

# Premier Women's Health Center "Making a difference in women's lives!" OBGYN offices of:

Ashley De Witt, D.O., PC Michael Nobles, M.D., PC Saharra Jewell, APN

		Today's Date:
Patient's name:		
Date of Birth:	Age:	Social Security #
Mailing Address or P.O. Box		city City Cell:()
State Zip Code Sex	: Hon	ome Phone:( Cell:()
Workplace phone:	Mari	rital Status:
Are you a student?Full time	Part time_	Email
Employment	Job title	
Employment status: Full time Part to	ime Not Employe	yed Self Employed Retired Military
Name of Spouse( If you are under	21 name of par	arent)
In case of emergency, who may w	e notify( other	than spouse)?
Name Relationshi	.p	Phone
Do you have insurance? Na Subscriber name	me of insurance SS#	Date of Birth Subscriber phone
Your relationship to subscriber		Subscriber phone
Subscriber mailing address		•
Insurance ID#	Group #	Employer
Subscriber name	SS#	Date of Birth
Vour relationship to subscriber		Date of Birth Subscriber phone
Cubscriber mailing address		
Insurance ID#	Group #	Employer
msdrance ib#	Group "	
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 a	bove, please describe authority to do so

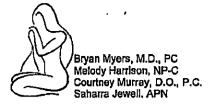


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#### Privacy Practices Notice of Acknowledgment

Name:	
Acknowledgment	
I acknowledge that I have been offered the Notice of	f Privacy Practices but declined.
I acknowledge that I have been offered the <b>Notice</b> of	f Privacy Practices.
I give my permission to speak to the following on any me	edical issue: Name
My spouse My child/children	
My caregiver	
Check all that apply.	
I give my permission to leave messages on my answer personal phone.	ering machine or with anyone answering my
I give my permission to contact me at my place of e for a message to be left to return the call.	mployment. If I am unavailable, I give permission
I give my permission for my physician to fax any in that may be covering for my doctor, or a physician that I have	aformation regarding me to another physician's office we been referred to.
I give my permission for my pharmacy to be contac (pharmacy/city).	ted regarding my medications. My pharmacy is
I will notify this office in writing (verbal will not be acce permission.	epted) if there is any change in my above
Name	Dat3



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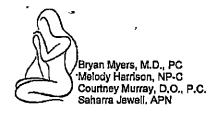
		•
	My appointment is with:	
Patient Name:	DOB:	Age:
Reason for your visit today:		<u> </u>
Who is your primary care physician?		
Current Medications:		
What pharmacy do you use for prescriptions?		
First day of last period:	Do you have regular monthly perio	ds? Y / N
How often do your periods come?		period
Periods are: Mild Moderate Heavy	Cramps are: Mild Mod	erate Severe
Drug Allergies:		•
Current birth control:		
Age at first intercourse:	Number of partners (lifeting	ne):
Are you having any libido changes? Y/N (p		<del></del>
Do you have pain with intercourse? Y/N (pl	lease explain)	
Have you ever had a sexually transmitted dis	sease? Y / N (circle any that apply)	
Gonorrhea Chlamydia Herpes Hepatitis I	B HIV Syphilis Genital Warts	PID Trichomonas HPV
Do you use tobacco products? Y/N	Aboutcigarettes	
Do you drink alcohol? Y/N	Aboutdrinks pe	r week
		:
Are you experiencing any vaginal or urinary		
Discharge Odor Burning Itchir	ng Frequency Urgency I	oss of Urine
Other:	<u></u>	
<del></del>	•	
Last Pap smear (month and year):	Results:	

