

Preferred Women's Healthcare, L.L.C

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PREFERRED WOMEN'S HEALTHCARE MANAGED CARE OFFICE POLICY

Preferred Women's Healthcare is currently participating in numerous managed care plans. While we are pleased to be able to participate with these plans, it is impossible for our office staff to be aware of each plan's specific requirements. Each plan may have limitations of the frequency of services performed and where services may be performed (i.e. laboratory work, diagnostic testing). Some plans may require a referral from your primary care physician as well.

Unfortunately, if you do not inform us of special limitations your contract stipulates and we subsequently order services, these services will be considered non-covered and will not be paid by the insurance company. **Payment for these services will be your responsibility.**

In the event that services are provided and your coverage is not in effect on that date, then fees submitted and denied by the carrier will become your responsibility.

I have read and understand the above office policy and agree to accept responsibility as described.

Patient Signature

Date

Preferred Women's Healthcare, L.L.C
Patient Information Form

Last Name			First			Middle Initial		
Street Address					City		State	Zip
Billing Address (if not the same as above)					City		State	Zip
Home Telephone # ()			Work Telephone # ()			Alternative Telephone # ()		
Birthdate	Sex	M	F	Social Security #			Driver's License #	
E-mail Address			Single	Married	Divorced	Widowed	Separated	Other
Employer				Employer Address				
Spouse(or if Minor/Parent Name)			Birthdate			Social Security #		
Employer					Employer Telephone #			
Any other last names used?								

IN CASE OF EMERGENCY, NEAREST RELATIVE/FRIEND NOT RESIDING AT THE SAME RESIDENCE AS YOURS:

Name			Telephone #		
Address			City	State	Zip

INSURANCE INFORMATION

Name of Insurance Company	Policy Holder's Name	Relationship	Birthdate	Social Security #
Member ID Number		Group Number		Employer
Name of Add'l Insurance Company	Policy Holder's Name	Relationship	Birthdate	Social Security #
Member ID Number		Group Number		Employer

HOW DID YOU HEAR ABOUT US?

Referred By	Ins. Directory	Friend	Yellow Pages	Internet	Hospital	PWH Website	Physician
Referral's Name							

AUTHORIZATION FOR RELEASE OF INFORMATION - I hereby authorize this practice to furnish any medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment of my care.

ASSIGNMENT OF BENEFITS - I hereby authorize payment directly to this practice of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the charges for these services. I understand that I am financially responsible for charges not covered by this assignment.

GUARANTEE OF ACCOUNT - For services furnished by Preferred Women's Healthcare, L.L.C., I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Georgia and agree to pay, if necessary, all costs of collection, including attorney's fee.

Signature _____ Date _____

PREFERRED WOMEN'S HEALTHCARE LLC
Confidential Medical Questionnaire

Date _____

MR# _____

FOR OFFICE USE ONLY

Age ____ Wt ____ BP ____ Ht ____ W/P ____ U/A ____ UPT ____ G ____ P ____ TAB ____ SAB ____ L ____

Name _____ Date of Birth _____

Main reason seeking medical attention: Routine Physical Problem

Describe problem:

DRUG ALLERGIES: _____

GYNECOLOGICAL HISTORY:

1. Age at first period _____ Date of last menstrual period _____ Previous period _____
2. When not on birth control pills, the interval between the first day of one period to the first day of the next period ranges from ____ to ____ days. Duration of flow is ____ days.
3. Menstrual flow is usually light medium heavy excess flow with clots
4. Do you ever have bleeding between periods or after intercourse? Yes No
5. Do you have pain with periods? Yes No At other times? Yes No If yes, when? _____
6. When was your last Pap smear? _____ Was it normal? Yes No
7. When was your last mammogram? _____ Was it normal? Yes No
8. What are you using for birth control? Birth Control Name _____
 IUD Essure Implanon NuvaRing Vasectomy Depo Provera Rhythm method
 None Condoms Not active Diaphragm Tubal Ligation Ortho Evra patch

	YES	NO	COMMENTS
9. Are you satisfied with the present method of birth control?	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Do you have any new sexual partners?	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Have you had five or more sexual partners? (V69.2)	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Have you had sexual activity before age of 16 years of age? (V69.2)	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Do you ever have pain with intercourse (sex)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. Would you like testing for STD's? (sexually transmitted diseases)	<input type="checkbox"/>	<input type="checkbox"/>	_____
15. Do you have any other sexual difficulties?	<input type="checkbox"/>	<input type="checkbox"/>	_____
16. Do you have any vaginal discharge, irritation, or dryness?	<input type="checkbox"/>	<input type="checkbox"/>	_____
17. Do you ever leak urine when you cough or sneeze?	<input type="checkbox"/>	<input type="checkbox"/>	_____
18. Do you frequently have a sudden urge or need to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	_____
19. Do you have problems with urinating frequently at night or bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>	_____
20. Do you have painful urination or difficulty in starting urination?	<input type="checkbox"/>	<input type="checkbox"/>	_____
21. Do you ever have protrusion or bulging sensation from your vagina?	<input type="checkbox"/>	<input type="checkbox"/>	_____
22. Have you ever had a herpes virus infection?	<input type="checkbox"/>	<input type="checkbox"/>	_____
23. Have you ever had gonorrhea, chlamydia, syphilis, or venereal warts?	<input type="checkbox"/>	<input type="checkbox"/>	_____
24. Have you ever had an abnormal pap smear?	<input type="checkbox"/>	<input type="checkbox"/>	_____
25. Has it been seven years without a pap smear? (V15.89)	<input type="checkbox"/>	<input type="checkbox"/>	_____
26. Have you had three consecutive negative pap results? (795.0x)	<input type="checkbox"/>	<input type="checkbox"/>	_____
27. Have you felt any lumps or changes in your breasts?	<input type="checkbox"/>	<input type="checkbox"/>	_____
28. Have you had any nipple discharge?	<input type="checkbox"/>	<input type="checkbox"/>	_____
29. Do you have breast implants?	<input type="checkbox"/>	<input type="checkbox"/>	_____
30. Do you do monthly self-breast examinations?	<input type="checkbox"/>	<input type="checkbox"/>	_____

