Women's Wellness at Flower Mound

ANNUAL ESTABLISHED

Vitals: Height _____ Weight _____ BP _____ HR _____ Temp. _____ LMP _____

Name: _____ D.O.B. _____ Age: _____ Date: _____
Change of address: _____
Referred by: _____
Employer/Occupation: _____ Single Married Divorced Widowed

*I understand if I am being seen for a problem visit with my Well Woman visit, I may be charged a co-pay for the problem visit. _____ Initials

Reason for visit: Well Woman Exam Problem Visit
Problem: _____
When did it start? _____Mild Moderate Severe
What makes it better or worse? _____
How has it been treated? _____

Menstrual History:

Last menstrual period: _____ Menstrual cycle: regular irregular Painful periods? Yes No
Amount of flow: light medium heavy clots
Was last menstrual period normal? Yes No if no, when was the last normal one? _____
Number of days between cycles: _____ Cycle lasts _____ days Age when menstrual cycle started_____

Pregnancy History:

Total # of pregnancies	# of Full Term Births (37-42 weeks)	# of Preterm (20-36 weeks)	# of induced abortions (before 20 weeks)	# of spontaneous abortions/ miscarriages (before 20 weeks)	# of ectopic pregnancies	# of multiple births	# of Living children0

#	Date	# weeks pregnant	# hours of in labor	Baby's weight	Type of delivery	Type of anesthesia	Place of delivery	Complications	Baby's sex
1									
2									
3									

PREVENTATIVE HEALTH	YEAR	History of abnormality:	If yes, when?	Abnormality?	Treatment?
Last Pap Smear		YES NO			
Last Mammogram		YES NO			
Last Colonoscopy		YES NO			
Last Bone Density Scan		YES NO		Osteopenia Osteoporosis	

Types of past contraceptives: _____ Current contraceptive(s): _____
Are you sexually Active? Yes No Any issues? Yes No if yes, explain _____

CURRENT PHARMACY:
Wal-Mart Kroger Tom Thumb Flower Mound Pharmacy Long Prairie Pharmacy CVS CVS CareMark Walgreens
OTHER:_____ STREET:_____ CITY/ZIP CODE:_____

Tobacco: Smoker Packs per day: _____ Former Smoker # of years: _____ Quit date: _____ Never Smoker
Alcohol: How often do you drink? _____ How much do you drink? _____ Never drinker
History of/Current Drug use: Marijuana Cocaine PCP Ketamine LSD Crack Ecstasy Methamphetamine Heroin
Explain: _____

Name: _____ D.O.B. _____ Age: _____ Date: _____

FAMILY HISTORY QUESTIONNAIRE FOR COMMON HEREDITARY CANCER SYNDROMES

Instructions: Please circle Y to those that apply to YOU and/or YOUR FAMILY. Then, please list relationship of the individual diagnosed (mother, father, brother(s), sister(s), maternal aunt(s), maternal uncle(s), maternal grandmother(s), maternal grandfather(s), paternal aunt(s), paternal uncle(s), paternal grandmother(s), paternal grandfather(s), son(s) or daughter(s), & their age at diagnosis. If you circle **Y** to any statements below, you MAY be appropriate for genetic testing.

		Breast & Ovarian Cancer (BRCA)	Relationship	Mother's Side	Father's Side	Age Diagnosed
Y	N	Breast Cancer		Y	Y	
Y	N	Ovarian Cancer		Y	Y	
Y	N	Breast Cancer in both breasts or multiple primary Breast Cancers		Y	Y	
Y	N	Male Breast Cancer		Y	Y	
Y	N	Pancreatic Cancer		Y	Y	
Y	N	Are you of Jewish descent?		Y	Y	
Y	N	Triple Negative Breast Cancer		Y	Y	
Y	N	Family member with known BRCA Mutation		Y	Y	
Colon & Uterine Cancer						
Y	N	Uterine (Endometrial) Cancer		Y	Y	
Y	N	Colon Cancer		Y	Y	
Y	N	Ovarian, Stomach, Kidney/Urinary Tract, Pancreatic, Brain or Small Bowel Cancer		Y	Y	
Y	N	10 or more Colon Polyps found in a lifetime (in an individual or a family)		Y	Y	

Name: _____ D.O.B. _____ Age: _____ Date: _____

CURRENT PROBLEMS WHICH <u>NEED TO BE ADDRESSED AT TODAY'S APPOINTMENT</u>:

