask the receptionist for additional information.