Women First Health Center
an Axia Women's Health Care Center

Patient Demographic Form

Please complete this form in order to ensure proper billing of your services.

Patient Information

Last Name: _____ First Name: _____ Today's Date: _____

Other Name: _____ Date of Birth: _____ Soc. Sec. No: _____

Address (street): _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

PCP: _____ Ref. Physician (if different): _____

Address (street): _____ Address (street): _____

City, State, Zip: _____ City, State, Zip: _____

Telephone #: _____ Telephone #: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partner

Employment Information

Employer: _____

Employer Address (street): _____ City, State, Zip: _____

Emp. Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self-Employed ☐ Active Military

Student Status: ☐ Full Time Student ☐Part Time Student

Insurance Information

PRIMARY CARRIER NAME: _____ Telephone #: _____

Address: _____ City, State, Zip: _____

ID/Cert #: _____ Group/Plan #: _____ Effective Date: _____

SECONDARY CARRIER NAME: _____ Telephone #: _____

Address: _____ City, State, Zip: _____

ID/Cert #: _____ Group/Plan #: _____ Effective Date: _____

Parent / Guardian Information

Contact: _____ Relationship to You _____

Home Phone: _____ Alt. Phone: _____

Contact: _____ Relationship to You _____

Home Phone: _____ Alt. Phone: _____

Electronic Communications

Portal: We offer secure electronic communications between you and our office via our Patient Portal. Secure messages and information can only be read by someone who knows the right password to log in to the Portal site. The communications are automatically encrypted and for those who want to participate, this secure communication can be a valuable tool to provide administrative and clinical information.

☐ Yes, I want to participate, please use the email provided on my HIPAA form.

☐ No, I do not wish to participate.

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

Automated Calls: As an added convenience, we offer automated appointment reminders via a text message or an automated call for those who want to participate. The reminders are sent from a computer and cannot be used as a way for you to communicate back to us. If you should need to reach us, please call our main number. If at any time you should change your mind, please let us know what other method you would prefer for appointment reminders.

I understand under the telephone consumer protection act, that in order for you to contact me by automated means for services relating to my medical care, including appointment reminders, monies I may owe, etc., I agree that Axia Women's Health and/or your agents may contact me by my cell phone, which may result in charges to me. You may also contact me by text messages, or emails providing that I have consented above. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automated dialing device, as applicable.

☐ Yes, I agree to participate in automated dialing, my cell number is provided below.

Cell Phone Number: _____

☐ No, I do not wish to participate.

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

Additional Information

Race: Which category best describes your racial background?

☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ Asian ☐ White

☐ Black or African American ☐ Unreported/Refused to Report

Ethnicity: How would you describe you ethnicity, such as your family background or ancestry?

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unreported/Refused to Report

Preferred Language: What language do you usually speak at home?

☐ English ☐ Spanish ☐ Other _____

How did you hear about our practice? ☐ Health Plan ☐ Internet ☐ Our Web Site ☐ ER/Hospital

☐ Newspaper/Magazine ☐ Patient _____ ☐ Other _____

Pharmacy Information

Pharmacy Name: _____ ☐ Local ☐ Mail away

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

Pharmacy Name: _____ ☐ Local ☐ Mail away

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

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Patient's Name: DOB:

Authorization for Treatment & Payment of Medical Benefits
Patient Financial Responsibility Form

Thank you for choosing our practice, an Axia Women's Health Care Center, as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment, and patient financial policies. If you would like to receive a more detailed explanation of our financial policies, please request a copy.

Authorization for Treatment & Payment of Medical Benefits

I give permission to the practice, an Axia Women's Health Care Center, to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to the practice, an Axia Women's Health Care Center.

Use of Photography

I agree that any photo identification taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of identification.

e-Prescription Consent for Medication History

With your consent, we may request and use your prescription medication history information using our e-prescription feature. This is for only informational purposes so that an up-to-date record of your medication is available for your treatment and safety.

☐ Yes, I give consent to obtain my medication history using the e-Prescribing feature.

☐ No, I do not give consent to obtain my medication history using the e-Prescribing feature. I understand that my medication information may not be complete when making treatment decisions.

Patient Financial Responsibilities

- I (or patient's guardian, if a minor) understand that I am ultimately responsible for the payment of my treatment and care.
- You will assist me by billing your contracted insurers. However, I understand that I am required to provide you with the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, and most major credit cards.
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include (but are not limited to):
    - Charge for returned checks.
    - Charge for the copying and distribution of patient medical records.
    - Charge for forms completion.
    - Charge for missed appointments.

