Women's Health History

NEXTGEN HEALTHCARE

Patient Name:

Birth Date: **Gender:**

Rendering Provider: **MRN:**

Appt Date:

Obstetric History

Are you currently pregnant? ☐ Yes ☐ No ☐ Possibly ☐ Not pertinent

Full term pregnancies:		SVD:		Ectopic pregnancies:	
Premature deliveries:		Live births:		Miscarriages:	
C-section:		Living biological children:		Abortions:	

Gynecologic History

☐ Premenopausal ☐ Perimenopausal ☐ Postmenopausal

Last menstrual period: mm / dd / yy Age at first menses: Age at first birth:

Age at menopause: Year of menopause:

Type: ☐ Bilateral oopherectomy ☐ Chemo induced ☐ Drug induced
☐ Hysterectomy w/BSO ☐ Natural ☐ Premature

Past Medical History

- ☐ Abnormal pap, h/o
- ☐ Anemia
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Bartholin's gland cyst
- ☐ Blood tranfusion, h/o
- ☐ Breast cancer
- ☐ Breast mass
- ☐ Bruising/bleeding disorder
- ☐ Cerebrovascular accident
- ☐ Cervical cancer
- ☐ Clotting disorder
- ☐ Congenital heart disease
- ☐ Cystocele
- ☐ Depression
- ☐ DES Exposure
- ☐ Diabetes mellitus
- ☐ Drug/alochol use
- ☐ Endometriosis
- ☐ Family hx of genetic disorder
- ☐ Fetal death, prior
- ☐ Fibroid uterus
- ☐ Gallbladder disease
- ☐ Genital herpes, exposure
- ☐ Genital herpes, h/o
- ☐ Heart murmur
- ☐ Hemoglobinopathy
- ☐ Hepatitis/Liver disease
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Hypercoagulable disorder
- ☐ Incompetent cervix
- ☐ Infertility
- ☐ Neonatal death, prior
- ☐ Phlebitis
- ☐ Obesity
- ☐ Ovarian cancer
- ☐ Ovarian cyst
- ☐ PID
- ☐ Polycystic ovary syndrome
- ☐ Prolapsed uterus
- ☐ Premature rupture of membranes
- ☐ Preterm delivery, prior
- ☐ Psychiatric disease
- ☐ Pulmonary embolism
- ☐ Recurrent miscarriages
- ☐ Seizure disorder
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Uterine cancer
- ☐ UTI, h/o recurrent
- ☐ Vagincal infections, recurrent
- ☐ STD

Review of Systems

NEXTGEN™ HEALTHCARE

Patient Name:

Birth Date: **Gender:**

Rendering Provider: **MRN:**

Appt Date:

Review of Systems

Please check all appropriate boxes.

Constitutional:

None of the following apply ☐

chills	☐ Yes	☐ No
fatigue	☐ Yes	☐ No
fever	☐ Yes	☐ No
weight loss	☐ Yes	☐ No
weight gain	☐ Yes	☐ No
night sweats	☐ Yes	☐ No

Respiratory:

None of the following apply ☐

stop breathing during sleep (sleep apnea)	☐ Yes	☐ No
shortness of breath	☐ Yes	☐ No
wheezing	☐ Yes	☐ No
snoring	☐ Yes	☐ No
cough	☐ Yes	☐ No
coughing up blood (hemoptysis)	☐ Yes	☐ No

HEENT:

None of the following apply ☐

blurred vision	☐ Yes	☐ No
choking on liquids	☐ Yes	☐ No
choking on solids	☐ Yes	☐ No
drooling	☐ Yes	☐ No
difficulty swallowing (dysphagia)	☐ Yes	☐ No
ear drainage	☐ Yes	☐ No
diplopia	☐ Yes	☐ No
pharyngitis	☐ Yes	☐ No
ringing in ear (tinnitus)	☐ Yes	☐ No
hoarseness	☐ Yes	☐ No
mouth ulcers	☐ Yes	☐ No
dizziness	☐ Yes	☐ No
vertigo	☐ Yes	☐ No
ear ache (otalgia)	☐ Yes	☐ No
hearing loss	☐ Yes	☐ No
vision changes	☐ Yes	☐ No

Cardiovascular:

None of the following apply ☐

chest pain	☐ Yes	☐ No
irregular heart beat (palpitations)	☐ Yes	☐ No
heart murmur	☐ Yes	☐ No

Metabolic/Endocrine:

None of the following apply ☐

cold intolerance	☐ Yes	☐ No
heat intolerance	☐ Yes	☐ No
increased thirst	☐ Yes	☐ No

