Medford WOMEN'S CLINIC LLP
obstetrics and gynecology

Thank you for scheduling your gynecologic appointment with Medford Women's Clinic. By following the suggested guidelines below, you will help us provide you with the best care and save you time at your appointment.

Things to do before your appointment:

- ✓ Fill out the enclosed information sheets. Remember to complete both sides. Answer all questions to the best of your ability.
- ✓ Contact your health plan insurance. In some cases, **preventive services are not covered by health insurance. Medicare is one example.** Ask your health plan to see if they cover "preventive services."
- ✓ Please check with your Primary Care Provider to be sure a **referral** is sent to us prior to your appointment if one is needed.

The day of your appointment:

- ✓ Arrive **fifteen minutes** before your scheduled appointment.
- ✓ Have your insurance card and photo ID with you.
- ✓ Have your forms completed and here with you on your visit.
- ✓ Bring any pertinent medical records with you, such as a medication list.
- ✓ If you are Private Pay, payment is due on the day of service.

If you are unable to keep this appointment, please give our office at least a twenty-four hour notice. Should you have any questions or need assistance in completing any of the forms, please contact our office. Thank you for selecting us to help you with your health care needs.

TELEPHONE: 541.864.8900 • FACSIMILE: 541.245.3315 • E-MAIL: mwc@medfordwomensclinic.com • WEB: www.medfordwomensclinic.com
ADDRESS: 3170 State Street, Medford, OR 97504-8450

Patient Registration

Date:

LEGAL NAME:				DATE OF BIRTH:	
SOCIAL SECURITY:		MARITAL STATUS:		SEX:	
HOME PHONE:		CELL:		EMAIL:	
ADDRESS:					
RACE:	White Asian Black Pacific Islander American Indian Other:_____				
ETHNICITY:	Hispanic or Latino Non-Hispanic or Non-Latino				
PREFERRED PHARMACY:	(name and city)				
EMPLOYER:					
OCCUPATION:		WORK PHONE:			
HAVE YOU EVER RECEIVED MEDICAL TREATMENT UNDER ANOTHER NAME? Yes No IF YES, UNDER WHAT NAME? _____					
EMERGENCY CONTACT: NAME		Phone:			
RELATIONSHIP:					

GUARANTOR (RESPONSIBLE PARTY if different from patient) OR CUSTODIAL PARENT

NAME:		ADDRESS:			
HOME PHONE:		SS#		DATE OF BIRTH:	
EMPLOYER:				OCCUPATION:	
RELATIONSHIP:				WORKPHONE:	

PROVIDER INFORMATION

Primary Care Physician:	
REFERRING DR:	

INSURANCE INFORMATION

I HAVE: MEDICARE MEDICAID CARD HEALTH INSURANCE NO INSURANCE
MEDICARE ID# _____ OREGON HEALTH PLAN ID# _____

Primary Insurance Information

NAME:		ADDRESS:			
ID/POLICY #:		GROUP #:			
INSURED NAME:		DOB:		SEX:	
RELATIONSHIP TO PT:		EMPLOYER:			

Secondary Insurance Information

NAME:		ADDRESS:			
ID/POLICY #:		GROUP #:			
INSURED NAME:		DOB:		SEX:	
RELATIONSHIP TO PT:		EMPLOYER:			

I give permission for you to share any information in my medical history with: _____
I authorize the medical treatment of this patient. _____ Date:_____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services, for services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents under 18, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

Patient Signature_____Date_____ hereby authorize_____ to pay and hereby assign

(authorized signature of subscriber) (name of ins co.)

Medford Women's Clinic, LLP all benefits, if any, otherwise payable to me for my physician's services.

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3170 State Street
Medford, OR 97504-8450
(541) 864-8900

Med Rec #: _____

Name: _____

Birthdate: _____ Age _____

Phone (H) _____ (W) _____

PCP _____

Date _____ Referring physician _____

Occupation (past and present) _____

Reason for coming to the Clinic _____

Marital Status _____ Next of Kin _____ Phone # _____

PAST MEDICAL HISTORY: Have you had any of the following problems?

