North Scottsdale Women's Health

Patient Medical History Form

Name _____ Date of Birth_____ Age_____

Date of most recent:	**Normal** or	**Abnormal**	Explanation (if needed)
Pap Smear _____	____	____	_____
Mammogram_____	____	____	_____
Colonoscopy_____	____	____	_____
Bone Density_____	____	____	_____
Gardasil _____			

Menstrual History
Age of first period _____ Date of Last period_____

If menopausal, are you on hormone replacement? How long? _____

Current cycle is:
Regular _____ Irregular _____ Absent _____
They occur how often? _____ days
They generally last _____ days
The flow is:
Light _____ Medium _____ Heavy _____ Variable _____
Cramps are:
Mild _____ Average _____ Severe _____

What medications do you take to relieve cramps? _____
Is this helpful? _____

Are you sexually active	Yes___	No___	Never ___
New Partner since last exam	Yes___	No___	Never___

Are you concerned of exposure to a sexually transmitted disease? Yes___ No____
Sexual Preference heterosexual___ homosexual___ bisexual___

Method of Pregnancy Prevention

- ☐ Condoms
- ☐ NuvaRing
- ☐ Partner with vasectomy
- ☐ Birth Control pills
- ☐ Tubal Ligation
- ☐ Essure
- ☐ Natural family planning
- ☐ Contraceptive Patch
- ☐ IUD (Mirena, Paragard, Skyla)
- ☐ Other _____
- ☐ None

Have you ever had a sexually transmitted disease?

- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Herpes (Oral/Vaginal)
- ☐ HIV
- ☐ Syphilis
- ☐ Condyloma
- ☐ Hepatitis C

Have you ever had an abnormal pap?
If yes, Date _____ Diagnosis _____
Treatment or follow up _____

Have you ever had any of the following (please provide dates if available)

- ☐ Colposcopy _____
- ☐ Cryo Surgery _____
- ☐ LEEP _____
- ☐ Laser/Conization _____

Have you ever had any of the following gynecological issues:

- ☐ Fibroids
- ☐ Ovarian Cysts
- ☐ Endometriosis
- ☐ Lichen Sclerosus
- ☐ PCOS

Obstetrical History

Date of Delivery	Gestational Age	Forceps/Vacuum/ Vaginal/ C-Section	Male/ Female	Weight	Complications

Medical History

Please check boxes below if you've ever been diagnosed with any of the following

- ☐ Breast Cancer (date diagnosed) _____
- ☐ Cancer (other than breast) _____
- ☐ Anemia
- ☐ Arthritis
- ☐ High Cholesterol
- ☐ Asthma
- ☐ Kidney Disease
- ☐ Blood Transfusion
- ☐ Chicken Pox
- ☐ High Blood Pressure
- ☐ Depression
- ☐ Anxiety
- ☐ Diabetes
- ☐ Ischemic Colitis
- ☐ Pulmonary Embolus
- ☐ Blood Clotting Disorder
- ☐ Deep Vein Thrombosis (DVT or bloodclots)
- ☐ Epilepsy
- ☐ Seizures
- ☐ Heart Attack/Heart Disease
- ☐ Liver Disease
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ Pneumonia
- ☐ Sickle Cell
- ☐ Stroke
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Thyroid Nodules
- ☐ Other _____

Surgical History

Date	Surgery Performed	Reason for Procedure

Immediate Family History

(Please indicate if any, which family member has been diagnosed)

- ☐ Breast Cancer/Relative _____
- ☐ Colon Cancer /Relative _____
- ☐ Ovarian Cancer/ Relative_____
- ☐ Uterine Cancer/ Relative_____
- ☐ Diabetes/ Relative _____
- ☐ Heart Disease/ Relative _____
- ☐ High Blood Pressure/Relative _____

Please list all medications you are currently taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list all known allergies (medication and seasonal):

_____ _____

_____ _____

Social History

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Alcohol Use	Yes___	No___	If yes, _____ drinks per day/week/month
Tobacco Use	Yes___	No___	If yes, _____ packs per day for____years
Street Drugs	Yes___	No___	Type and frequency _____
Exercise	Yes___	No___	Type and frequency _____

Do you have any religious or cultural beliefs that would interfere with you receiving blood or blood products? Yes___ No___

