Comprehensive Women's Health Services, PLLC

Name _____ DOB_____ SSN _____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Phone # _____ Cell # _____ Work # _____

How do you prefer to be contacted: Home Cell Work Mail

Emergency Contact Name _____ Phone # _____

Primary Care Physician _____ Phone # _____

Address _____ City_____ State _____

Pharmacy _____ Phone # _____

Prescription preference: 30 day supply or 90 day supply

Person financially responsible for the account _____

Relationship to patient _____ DOB _____ SSN_____

Address if different than above _____

Primary Insurance _____ Secondary Insurance _____

Do you have a Health Care Proxy or Power of Attorney? If so, please provide a copy.

Signature _____ Date _____

COMPREHENSIVE WOMEN'S HEALTH SERVICES, PLLC

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS AND OTHERS

I, _____, authorize Comprehensive Women's Health Services, PLLC to disclose my protected health information for the purposes of communicating with the family members or others I have designated below. I specifically authorize any current employee or physician of Comprehensive Women's Health Services, PLLC to use or disclose the protected health information as described on this form to the recipients listed below.

Description of the information to be disclosed *(check all that apply)*:

[ ] Sections of the patient's medical record relevant to my current treatment or payment.

_____

_____

_____

[ ] Medical Data/Information as related to:
- [ ] Specific condition(s): _____
- [ ] Specific professional service(s): _____
- [ ] Specific medication(s): _____
- [ ] Other: _____

[ ] The patient's billing/payment information:

[ ] Other: _____

_____

Authorized recipients of the protected health information (list individuals to whom the Practice may disclose):

1. _____
2. _____
3. _____

The information will be used/disclosed for the following purpose(s): *(all purposes must be checked)*

[ ] To coordinate my care/treatment
[ ] To assist in my billing
[ ] As directed by the patient

[ ] *(Check if applicable)* This authorization permits Comprehensive Women's Health Services, PLLC discuss the above designated information in person or by telephone or by fax.

This authorization has been given voluntarily. I understand that unless otherwise permitted by law, Comprehensive Women's Health Services, PLLC will not condition treatment or payment on this authorization. I further understand that I have a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.

I understand that I may revoke this authorization at any time by notifying Comprehensive Women's Health Services, PLLC's Privacy Officer, **[INSERT NAME OF PRIVACY OFFICER], in writing**, except that revocation may not be valid if Comprehensive Women's Health Services, PLLC has taken action in reliance on this authorization. In order for the revocation to be effective it must include:

- The patient's name, address, and patient number, if applicable,
- The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- The patient's desire to revoke this authorization, and
- The date of the revocation, and the signature of the patient or authorized representative.

This authorization will expire _____. After this date, Comprehensive Women's Health Services, PLLC can no longer use or disclose the protected health information without first obtaining a new authorization form.

_____ _____

Patient or Personal Representative's Signature Date

_____

Printed name of Patient or Personal Representative

FOR OFFICE USE ONLY

Authorization witnessed by _____

Authorization added to the patient's medical record on

_____

Comprehensive Women's Health Services, PLLC

RESPONSIBILITY AGREEMENT

Please be advised that many insurance policies will not cover Annual Screening/Preventative Exam, Well Woman exam or any other exam, if you have had this service performed within the last 12 months or time limit outlined by your insurance policy. If this exam has been performed within the last 12 months or the time limits of your insurance policy, you may not be covered or you will be responsible for some, if not all of the financial obligations your insurance carriers deem your responsibility. Please check your individual insurance policies for limitations on this service.

I have read the above and agree to pay any charges not covered by my insurance policy.

_____ _____

Patient Name (Print) Date

_____

Patient Name (Signature)

X

V 2.0

PATIENT HISTORY FORM (Please Print)

Office Use Only: ID:

Last Name:

First Name:

Primary Care Doctor:

Reason for visit:

☐ Annual ☐ Problem

MENSTRUAL HISTORY

Last Menstrual Period: ☐☐/☐☐/☐☐

Age at 1st Menstrual Period: ☐☐ # Days: ☐☐

Frequency: # Weeks: ☐ or Irregular: (check) ☐

Amount: (check) ☐ light ☐ normal ☐ heavy

Menopause: ☐

Method of Birth Control (check one)