Gastrointestinal:

None of the following apply ☐

abdominal pain	☐ Yes	☐ No
heart burn	☐ Yes	☐ No
constipation	☐ Yes	☐ No
diarrhea	☐ Yes	☐ No
vomiting	☐ Yes	☐ No

Genitourinary:

None of the following apply ☐

change in urine color	☐ Yes	☐ No
pain during urination (dysuria)	☐ Yes	☐ No
urinary frequency	☐ Yes	☐ No

Immunology:

None of the following apply ☐

food allergies	☐ Yes	☐ No
environmental allergies	☐ Yes	☐ No

Skin:

None of the following apply ☐

rash	☐ Yes	☐ No
skin infections	☐ Yes	☐ No

Please continue on other side

Hematology:

None of the following apply ☐

bruising	☐ Yes	☐ No
bleeding	☐ Yes	☐ No

Psychiatric:

None of the following apply ☐

anxiety	☐ Yes	☐ No
depression	☐ Yes	☐ No
hallucinations	☐ Yes	☐ No

Neurological:

None of the following apply ☐

numbness in extremities	☐ Yes	☐ No
tingling	☐ Yes	☐ No
fainting (syncope)	☐ Yes	☐ No
difficulty falling asleep	☐ Yes	☐ No
non-restorative sleep	☐ Yes	☐ No
difficulty staying asleep	☐ Yes	☐ No
excessive daytime sleepiness	☐ Yes	☐ No
tremors	☐ Yes	☐ No
weakness	☐ Yes	☐ No

Patient Intake

NEXTGEN HEALTHCARE

Patient Name:

Birth Date: **Gender:**

Rendering Provider: **MRN:**

Appt Date:

Past Medical History

- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Benign prostatic hypertrophy
- ☐ Blood clots
- ☐ COPD
- ☐ Cancer
- ☐ Cerebrovascular accident
- ☐ Coronary artery disease
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diabetes
- ☐ GERD
- ☐ Gallbladder disease
- ☐ Hepatitis C
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irritable bowel disease
- ☐ Liver disease
- ☐ Migraine headaches
- ☐ Myocardial infarction
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic ulcer disease
- ☐ Renal disease
- ☐ Seizure disorder
- ☐ Stomach / Duodenal ulcer
- ☐ Thyroid disease

Past Surgical History

Procedure	Year
☐ Angioplasty	
☐ Angio w/stent	
☐ Appendectomy	
☐ Arthroscopic knee	
☐ Back surgery	
☐ CABG	
☐ Carpal tunnel release	
☐ Cataract extraction	
☐ Cholecystecotmy	
☐ Colectomy	
☐ Colostomy	
☐ Gastric bypass	
☐ Hernia repair	
☐ Hip replacement	
☐ Knee replacement	
☐ LASIK	
☐ Liver biopsy	
☐ ORIF	
☐ Pacemaker	
☐ Small bowel resection	
☐ Thyroidectomy	
☐ Tonsillectomy	

Family History

Has anyone in your immediate family ever had any of the following diseases? If so please select the disease(s).

- ☐ ADD/ADHD
- ☐ Alcoholism
- ☐ Allergies
- ☐ Alzheimer's disease
- ☐ Asthma
- ☐ Blood disease
- ☐ CAD
- ☐ CAD - premature
- ☐ Cancer
- ☐ CVA (stroke)
- ☐ Depression
- ☐ Developmental delay
- ☐ Diabetes
- ☐ Eczema
- ☐ Hearing deficiency
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irritable bowel disease
- ☐ Learning disability
- ☐ Mental illness
- ☐ Migraines
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ PVD
- ☐ Renal disease
- ☐ Seizure disorder

Other family history

Please continue on other side

Social History

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Life partner

Race: ☐ White ☐ African-American ☐ Hispanic ☐ Asian Other: ____

Language: ☐ English ☐ Spanish ☐ Chinese ☐ French Other: ____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Hand dominance ☐ Left ☐ Right ☐ Ambidextrous

Exercise frequency: ☐ 2-3 times/week ☐ 3-4 times/week ☐ Daily ☐ Occasionally ☐ Never

What is your tobacco use history?

Uses tobacco: ☐ Currently ☐ Never ☐ Formerly

Tobacco type: ☐ Cigarettes ☐ Chewing ☐ Cigar ☐ Pipe ☐ Smokeless ☐ Snuff

Second-hand smoke exposure: ☐ Yes ☐ No

What is your alcohol use history?

