CHOCTAW WOMEN'S CLINIC, PLLC
Sara Botchlet APRN-CNP
A Step Up In Women's Health Care

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 O Female O

Marital Status: Married: ____ Divorced: _____ Single: ___
Widowed: _____

Social Security: _____-_____-_____ (**REQUIRED**)

Driver's License #: _____ State_____

Race: American Indian or Alaska Native O Asian O
Native Hawaiian O Hispanic O African American O
White O Other Race O
Ethnicity: Hispanic O Non-Hispanic O

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: _____

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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:

_____

_____

_____

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

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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.

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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):_____

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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

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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: _____

O Leave message on answering machine - Phone Number: _____

O 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):
O Any other information (No limitation) includes all communication.
O Appointment Time O Test/Lab Results
O Procedures O Medications

The following items may be picked up on my behalf by the above individuals: (please check all you agree to):
O Written Prescriptions O Copy of Medical Recordsl
O Radiology Films O Laboratory Results
O 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.