☐ Abstinence ☐ DepoProvera ☐ Oral contraceptives

☐ Condoms ☐ Early Withdrawal ☐ Tubal Ligation/ Vasectomy

☐ Contraceptive Patch/ring ☐ IUD ☐ Other

☐ None

MEDICAL/FAMILY HISTORY

Check problems you (P) or your family (F) have or had:

P	F		P	F	
☐	☐	Anemia	☐	☐	Kidney Stones
☐	☐	Arthritis	☐	☐	Hepatitis
☐	☐	Asthma	☐	☐	Lung Disease
☐	☐	Bladder Problems	☐	☐	Lupus
☐	☐	Clots in veins	☐	☐	Osteoporosis
☐	☐	Blood Transfusion	☐	☐	Reflux
☐	☐	Diabetes	☐	☐	Stroke
☐	☐	Heart Disease	☐	☐	Thyroid
☐	☐	High Blood Pressure	☐	☐	Ulcers
☐	☐	High Cholesterol	☐	☐	Breast Cancer
☐	☐	Intestinal Disease	☐	☐	Ovarian Cancer
☐	☐	Irritable Bowel Syndrome	☐	☐	Uterine Cancer
☐	☐	Kidney Disease	☐	☐	Colon Cancer
			☐	☐	Other Cancer

SEXUAL HISTORY

Age of first sexual Intercourse ☐ < 18 yrs old ☐ > 18 yrs old

# of sexual partners ☐ 3 or less ☐ 4 or more

Sexual activity: ☐ Never ☐ Females ☐ Males ☐ Both

GYNECOLOGIC HISTORY (Month/year)

Last pap smear: ☐☐/☐☐☐☐

Last Mammogram: ☐☐/☐☐☐☐

Check problems you have or had:

☐ Abnormal pap smears ☐ Infertility

☐ Endometriosis ☐ Painful Periods

☐ Fibroids ☐ Sexually Transmitted Diseases

OBSTETRICAL HISTORY (List number of pregnancies)

☐ # Preterm Vag Deliveries ☐ # Preterm C-Sect Deliveries ☐ # Miscarriages

☐ # Full term Vag Deliveries ☐ # Full term C-Sect Deliveries ☐ # Elective Terminations

SURGICAL HISTORY Check all that apply:

☐ Appendectomy ☐ Gall Bladder ☐ Tonsillectomy

☐ D & C ☐ Hysterectomy ☐ Other

MEDICATIONS

☐ None ☐ Blood Pressure ☐ Hormones

☐ Anti-Depressant ☐ Diabetes ☐ Thyroid

☐ Contraceptive ☐ Heart ☐ Other

DRUG ALLERGIES

☐ None ☐ Penicillin ☐ Other

☐ Codeine ☐ Shellfish

SOCIAL HISTORY

Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow

Employed: ☐ Yes ☐ No

(Check if Yes)

Cigarettes per day: ☐☐ Substance Abuse ☐

Alcohol drinks per wk: ☐☐ Seatbelt use ☐

Exercise: ☐ Yes ☐ No Physical/Sexual Abuse ☐

CURRENT/PREVIOUS MEDICAL CONCERNS

(check all that apply; (C) Current (P) Previous)

C	P		C	P	
☐	☐	Weight change	☐	☐	Bleeding between periods
☐	☐	Fever/chills	☐	☐	Heavy vaginal bleeding
☐	☐	Difficulty sleeping	☐	☐	Vaginal discharge
☐	☐	Eyes	☐	☐	Low sex drive/ sexual dysfunction
☐	☐	Hearing loss	☐	☐	Recurrent yeast infections
☐	☐	Sinus congestion	☐	☐	Painful intercourse
☐	☐	Chest pain/palpitations	☐	☐	Pelvic pain
☐	☐	Cough/wheezing/ difficulty breathing	☐	☐	Skin rashes
☐	☐	Bloody sputum	☐	☐	Breast pain/discharge/mass
☐	☐	Nausea/vomitting	☐	☐	Seizures
☐	☐	Diarrhea	☐	☐	Fainting episodes
☐	☐	Constipation	☐	☐	Mood changes/depression/ Anxiety
☐	☐	Bloody stools	☐	☐	Heat/cold intolerance
☐	☐	Frequent urination	☐	☐	Excessive thirst or urination
☐	☐	Painful/blood urination	☐	☐	Hot flashes
☐	☐	Leakage of urine	☐	☐	Abnormal bruising/bleeding

X