Signature_____**Date**_____

Please Print

Patient Information

Last name _____First Name _____Middle Initial_____

Date of Birth_____ Age_____ Social Security Number _____

Address_____ City_____ State_____ ZipCode_____

Emergency Contact *(please include phone number)*_____

Occupation _____ Employer_____

Whom may we thank for referring you? _____

Name of Primary Insurance Company_____

Primary Cardholder Name_____ Date of Birth_____

Policy/Member ID#_____ Group #_____

Name of Secondary Insurance Company_____

Policy/Member ID#_____ Group #_____

I certify that I, and or my dependent (s) have coverage with the above named Insurance Company(ies) and assign directly to North Scottsdale Women's Health all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am finally responsible for all charges whether or not paid by insurance. I authorize my signature on all insurance submissions.

The above named office may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of patient or Legal Guardian _____Date_____

Printed Name or Legal Guardian_____ Relationship to patient_____

NORTH SCOTTSDALE WOMEN'S HEALTH HIPAA PRIVACY ACKNOWLEDGEMENT

I_____(patient name) have received the HIPAA privacy notice regarding the uses and disclosures of my Protected Health Information and I understand my rights and responsibilities with respect to my medical records.

I authorize NSWH to release any medical or incidental information to my referring physician or any other physician who has been or may become involved with my care.

I authorize the release of information necessary in the processing of any insurance claims. I also authorize the release of my medical records including pharmacy records to NSWH upon request.

Personal Representatives (family members, other health professionals etc) I authorize North Scottsdale Women's Health and its employees to discuss, send and/or receive medical information to/with the following individuals, including leaving a message with them:

Name/Relationship _____

Name/Relationship _____

Consent for Message:
It is ok to leave messages on my cell phone # _____

- ○ Appointments
- ○ Test Results
- ○ Billing/Insurance

It is ok to leave messages on my home phone #_____

- ○ Appointments
- ○ Test Results
- ○ Billing/Insurance

Signature_____ Date _____

Signature_____ Date _____

Signature_____ Date _____

Signature_____ Date _____

Signature_____ Date _____

NORTH SCOTTSDALE WOMEN'S HEALTH

AGREEMENT REGARDING PAYMENT TERMS AND CONDITIONS

Payments for professional services are due at the time of service. North Scottsdale Women's Health accepts cash, personal checks, Visa, MasterCard, Discover, or American Express.

BENEFITS ARE NOT A GUARANTEE OF COVERAGE. ACTUAL COVERAGE IS DETERMINED WHEN THE CLAIM IS RECEIVED AND PROCESSED BY YOUR INSURANCE PLAN

MUST INTIAL EACH TERM AND AGREEMENT BEFORE THIS IS COMPLETE

_____**Insurance Copayments** – All co-pays must be paid at the time of service

_____**Deductibles/Coinsurance** – If your deductible has not been met, full payment will be required at the time of pre-op visits and OB prepays by contract, along with any applicable co-insurance amounts

_____**Private/Self Pay Patients** – if you have no insurance or an insurance plan that we do not participate with, you will be required to pay for services in full at the time of service. You can call the billing office for an estimate; however actual services performed determine the cost

_____**Cosmetic Procedures** – All Cosmetic procedures or product charges will be collected at the time of service

_____**Lab Services** – Specimens are sent out to your contracted laboratory for processing and billing. **You will need to contact that lab directly for any billing issues or questions**

_____**Collection Policy** – I understand that after 90 days my account will incur finance charges until payment is made in full or the account is recommended for collection action. I agree to be responsible for all charges incurred by me. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 40% of the debt, and all costs, and expenses, including reasonably attorneys' fees, we incur in such collection efforts. These fees are in additional to the original debt. I further understand that if my account is sent to collections or included in a bankruptcy, I will be terminated as a patient.

_____**No Show/ Cancellation policy** – If you do not cancel your appointment within 24 hours prior to, the fee is $25. If you no-show your appointment, the fee is $25. If you reschedule or cancel your appointment more than 3 times, we will charge a fee of $25. These fees will need to be paid prior to scheduling any future appointments.

It is very important to stay well informed regarding your insurance coverage. If you have a new insurance, it is your responsibility to provide updated and correct information to our office. You will be held responsible for the total amount of unpaid claims that are denied due to incorrect insurance information.

I have read and agree to abide by the above financial policies for North Scottsdale Women's Health

Printed Name _____

Signature/Legal Guardian_____ Date_____