GENITOURINARY/GYN	**EARS, NOSE, THROAT**	**MUSCULOSKELETAL**
□ Pain when urinating	□ Ear pain	□ Muscle weakness
□ Frequent urination	□ Ringing ears	□ Muscle pain or stiffness
□ Strong urgency to urinate	□ Hearing difficulties	□ Joint pain or stiffness
□ Difficulty urinating	□ Nose bleeds	□ Back pain
□ Bladder not emptying	□ Congestion, runny nose	□ Limited movement
□ Blood in urine	□ Mouth, gum, tongue sores	□
□ Leaking urine, incontinence	□ Sore throat, voice changes	**ENDOCRINE**
□ Genital sores	□ Dental	□ Heat intolerance
□ Abnormal vaginal discharge	**CARDIOVASCULAR**	□ Cold intolerance
□ Vaginal itching, burning	□ Chest pain or pressure	□ Excessive thirst & urination
□ Vaginal odor	□ Shortness of breath	□ Hair loss
□ Vaginal mass, protrusion	□ Difficulty breathing	□ Hot flashes/night sweats
□ Abnormal vaginal bleeding	□ Feel irregular heart beats	□ Weight changes
□ Abnormal periods	□ Swelling (edema)	□
□ Painful periods	□	**NEUROLOGIC**
□ Premenstrual syndrome PMS	**PULMONARY**	□ Dizziness or fainting
□ Pelvic pain	□ Wheezing	□ Tremors
□ Painful intercourse	□ Cough	□ Seizures
□ Low sex drive, libido	□ Coughing up blood	□ Numbness, tingling
□ Problems getting pregnant	□ Short of breath	□ Trouble with balance, walking
□	□ Painful breathing	□ Unusual memory loss
BREAST & SKIN	□	□ Frequent or severe headache
□ Breast pain	**GASTROINTESTINAL**	□
□ Breast lump, mass	□ Diarrhea	**HEMATOLOGIC/LYMPH**
□ Nipple discharge	□ Constipation	□ Abnormal bruising
□ Rash or hives	□ Abdominal pain	□ Prolonged bleeding from cuts
□ Sores, boils, abscesses, acne	□ Gas, bloating	□ Enlarged glands, lymph nodes
□ Abnormal moles or warts	□ Bloody stool or rectal bleeding	□
□ Dry, scaly skin or plaques	□ Nausea	**ADDITIONAL NOTES**
□	□ Vomiting	
CONSTITUTIONAL	□ Heartburn	
□ Weakness, unusual fatigue	□ Leaking stool, incontinence	
□ Fever	□ Hemorrhoids	
□ Unintentional weight loss	**PSYCHIATRIC**	
□ Abnormal weight gain	□ Depressed mood	
□ Lack of appetite, anorexia	□ Excessive anxiety	
□ Night sweats	□ Extreme mood swings	
EYES	□ Sleep disturbance	
□ Vision changes, problems	□ Unusual behaviors	
□ Wear glasses or contacts	□ Ideas of hurting self, others	
□	□ Hearing or seeing things	
	□	

Zika Virus Questionnaire:

1. In the past 4 weeks :
   Have you been in any of the areas on this list: If so please circle

- Anguilla
- Argentina
- Aruba
- Barbados
- Belize
- Bolivia
- Bonaire
- Brazil
- Colombia
- Costa Rica
- Cuba
- Curacao
- Denton, TX
- Dominica
- Dominican Republic
- Ecuador
- El Salvador
- Florida
- French Guiana
- Grenada
- Guadeloupe
- Guatemala
- Guyana
- Haiti
- Honduras
- Jamaica
- Martinique
- Mexico
- Nicaragua
- Panama
- Paraguay
- Peru
- Puerto Rico
- Saba
- Saint Barthélemy
- Saint Lucia
- Saint Martin
- Saint Vincent and the Grenadines
- Sint Eustatius
- Sint Maarten
- Suriname
- Trinidad and Tobago
- U.S. Virgin Islands
- Venezuela

Oceania/Pacific Islands

- American Samoa
- Fiji
- Kosrae, Federated States of Micronesia
- Marshall Islands
- New Caledonia
- Papua New Guinea
- Samoa
- Tonga

Africa

- Cape Verde

1. Have you had Zika Virus infection?
(Please circle) Yes / No

2. Have you had 2 or more of the following symptoms: Fever, rash, joint pain, muscle pain, conjunctivitis (pink eye), head ache?
(Please circle) Yes / No

3. Have you had sexual contact with a man, who in the 3 months prior to your sexual contact, had Zika virus infection or had 2 or more symptoms of Zika virus infection?
(Please circle) Yes / No

PATIENT REGISTRATION FORM

Women's Wellness at Flower Mound

Obstetrics, Gynecology, & Infertility

Sylvie H. Paroski, MD, FACOG • Cheryl Smitherman, DNP, CNM

Please clearly print your response to all requested information.
If you have any questions, please ask our staff. Thank you!

Name _____ Home Phone (____) _____ - _____

Address _____ • Okay to leave a detailed message regarding results?

City _____ _____ YES _____ NO

State _____ Zip_____ Cell Phone (____) _____ - _____

Date of Birth _____ Work Phone (____) _____ - _____

Employer _____ • Okay to leave a detailed message regarding results?