Patient Authorizations

- By my signature below, I hereby authorize the practice, an Axia Women's Health Care Center, to release medical and other information to the necessary insurance companies and third party payers required for payment of rendered health services.
- By my signature below, I hereby authorize assignment of financial benefits directly to the practice, an Axia Women's Health Care Center. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

I have read, understand, and agree to the provisions of this Authorization for Treatment & Payment of Medical Benefits and Patient Financial Responsibility Form:

Signature of Patient or Guardian Date

Women First Health Center
an Axia Women's Health Care Center

HIPAA
Acknowledgements and Authorizations

I. HIPAA Notice of Privacy Practices

Patient Acknowledgement

We are required by law to maintain the privacy of protected health information, and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have been given the option of receiving a copy or been afforded an opportunity to review our Notice of our Privacy Practices:

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

II. Authorization for use or Disclosure of Health Information

Patient Contact Information

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

I authorize Brief messages with medical information to be left on voicemail at (check all that apply): ☐ Home ☐ Cell ☐ Work

I authorize Extended messages with medical information to be left on voicemail at (check all that apply): ☐ Home ☐ Cell ☐ Work

I authorize secure electronic communications be sent to my email address at: _____

Restrictions/Instructions: _____

Release of Medical History and Treatment Information

I authorize the following individual(s) to receive information pertaining to any medical history and treatment received:

Name: _____ Relationship: _____ DOB: _____ Ph #: _____

Name: _____ Relationship: _____ DOB: _____ Ph #: _____

Restrictions: _____

Release of Billing Information

I authorize the following individual(s) to receive information pertaining to any billing issue and to act on my behalf:

Name: _____ Relationship: _____ DOB: _____ Ph #: _____

Name: _____ Relationship: _____ DOB: _____ Ph #: _____

Restrictions: _____

Patient Acknowledgement

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to our office address. My revocation will be effective once received by the practice, an Axia Women's Health Care Center.
2. A copy of this authorization may be used with the same effectiveness as the original.

This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

Print Name: _____ Date: _____

Signature: _____ Relationship: _____

Additional Authorizations

Emergency Contact: _____ Relationship: _____ Phone: _____

I request a female chaperone to be present during my examination? ☐ Yes ☐ No ☐ Other _____

Women First Health Center
Patient Medical History

Name:_____ DOB: _____

Please list any present medications: _____

_____

Medical History

Please check all that apply:

[ ] Anxiety [ ] Asthma [ ] Depression [ ] Melanoma [ ] Epilepsy

[ ] Fibroids [ ] Stroke [ ] Heart Murmur [ ] Colonic Polyps [ ] Kidney Stones

[ ] Cancer, Breast [ ] Cancer, Colon [ ] Cancer, Rectal [ ] Cancer, Ovarian

[ ] Cancer, Uterus [ ] Cancer, Endometrial [ ] Cancer, Cervical [ ] Diabetes

[ ] Hypertension [ ] Ovarian Cysts [ ] Endometriosis [ ] Intestinal Issues [ ] Heart Disease

[ ] Other _____

Allergies:

Please list any drug allergies: _____

GYN History:

Last Pap Smear (mm/yyyy): _____

Result of last pap: [ ] Normal [ ] Abnormal [ ] No pap ever done

Last Mammogram Date (mm/yyyy): _____

Result of last Mammogram: [ ] Normal [ ] Abnormal [ ] No mammo ever done

Last Dexa (Bone Density) scan (mm/yyyy): _____

Result of last Dexa scan: [ ] Normal [ ] Osteopenia[ ] Osteoporosis

Last colonoscopy (mm/yyyy):_____

Menstruation: (If you are menopausal, skip to Menopause section)

Age of Onset: At what age did your periods start? _____

LMP: Date of last menstrual period (mm/dd/yy): _____

(If menopausal, skip to Menopause section now)

Time Between Periods: [ ] Irregular [ ] 21- 32 Days apart

[ ] > 45 Days apart [ ] < 21 days apart

[ ] 33 – 44 Days

Duration: How long does your period last? [ ] < 7 days [ ] 2 - 7 days [ ] 3 days

Pad / Tampon Use Per Day: [ ] 1-3 [ ] 4-6 [ ] 7+

Associated Signs/ Symptoms: How would you describe your period:

[ ] with severe pain [ ] with moderate pain

[ ] with mild discomfort [ ] without discomfort/ pain

[ ] heavy [ ] light

Menstruation Symptoms:

Premenstrual Syndrome: [ ] Yes [ ] No

If yes, please mark any symptoms you are experiencing:

[ ] Withdrawal [ ] Weight gain [ ] Tension [ ] Pelvic pain

[ ] Mood swings [ ] Tiredness [ ] Headaches [ ] Depression

[ ] Bowel changes [ ] Bloating [ ] Anxiety [ ] Changes in desire

[ ] Breast swelling/discomfort

Menopause: [ ] Yes [ ] No

If yes, began at age: _____

Current menopausal symptoms:

[ ] None [ ] Headache

[ ] Hot flashes [ ] Irritability

[ ] Memory Loss [ ] Loss of Sexual Desire

[ ] Weight Gain [ ] Vaginal dryness

Self Breast Exam: [ ] Monthly [ ] Do not perform [ ] Sometimes

Birth Control:

[ ] Condoms

[ ] Oral contraceptive pills Indicate which pill: _____

[ ] Mirena IUD [ ] Paraguard IUD

[ ] Skyla IUD [ ] Diaphragm

[ ] Nuvaring [ ] Bilateral Tubal Ligation

[ ] Vasectomy [ ] None

[ ] Depo-Provera [ ] Ortho Evra Patch

[ ] Spermicide [ ] Nexplanon

Family History

Please check all that apply for the corresponding family member. Under status, please indicate "alive", "deceased", or "unknown". Please put an "X" in the appropriate boxes below.