# Bryan Myers, M.D., PC Melody Harrison, NP-C Courtney Murray, D.O., P.C. Saharra Jawell. APN

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	mmogram (month and	170ar);		Results:					
_ast Ma	mmogram (month and ou ever had an abnorma	1 mammogram? Y / N							
Have yo	ou ever han an abhorma	i anocequies	-						
if yes, p	do monthly breast exar	ne? V/N/Occasions	 allv						
Do you	do monthly breast exac	ms: 17147 Occasion	,						
Do νου	diet? Y / N	What type?							
_	Do you exercise? Y/N How often & how long?								
=	Do you take Calcium? Y/N If so, how much?								
-		<u> </u>							
Please	list all surgerics/hosp	italizations				<u></u>			
Surger	y/reason for hospitaliza	tion				Date			
				<u>.                                    </u>					
						<del> </del>			
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Pleas	e list all pregnancies			•					
	· • · ·	Gestational age	Sex	Weight	Comments/complicati	ons			
		·	<del> </del>	<del></del>					
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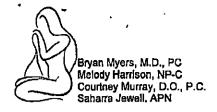
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Medical Problems	
Date of Diagnosis	Medical Problem
<del></del>	

# Personal & Family History (mark all those that apply)

Tersonal & Family				Matemal	Maternal	Paternal Grandmother	Paternal Grandfather	Brother/ Sister	Other
Disease	Self	Mother	Father	Grandmother	Grandfather	Grandmouter	Grandramer	Bister	Cuios
Alcoholism	<u> </u>								
Anemia	<u> </u>		ļ			<del> </del>	<del></del>	<del>                                     </del>	<del>                                     </del>
Arthritis		<u> </u>	<u> </u>		<u> </u>		<del> </del>	<u> </u>	<del>                                     </del>
Asthma/lung problems							<u> </u>	-	ļ
Blood clots			<u></u>				<del> </del>	<del> </del>	<del>                                     </del>
Bloody stools/ colon polyp									ļ
Cancer (note type of cancer in box)			<u> </u>				<u> </u>	<u> </u>	ļ
Diabetes		<u> </u>	<u> </u>	ļ <u> </u>	<del> </del>		<del> </del>		<del> </del>
Heart disease	<u> </u>				\	<del>                                     </del>	<del> </del>	-	<del> </del>
High cholesterol	<u> </u>				ļ_ <del></del>		<del> </del>		<del> </del> -
High blood pressure		-	<u> </u>	<del></del>			<del> </del> -	<del>  -</del> -	┼
Kidney disease/UTIs	↓	ļ	<del> </del>	<u> </u>	<del></del>	<del> </del>	<del> </del>	-	╁─╌
Liver disease	ļ	<u>  </u>	ļ	<del></del>	<del>-</del>	<del> </del>	<del> </del>	<del></del>	<del> </del>
Mental illness	<b>.</b>	_		<del> </del>	<u> </u>	<del> </del>		<del> </del>	┼
Osteoporosis	<del> </del>		<del> </del>	<del></del>		<del> </del>	<del> </del>	<del> </del>	<del></del>
Seizures	ļ			<del>                                     </del>		<del> </del>	<del> </del> _	-	╅──
Stomach ulcers		ļ	<b></b>				<del>                                     </del>	<del>                                      </del>	+
Stroke	<del> </del>	<del> </del>	<del> </del>	<del> </del> -		<del> </del>	<del></del>	-	+
Thyroid disease	↓_	-			<del> </del>	<del> </del>	<del> </del>	<del> </del>	<del></del>
Tuberculosis			<del>                                     </del>			<del> </del>	<del>                                     </del>		+
Other								<u> </u>	



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General wellness		N	problems in the ioi	lowing areas by marking Muscle/joints/bones		x in the appropriatN_	e column.
Eyes	_	N		Skin	Υ.	N	
Ear, nose, throat	Y_	N		Neurological	Y	N	
Heart/circulation	Y_	N		Psychiatric	Y.	N	
Lungs/breathing	Y_	N		Endocrine	Y.	N	`
Stomach/digestion	Υ_	N		Blood/lymph	Y.	N	
Reproduction/urinary	Υ_	N		Allergies	Y.	N	
•							
Completed by:		_ <del></del>	Signature:_			Date:	_