Social Security # _____ _____ YES _____ NO

Single __ Married __ Divorced __Widowed __ Email Address _____

Spouse's Name _____ • Okay to send you offers & information about healthcare?

_____ YES _____ NO

HOLDER OF INSURANCE POLICY (You do not need to fill out if you are the policy holder)

Patients Relationship to policy holder ◯ Self ◯ Spouse ◯ Child ◯ Other_____

Name _____ Office Phone (____) _____ - _____

Home Address _____ City_____ State_____ Zip_____

Employer _____ Occupation _____

Social Security # _____ Date of Birth _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Primary Telephone (____) _____ - _____

I hereby assign all medical and/or surgical benefits, to include major medical to which I am entitled including Medicare, Private Insurance, PPO Plans, and all other health plans to Women's Wellness at Flower Mound, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges weather or not paid by said insurance. I hereby authorize said assignee to release all information needed to secure the payment.

Signature _____ Date _____

Women's Wellness
AT FLOWER MOUND

PATIENT CONSENT FORM

I understand that as a part of my healthcare, Women's Wellness at Flower Mound, P.A. ("The PRACTICE") originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The PRACTICE'S *Notice of Privacy Practices* provides specific information and complete descriptions of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice or Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that the PRACTICE is required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that the PRACTICE has already taken action in reliance on my prior consent. The consent is valid until revoked by me in writing.

I further understand that any and all records, weather written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed the PRACTICE'S *Notice of Privacy Practices 2017.*

_____ _____

Signature of Patient or Legal Representative Date

_____

Print Name of Patient or Legal Representative

I hereby give my authorization to disclose my protected health information, only in the specific manner, for the named reason, and to the specific individual(s) below:

Specific description of information to be released:

_____

_____

Person(s) you allow to request and receive the information stated above:

_____

I understand this authorization provides that:

- I have the right to access my protected health information to be used or disclosed.
- I may revoke this authorization at any time by contacting your Privacy Officer in writing at the address above.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPPA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use of disclosure.

Signature:_____ **Date:**_____

Relationship to patient (if signed by a representative of patient)_____

DISCLOSURE OF PHYSICIAN OWNERSHIP IN HEALTHCARE FACILITIES

Please carefully review the following information:
Dr. Sylvie Paroski MD, is required by federal and state law to disclose any ownership or financial interest in any healthcare facilities to which our patients may be referred. Your physician holds ownership interest in Texas Health Presbyterian Flower Mound ("THFM"). Please contact the scheduler at THFM for a current list of physician's owners or go to www.texashealthflowermound.com

We respect your right to choose not only your physician, but also where you wish to receive medical care. You will not be treated differently by your physician if you choose to use a different facility. We encourage you to ask questions or discuss any concerns you have with us at the time of your office visit.

ACKNOWLEDGMENT:
I have been notified, at the time of referral, that my physician and other treating physician(s) have an ownership interest in Texas Health Presbyterian Hospital Flower Mound. I further acknowledge this disclosure will be maintained in my medical record and made available to Texas Presbyterian Hospital Flower Mound.

Patient Name (please print):_____

SIGNATURE
Patient: _____ Date: _____

OR

Legal Representative: _____

Relationship to Patient: _____

Sylvie H. Paroski, MD, FACOG
Cheryl Smitherman, DNP, CNM

Women's Wellness
AT FLOWER MOUND

2017 Office Policy Charges

$25.00 - Appointments cancelled with less than 24 hours' notice.

$25.00 - No show to appointment.

$25.00 - FMLA / Disability Paperwork, if less than 10 day notice there will be an additional $5.00 charge.

$25.00 - Claims Paperwork, if less than 10 day notice there will be an additional $5.00 charge.

$25.00 – Medical Records not requested by physician.
Additional $5 per 100 pages after initial100 pages.
If less than 10 day notice there will be an additional $5.00 charge.
****RECEIVE MEDICAL RECORDS UP TO 30 DAYS****

Patient Signature: _____ **Date:** _____

Ofc: 972-355-9436 • Fax: 214-513-2244 • 3051 Churchill Dr., Suite 220 • Flower Mound, TX 75022
www.WomensWellnessFM.com

Dr. Sylvie H. Paroski, MD, FACOG
Cheryl Smitherman, DNP, CNM

Patient Financial Responsibility Statement Acknowledgement

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

_____
Print Name

_____ _____
Signature of Patient or Guardian Date

For self-pay or if you are submitting to insurance on your own

Waiver of Patient Authorizations I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion. If you are self-pay there will be a separate bill from PathAdvantage for your pap smear that you are responsible for and all labs will be paid for at the time of visit.

_____
Print Name

_____ _____
Signature of Patient or Guardian Date