Drinks alcohol: ☐ Yes ☐ No ☐ Formerly

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Emergency Contact Information

Last Name ____ First Name ____ M.I. ____

Address Line 1 ____

Address Line 2 ____

City ____ Phone ___ - ___ - ____

State ____ Zip ____ Alt Phone ___ - ___ - ____ Alt Phone Description ____

Relationship: ☐ Spouse ☐ Daughter ☐ Son ☐ Mother ☐ Father ☐ Sister

NEXTGEN
HEALTHCARE

HIPAA AUTHORIZATION FORM

Patient Name:

Birth Date: **MRN:**

I, ____, give permission to [Name of Institution] to:
_ use the following protected health information, and/or
_ disclose the following protected health information to:

____

____
[Name(s) of entity to receive information]
Information to be disclosed (check all that apply):
_ Medical Records
_ Treatment Records
_ Diagnostic Records
_ Other: ____

____

This protected health information is being used or disclosed for the following purposes:

____

____

This authorization expires [specify (1) date or (2) event that relates to the purpose of this use or disclosure].

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in writing at any time by sending written notification to [Name of Privacy contact] at [office address]. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

____
Signature of Participant or Personal Representative

____
Date

____
Printed Name of Participant or Personal Representative

____
Description of Personal Representative's Authority

2790 Godwin Blvd., Ste 360
Suffolk, VA 23434

Specialists for Women
(757) 539-3911

5833 Harbour View Blvd., Ste C
Suffolk, VA 23435

Section A: Patient Information

First Name:	Preferred Name:	Middle Name:	Last Name:	SSN:	
Street Address (include apt/P.O. box #, if any):			City :	State:	Zip:
HOME Phone:	Date of Birth:	Age:	Marital Status: ☐ S ☐ M ☐ Other ________		
CELL Phone:	Occupation (area of study, if student)	Employer Name and Phone:			
Preferred Language: ☐ English ☐ Spanish		Emergency Contact Name: Relationship:			
Email Address:		Emergency Contact Phone Number(s) Home: Cell/Work:			
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino			Race:		

Section B: Insurance Information

◆ Primary Policy ◆

Subscriber: ☐ Patient ☐ Spouse ☐ Parent ☐ Other ____________________

Subscriber Name:	Subscriber Date of Birth:	Primary Company Name:
Subscriber ID Number:	Group or Policy Number:	Primary Company's Phone Number:
Effective Date of Policy:	Subscriber's Address:	Phone Number:

◆ Secondary Policy ◆

Subscriber: ☐ Patient ☐ Spouse ☐ Parent ☐ Other ____________________

Subscriber Name:	Subscriber Date of Birth:	Secondary Company Name:	
Subscriber ID:	Group or Policy Number:	Phone Number:	Effective Date:
Subscriber's Address:	City	State:	Zip:

Section C: Spouse or Parent Information

Patients relationship: ☐ Spouse ☐ Parent ☐ Other ____________________

Full Name:	Social Security #:	Date of Birth:	Living w/patient: ☐ Yes ☐ No
Occupation:	Employer /School Name:		Business Phone:
Street Address (include apt/P.O. Box #, if any)	City	State	Zip

Patient Signature: ____________________ ***Date:*** __________

Specialists for Women Financial Agreement

ALL PATIENTS: I/WE understand and agree that this agreement authorizes that my insurance benefits be paid directly to Specialists for Women. I/WE understand that my insurance is a method to receive reimbursement for fees I have paid to physicians for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on the patient's contract with them and not on a contract with the doctor. I/WE understand and agree that it is my responsibility to pay the deductible, co-insurance, and any other balances not paid for by my insurance and that I/WE are responsible for the total bill due for services rendered by Specialists for Women. I/WE agree that I/WE have read this agreement and understand it.

AUTHORIZATION TO PULL CREDIT REPORT: By signing this agreement below, I/WE, who are either a patient seeking services or a personal guarantor of the patient, hereby provide written authorization to Specialists for Women, its agents, attorneys, and any assignee or potential assignee of this agreement authorizing review of my/our personal credit profile from one or more of the national credit bureaus. Such authorization shall extend to obtaining a credit profile in considering the application for service and subsequently for the purposes of update, renewal or extension of such credit or additional credit and for reviewing or collecting the resulting account. A photocopy, a facsimile or electronic copy of this authorization shall be valid as the original. By signing this agreement below, I/WE affirm my/our identity as the individual(s) identified below and authorize Specialists for Women to review my/our personal credit profile from one or more of the national credit bureaus as indicated above. A photocopy of this authorization is to be considered as valid as the original.