Medical Illnesses

- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Cholesterol problem
- ☐ Lung disease
- ☐ Ulcers
- ☐ Brain or nerve disease (stroke)
- ☐ Liver disease or hepatitis
- ☐ Arthritis
- ☐ Tuberculosis
- ☐ Cancer _____
- ☐ Blood clots or phlebitis
- ☐ Depression/Anxiety
- ☐ Kidney disease/stones
- ☐ Acid reflux or hiatal hernia
- ☐ Migraine
- ☐ Environmental allergies
- ☐ Seizures
- ☐ Asthma
- ☐ Tuberculosis or abnormal skin test
- ☐ Osteoporosis
- ☐ Thyroid disorder
- ☐ Sexually transmitted disease
- ☐ Other _____

Operations/Hospitalizations (includes tonsillectomy and apendectomy)

Date	Operation/Hospitalization	Complications

Severe Accidents and Injuries

_____

Do you regularly wear a seat belt? ☐ No ☐ Yes Do you regularly wear a helmet when bicycling or motorcycling? ☐ No ☐ Yes

Allergies and Adverse Medication Reactions (please list reaction)

_____

Tobacco Use? ☐ No ☐ Yes Pkgs/day _____ # years _____ Quit? _____ Year quit _____

Alcohol Use? ☐ No ☐ Yes Drinks/day _____ Drinks/week _____ ☐ Beer ☐ Wine ☐ Hard liquor

	No	Yes
Have you ever felt you should cut down on your drinking?	☐	☐
Have you ever been annoyed by people criticizing your drinking?	☐	☐

Recreational drugs? ☐ No ☐ Yes **IV drug test?** ☐ No ☐ Yes **Last HIV test?** _____

Female Patients

Last menstrual period _____ Last pap smear _____ Last mammogram _____

Number of pregnancies _____ Number of births _____ ☐ Contraception _____

☐ Irregular periods ☐ Abnormal pap smear ☐ Painful periods ☐ Heavy periods

MEDICATIONS CURRENTLY TAKEN regular or occasionally. Include vitamins, birth control pills, sleeping pills, pain pills, laxatives, aspirin – with dosage.

_____

_____

Glasses milk/day? _____ Last osteoporosis scan _____ Calcium supplements (mg/day)? _____

Flu shot ☐ No ☐ Yes When _____ How often do you exercise? _____

Tetanus booster ☐ No ☐ Yes When _____ What is your workout? _____

Pneumonia vaccine ☐ No ☐ Yes When _____ _____

Hepatitis B vaccine ☐ No ☐ Yes When _____ Last lower GI or lower scope? _____

SEE REVERSE SIDE

FAMILY HISTORY

	Age of death	Age if alive	General health; major health problems & illnesses, OR age and cause of death
Mother			
Father			
Brothers			
Sisters			

Significant Illness in Grandparents, Cousins, Aunts, Uncles or Children?

Remember, most diseases that "run in the family" are <u>not</u> genetic, but rather reflect lifestyle or behavior patterns that we learn in our families.

	No	Yes
Osteoporosis	☐	☐
Diabetes	☐	☐
Alcoholism	☐	☐
Heart Attack	☐	☐
Stroke	☐	☐
Cancer	☐	☐
Thyroid Disease	☐	☐
Ulcers	☐	☐
Mental Illness	☐	☐
Blood Clots	☐	☐
High Blood Pressure	☐	☐
TB	☐	☐

REVIEW OF SYSTEMS: Do you have, or have had in the past month, any of the following? (Place a check mark next to those you have experienced).