	Status	Year of Birth	Age	Blood Clotting Disorder	Bleeding Disorder	Breast Cancer	Ovarian Cancer	Colon Cancer
Mother								
Father								
Sister #1								
Sister #2								
Brother #1								
Brother #2								
Son #1								
Son #2								
Daughter #1								
Daughter #2								
Maternal Grandmother								
Maternal Grandfather								
Paternal Grandmother								
Paternal Grandfather								

Social History:

Smoking:

Current smoking status: [ ] Current smoker [ ] Current every day smoker

[ ] Current some day smoker [ ] Smoker [ ] Former smoker

[ ] Current status unknown [ ] Nonsmoker [ ] Unknown if ever smoked

How many cigarettes a day do you smoke?

[ ] 5 or less [ ] 6-10 [ ] 11-20 [ ] 21-30 [ ] 31 or more

Are you interested in quitting?

[ ] Ready to quit [ ] Thinking about quitting [ ] Not ready to quit

Alcohol:

Did you have a drink containing alcohol in the past year?: [ ] Yes [ ] No

How often did you have a drink containing alcohol in the past year?

[ ] Never [ ] Monthly or less [ ] 2-4 times a month [ ] 2-3 times a week

[ ] 4 or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

[ ] 1-2 drinks [ ] 3-4 drinks [ ] 5-6 drinks [ ] 7-9 drinks [ ] 10 or more drinks

How often did you have 6 or more drinks on one occasion in the past year?

[ ] Never [ ] Less than monthly [ ] Monthly [ ] Weekly [ ] Daily or almost daily

Drugs:

Have you used drugs other than those for medical reasons in the past year? [ ] Y [ ] N

Caffeine Intake: [ ] None [ ] 1-2 cups per day [ ] 2-3 cups per day

[ ] 3-4 cups per day [ ] More than 4 cups per day

Exercise Frequency: [ ] Never [ ] Occasionally [ ] 1-2 times per week

[ ] 2-3 times per week [ ] 3-4 times per week [ ] 4-7 times per week

Any history of domestic violence?

[ ] None [ ] History in the past [ ] Has restraining order

[ ] Feel unsafe at home [ ] Have a safety plan

Any history of verbal abuse?

[ ] None [ ] Occasional [ ] Frequent

[ ] Seeking counseling [ ] Has safety plan

Has your current partner ever threatened you or made you feel afraid?

[ ] Yes [ ] No

Does your current partner or someone important to you hurt you physically or emotionally? [ ] Yes [ ] No

CANCER HISTORY FORM

Name: _____ **Date:** _____

Date of Birth: _____

I HAVE HAD CANCER GENETIC TESTING:

☐ **YES** WHEN? _____ RESULTS: ☐ Negative ☐ Positive, Gene: _____

☐ **NO** → ***PLEASE COMPLETE FORM BELOW***

If you have either of the following insurances, please indicate by checking the corresponding box:
☐ Amerigroup (Medicaid) ☐ Medicare (Do you have a secondary insurance? Y/N)

Please provide information about the cancer in yourself and/or family in the table below. Specify who had what kind of cancer, and estimate the age of diagnosis. Include information on yourself and the following relatives on both sides of your family:

Parents, Siblings, Children, Grandparents, Aunts, Uncles, Nieces, Nephews, Cousins

		CANCER HISTORY	You	Siblings/ Children	Mother's Side	Father's Side	Age of Diagnosis
No	Yes	Breast Cancer **UNDER AGE 50**					
No	Yes	Ovarian Cancer at ANY age					
No	Yes	Ashkenazi Jewish with one Breast, Ovarian, or Pancreatic Cancer at ANY age					
No	Yes	**3 OR MORE** Breast, Prostate, or Pancreatic Cancers (same family side at ANY age)					
No	Yes	Male Breast Cancer at ANY age					
No	Yes	Colon or Endometrial/Uterine Cancer diagnosed **under age 50**					
No	Yes	**3 OR MORE** Colon, Endometrial/Uterine, Gastric, Pancreatic Cancers (same family side at ANY age)					
No	Yes	Have **YOU** been diagnosed with endometrial/uterine cancer?					

Have any of your family members had genetic testing? _____

Patient Signature _____

OFFICE USE ONLY
Patient offered genetic testing: Yes / No Accepted / Declined / Informed Provider Initials: _____

As we comply with government requirements in an effort to protect your identity, you will be required to show your picture id and insurance card at each visit.

Thank you for your cooperation.