Premier Women's Health Center

"Making a difference in women's lives!"

Bryan Myers, M.D., PC
Ashley De Witt, D.O., PC
Courtney Murray, D.O., P.C.

Mary Beth McClain, APN
Melody Harrison, NP-C
Saharra Jewell, APN

Today's Date:_____

Patient's name:_____
Date of Birth:_____ Age:_____ Social Security #_____
Mailing Address or P.O. Box_____ City_____
State_____Zip Code_____ Sex:_____ Home Phone:(___)_____ Cell:(___)_____
Workplace phone:_____ Marital Status:_____
Are you a student?Full time_____ Part time_____ Email_____
Employment_____ Job title_____
Employment status: Full time Part time Not Employed Self Employed Retired Military
Name of Spouse(If you are under 21 name of parent)_____
In case of emergency, who may we notify(other than spouse)?
Name_____ Relationship_____ Phone _____

Insurance Information

Do you have insurance?_____ Name of insurance_____
Subscriber name_____ SS#_____ Date of Birth_____
Your relationship to subscriber_____ Subscriber phone_____
Subscriber mailing address_____
Insurance ID# _____ Group #_____ Employer_____

Secondary insurance/Name of company_____
Subscriber name_____ SS#_____ Date of Birth_____
Your relationship to subscriber_____ Subscriber phone_____
Subscriber mailing address_____
Insurance ID# _____ Group #_____ Employer_____

Who is your primary physician ? _____ Phone_____
Who referred you to our office?_____
Who is responsible for this bill?_____

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I, the undersigned, certify and acknowledge the following:

- I authorize this office to release any health information for the use of treatment, payment, and healthcare operations which include insurance companies, specialists, and other healthcare providers and institutions.
- I am 18 years or older. If you are under 18, your parent or guardian must sign this form.
- I understand that diagnostic tests may be recommended and denial of these tests can result in undiagnosed and untreated health conditions.
- I understand that I am financially responsible for all charges not covered by insurance assignment.
- I assume responsibility for all costs of collections, including financial charge, attorney fees and court costs.
- I have checked and know that my insurance company covers Premier Women's Health Center as a provider in or out of network.
- I understand that medical treatment carries with it some statistical risks even when performed with the utmost care.
- I understand that all co-pays, deductible amounts, or self pay services are due at the time of service.
- I understand that appointment times are reserved specifically for me and that any necessary changes should be finalized two working days prior to the original appointment or a late cancellation fee may be charged.
- I acknowledge I received the Premier Women's Health center privacy notice attached to this form.
- I have accurately answered all the questions here and on the medical history form, and have read all the above information.
- I understand that it is necessary to bring all forms such as disability and FMLA forms in the office one week prior to the time that they are due. I understand that there is a 20.00 fee for these forms.

Signature_____ Date signed_____

Printed name_____

If personal representative signature appears above, please describe authority to do so

_____

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Privacy Practices Notice of Acknowledgment

Name:_____

Acknowledgment

_____I acknowledge that I have been offered the **Notice of Privacy Practices** but declined.

_____ I acknowledge that I have been offered the **Notice of Privacy Practices.**

I give my permission to speak to the following on any medical issue:

	Name
_____My spouse	_____
_____My child/children	_____
_____My caregiver	_____
_____Other	_____

Check all that apply.

_____I give my permission to leave messages on my answering machine or with anyone answering my personal phone.

_____ I give my permission to contact me at my place of employment. If I am unavailable, I give permission for a message to be left to return the call.

_____ I give my permission for my physician to fax any information regarding me to another physician's office that may be covering for my doctor, or a physician that I have been referred to.

_____ I give my permission for my pharmacy to be contacted regarding my medications. My pharmacy is___ _____(pharmacy/city).

I will notify this office in writing (verbal will not be accepted) if there is any change in my above permission.

_____ _____

Name Date

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Annual Gynecological Update

Name:_____ DOB:_____ Date:_____

Welcome Back! Please take a few minutes to fill out this form to help us update your records.

Reason for today's visit? _____Annual Exam _____Problem Visit

Please list any new medical problems:_____
What was the first date of your last period?_____
Please list all allergies:_____
Any new medical problems in your family?_____
Social Status/Life changes (divorce/death/etc)?_____
Please list all surgeries:_____
Please list all current medications:_____
Please list all allergies to medications:_____

Allergic to latex?	_____Yes	_____No	
Do you smoke cigarettes?	_____Yes	_____No	If so, how much per day?_____
Do you drink alcohol?	_____Yes	_____No	If so, how much per week?_____
Do you use street drugs?	_____Yes	_____No	
Problems with violence at home?	_____Yes	_____No	

General	___Weight Loss	___Weight gain	___Fever	___Fatigue
HEENT	___ Vision changes	___Hearing loss	___Sore throat	
CV	___Chest pain/pressure	___Irregular heartbeat	___Swelling of legs	
RESP	___Shortness of breath	___Chronic Cough	___Spitting of blood	
GI	___Bloody Stool	___Nausea/indigestion	___Vomiting	___Diarrhea
Urinary	___Frequent urination	___Painful urination	___Loss of urine	
MS	___Muscle pain	___Joint Pain	___Swelling of joint(s)	
Skin	___ Rash	___Changes in color/size of mole(s)		
Neuro/psych	___Headaches	___Depression/Crying spells		
Endocrine	___Appetite changes	___Excessive thirst		
Hematology	___Excessive bleeding	___Easy Bruising	___Enlarged lymph nodes	

Do you perform month self breast exam?___Yes___No

Last Mammogram check:_____ Last Bone Density testing:_____

For those over 40, date of last sigmoidoscopy/colonoscopy/stool checked for blood?_____

Does your insurance cover routine, preventative gynecological care?_____Yes___No

What pharmacy do you use for prescriptions?_____

What physician/clinic do you use for primary care?_____