CURRENT MEDICATIONS: _____

OBSTETRICAL HISTORY

Number of times pregnant? _____ Number of children living _____ Number of miscarriages _____ Number of abortions _____
 If trying to get pregnant –How long? _____months _____year(s)

Date Delivered	Weeks pregnant @ delivery	Birth Wt.	Vaginal/Cesarean delivery	Sex	Complications/Comments

HOSPITALIZATIONS – List all hospitalizations including operations you have had in the past.

Date	Hospital	Reason

Have you ever had a blood transfusion? Yes No History of HIV? Yes No (V08 or 042)

ILLNESSES

Have you or any blood relative had any of the following?

	You	Family	Relationship		You	Family	Relationship		You	Family	Relationship
Arthritis				Down syndrome				Stroke			
Asthma				Epilepsy				Thyroid problem			
Birth defects				Hay fever				Breast cancer			
Bleeding disorder				Heart problems				Colon cancer			
Blood clots				High blood pressure				Ovarian cancer			
Colon polyps				High cholesterol				Uterine cancer			
Depression				Kidney problems				Other cancer			
Diabetes				Liver or Gallbladder				Other			

SYSTEMS REVIEW: - (Check any of the following that you have now or have had in the past six months.)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Weight gain or loss | <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Varicose veins or easy bruising |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numbness or tingling | <input type="checkbox"/> Changes in skin or hair | <input type="checkbox"/> Abdominal pain, nausea, or vomiting |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Headaches, dizziness | <input type="checkbox"/> Hot flashes or night sweats | <input type="checkbox"/> Chronic cough or coughing up blood |
| <input type="checkbox"/> Visual changes | <input type="checkbox"/> Bloody or black stools | <input type="checkbox"/> Chest pain, shortness of breath | <input type="checkbox"/> Diarrhea, constipation, changes in stool |

Comments _____

When was your last Tetanus booster shot? _____ Are you immune to Rubella? (German measles) Yes No
 When did you last have your cholesterol level checked? _____ What was it? _____

SOCIAL HISTORY:

Occupation: _____ Employer: _____
 Marital status Single Married Husband's age: _____ Separated Divorced Widowed
 Education: Last grade completed _____ Religion _____
 Do you smoke? Yes _____ packs per day No Do you drink alcohol? never occasionally socially daily
 Have you ever used any other drugs? Yes No If so, what? _____
 Do you exercise regularly? Yes No What type of exercise? _____
 Do you have any history of physical, emotional, sexual abuse? Yes No
 Do you wear seatbelts? always sometimes never

Patient Signature _____ **Pharmacy name & phone number** _____

Family History Questionnaire

Name: _____

Date of Birth: _____

Instructions: Please circle **Yes** to those that apply to **YOU** and/or **YOUR FAMILY** (On both your mother OR father's side). Circle **No** if there is no family history. Beside each statement, please list the relationship to you of the individual diagnosed (example: self, mother, maternal aunt, sister) and their age at diagnosis.

HEREDITARY BREAST AND OVARIAN CANCER SYNDROME

			Relationship	Age at Diagnosis
Yes	No	Breast cancer before age 50	_____	_____
Yes	No	Ovarian cancer at any age	_____	_____
Yes	No	Bilateral breast cancer at any age	_____	_____
Yes	No	Both breast & ovarian cancer (in an Individual or family at any age)	_____	_____
Yes	No	Male breast cancer at any age	_____	_____
Yes	No	2 or more breast cancers (on one side of the family <u>or</u> in an individual	_____	_____
Yes	No	Ashkenazi Jewish with a personal or family History of breast or ovarian cancer at any age	_____	_____

HEREDITARY NONPOLYPOSIS COLORECTAL CANCER SYNDROME

			Relationship	Age at Diagnosis
Yes	No	Endometrial cancer before age 50	_____	_____
Yes	No	Colorectal cancer before age 50	_____	_____
Yes	No	Colorectal cancer after age 50 and an family member with any cancer below*?	_____	_____

***Please circle those that apply:** Colorectal, ovarian, endometrial, stomach, biliary tract, small tract, small bowel, pancreas, kidney (ureter/renal pelvis), brain, sebaceous adenoma

If you circled yes to TWO or more statements on the Family History Questionnaire, you may qualify for a blood test to help determine if you have an inherited risk of cancer.

- Patient offered genetic testing
 Information given to patient for review
 Patient not a candidate
 Accepted
 Declined
 Follow up appointment scheduled
 Date: _____

Pt. Signature _____ Date _____ Dr. Initial _____