Promissory Note for balance due

I/WE understand that ANY balance due on my bill, regardless of the reason for the balance due, is my/our responsibility. I/WE promise to pay Specialists for Women any such balance due within TEN (10) days after notification of the balance due. **I/WE HEREBY WAIVE, THE BENEFIT OF ANY EXEMPTIONS UNDER THE HOMESTEAD OR BANKRUPTCY LAWS AS TO THIS DEBT AND ALL NOTICE OF SUCH MATTERS** and agree to pay all the costs, fees and expenses incurred by Specialists for Women in collecting this debt, including attorney's fees of 33.33%, all postage fess, skip trace fees of $30.00, employment verification fees of $20.00, credit report fee of $5.00 for each report, and interest from the date of default at the rate of 21%. A photocopy of the Promissory Note is to be considered as valid as the original. (All fees subject to change)

______________________	______________________	__________
Print the Patients Name	Signature of Patient	Date
Print the Guarantors Name	Signature of Guarantor	Date
Print the Minor's Name	Minor's Relationship to Guarantor	

Witness to Signature: ______________________________ Date: ______________

The front and back of the Agreement comprise the entire agreement between the parties affecting the service provided by Specialists for Women. No oral agreements or understanding shall be binding. Client acknowledges that I/WE have been given the opportunity to review this document prior to signing it. By signing this agreement, I/WE acknowledge that I/WE have read all of the Agreement Terms. Guarantor certifies that he/she is 18 years or older.

THE NON-MEDICARE PATIENT: I/WE authorize the release of all medical information necessary to process this claim and is pertinent to my medical care. I/WE understand that the information used or disclosed may be subject to re-disclosure by Specialists for Women, or an attorney collecting on the debt created by the services received, and that it would then no longer be protected by federal privacy regulations. I/WE assign all medical and/or surgical benefits including major medical benefits to which I am entitled to Specialists for Women. The assignment still remains in effect until revoked by me in writing. I/WE HEREBY WAIVE THE RIGHT TO REVOKE THIS ASSIGNMENT ONCE SERVICES ARE PROVIDED BY SPECIALISTS FOR WOMEN. A photocopy of this assignment is to be considered as valid as the original.

THE MEDICARE PATIENT: I/WE request that payment of authorized Medicare benefits be made to me or on my behalf to Specialists for Women, for any services furnished me by that provider. I/WE authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment still remains in effect until revoked by me in writing. I/WE HEREBY WAIVE ALL RIGHT TO REVOKE THIS ASSIGNMENT ONCE SERVICES ARE PROVIDED BY SPECIALISTS FOR WOMEN. A photocopy of this assignment is to be considered as valid as the original.

PAYMENT DUE WHEN SERVICES RENDERED: Payment is due on the day services are received. Cash, check or credit card payment received on date of service may receive a discount at the sole discretion of Specialists for Women in appreciation of the prompt payment. Clients who present checks that are returned or do not make payments when services are received will not receive any discretionary discount and will be billed for the full amount due for the services received in addition to collection costs.

APPLICATION OF PAYMENTS: All payments shall be applied first to the payment of any interest, collection costs or expenses of Specialists for Women due hereunder, then any late charge due hereunder, then to reduction of principal.

LEGAL TENDER: All payments hereunder shall be payable in lawful money of the United States which shall be legal tender for public and private debts at the time of payment.

SEVERABILITY: In the event any covenant, term, or condition of this agreement shall be held for any reason to be invalid, illegal, or unenforceable in any respect, the invalidity, illegality, or unenforceability of such covenant, term, or condition shall not affect the validity, legality or enforceability of the remaining covenants, terms, and conditions of this agreement.

GOVERNING LAW: This agreement shall be governed by and construed in accordance with the laws of the Commonwealth of Virginia.

FAILURE TO EXERCISE RIGHTS: Any failure by Specialists for Women to exercise any right hereunder shall not be construed as a waiver of the right to exercise the same or any other rights at any time.

BANKRUPTCY: Patient or Guarantor specifically warrant that a bankruptcy proceeding is not in progress nor expected.

CHANGE OF ADDRESS: Patient or Guarantor specifically warrant that he/she will notify Specialists for Women of a change of address within five (5) days of changing an address by written notice to Specialists for Women.

APPOINTMENT CANCELLATION FEE: I/WE understand that if I/WE do not reschedule or cancel an appointment within 24 hours prior to the scheduled appointment I/WE agree to a charge of $50.00 for time/service loss to the Physician.

SURGERY AND PROCEDURE FEE: I/WE understand that if I/WE cancel a surgery and/or procedure, I/WE agree to the charge of $250.00 for time/services loss to the Physician.