General
- ☐ Recent fever
- ☐ Weight loss
- ☐ Night sweats
- ☐ Loss of energy
- ☐ Change in lymph nodes
- ☐ Snoring
- ☐ Trouble sleeping

Skin
- ☐ Rashes
- ☐ Changes in mole

Blood
- ☐ Easy bruising
- ☐ Excessive bleeding
- ☐ Transfusions

Ears
- ☐ Ringing
- ☐ Deafness

Eyes
- ☐ Cataracts
- ☐ Blind spots
- ☐ Double vision
- ☐ Trouble seeing
- ☐ When was you last eye exam?

  by eye DR? _____

Nose and Mouth
- ☐ Nosebleeds
- ☐ Tooth pain
- ☐ Sore throat
- ☐ Sinus pain
- ☐ Nasal congestion

Neck
- ☐ Goiter
- ☐ Difficulty swallowing

Breasts
- ☐ Discharge from nipples
- ☐ Lumps

Cardiovascular
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Leg swelling
- ☐ Heart murmur
- ☐ Palpitations
- ☐ Varicose veins

Pulmonary
- ☐ Wheezing
- ☐ Cough
- ☐ Pain when you breathe
- ☐ Excessive sputum
- ☐ Cough up blood

Digestive
- ☐ Poor appetite
- ☐ Gas or heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Abdominal pain or cramping
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Jaundice
- ☐ Rectal bleeding

Genitourinary
- ☐ Burning on urination
- ☐ Bloody urine
- ☐ Incontinence
- ☐ Infections
- ☐ Difficulty urination
- ☐ Urination at night: # times
- ☐ Difficulty with erections
- ☐ Sexually transmitted diseases
- ☐ Multiple sexual partners

Skeletal
- ☐ Fractures
- ☐ Arthritis
- ☐ Leg pain when you walk
- ☐ Back or neck pain

Brain and nerves
- ☐ Convulsions
- ☐ Dizziness
- ☐ Blackouts
- ☐ Weakness
- ☐ Stroke
- ☐ Headaches
- ☐ Depression, low motivation
- ☐ Numbness
- ☐ Anxiety, excessive worry

Is there anyone that you're afraid of?_____

Source of stress?_____

Do you have an Advanced Directive for end-of-life?_____

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Financial Policy of Medford Women's Clinic

Thank you for choosing Medford Women's Clinic (MWC). If you do not understand our financial policy please feel free to ask our patient billing representative for clarification.

- Your financial responsibility is to provide payment for services rendered.
- Come prepared to pay in full if your insurance deductible has not been met.
- It is your responsibility to provide accurate billing information, we bill your insurance as a courtesy. Should you not give us accurate information it will be your responsibility to pay in full.
- Payment options are: Cash, Check, Visa, Mastercard, Discover, American Express, and Care Credit.
- Returned checks will be subject to our bank's NSF fee. Currently this is $50.
- Should your account become delinquent a collection fee will be assessed. No-Shows will also be charged a fee.
- For patients who have made payment arrangements and the account is older than 60 days will receive a service charge of 1.5% per month (18% annual) until the account is paid in full.
- Labs and Hospital charges are billed separately and you will receive a separate statement for those costs.
- Minor children are the parent's responsibility for all services rendered.
- Pre-authorization /Second Opinions/Referrals are your responsibility. Our Billing Department will assist you in this effort.
- By signing below you are giving authority to MWC to release any information required to complete your insurance claim. This is in effect until it is revoked in writing.
- By signing below you understand this policy and are bound by it.

Email Address_____, Does MWC have permission to contact you through your email address?_____yes _____no

Patient or Authorized Signature_____ Date_____

Print Name of Patient_____Date of Birth_____

This policy is subject to change

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Acknowledgment and Consent for Treatment

I understand that Medford Women's Clinic (MWC) will use and disclose health information about me.

I understand that my health information may include information both created and received by MWC, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand and agree that MWC may use and disclose my health information in order to:

- make decisions about and plan for my care and treatment
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how MWC will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of MWC, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of MWC's Notice of Privacy Practices in effect will be posted in the waiting/ reception area.

I would like to be informed of any clinical studies that may enhance my medical treatment. I authorize my medical information, securely and confidentially, transferred to the Advanced Clinic Research department affiliated with the Medford Women's Clinic. Initial Here: _____I agree

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that MWC is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By:_____ Date:_____
(Patient)

By_____Date:_____
(Patient Representative)

Description of Representative's Authority:_____