

Today's Date: _____



Patient Information:

Patient Name: _____ DOB: _____ Age: _____

Mailing Address: _____ City: _____

State: _____ Zip Code: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____

Which number is best to contact you? (Circle preference): Home Cell

Last 4 digits of SS # _____

Can we leave messages regarding your care on this phone? (Circle One): Yes No

Social Security Number: _____ Marital Status: _____

Employer: _____ Occupation: _____

Employment Status: (Circle One)

Full Time Part Time Retired Self Active Duty Not Employed Student

Students: Full Time _____ Part Time _____ Name of School: _____

Emergency Contact (Someone Not Living With you):

Name: _____ Phone Number: _____

Relationship to patient: _____

How did you hear about us? (Circle One)

Internet Ins Co. Phone Book Advertisement Friend Other

Spouse/Significant Other/Parent Information:

Name: _____ DOB: _____ SSN: _____

Mailing Address: _____ City: _____

State: _____ Zip Code: _____ Apt#: _____

Home Phone: _____ Cell Phone: _____

Work #: _____ Employer Name: _____

Patient Name: _____



Primary Insurance Information:

Name of Insurance: _____ (Circle One): HMO PPO

If HMO name of Medical Group: _____ Insurance Phone #: _____

Name of Insured: _____ DOB: _____ SSN: _____

Relationship to patient: (Circle One) Self Spouse Child Other

Member Id#: _____ Group#: _____ Plan#: _____

Secondary Insurance Information:

Name of Insurance: _____ (Circle One): HMO PPO

If HMO name of Medical Group: _____ Insurance Phone #: _____

Name of Insured: _____ DOB: _____ SSN: _____

Relationship to patient: (Circle One) Self Spouse Child Other

Member Id#: _____ Group#: _____ Plan#: _____

I authorize treatment for the person named on this information form. I authorize all insurance benefits to be paid directly to Platinum Women's Health and Wellness. I further expressly agree to acknowledge that my signature on this document authorized by my physician to submit claims for services rendered without obtaining my signature on each and every claim submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

Note: If you do not have insurance coverage, full payment is expected at the time of your visit.

I accept financial responsibility for any medical fees incurred at Platinum Women's Health and Wellness. I further agree to pay all finance charges, collection cost, attorney fees and any other cost that may be incurred to enforce collection of any amount outstanding. I also authorize the release of any information required by an insurance company to process a claim.

Signature: _____ Date: _____

Today's Date: _____

Medical Information:

Patient Name: _____ DOB: _____

Reason for visit: _____

Name of primary care physician: _____

Preferred Pharmacy Information:

Name: _____ Ph#: _____

Location: _____

Allergies: _____ Reaction: _____

Last menstrual period: _____ Last Pap: _____ Normal: _____

Marital Status: _____

Sexual History:

Are you sexually active? (Circle One) Yes or No

How many sex partners in the last 6 months _____ Last year _____ Last 2 years _____
Life time _____

Do you have or have you ever had: (Please circle any that apply)

Genital Warts Herpes Chlamydia Gonorrhea Trichomonas Syphilis

Current birth control method used: _____

Last Mammogram: _____ Normal: _____

Last Colonoscopy: _____ Normal: _____

Last DEXA scan: _____ Normal: _____

Menstruation History:

Age of 1st menses: _____ Days between cycles: _____ Days you bleed: _____

Flow: (circle) Light Moderate Heavy

How many tampons/pads/day/hour?: _____

Cramping/clotting/pain: (Circle One) Yes or No

Patient Name: _____



Obstetrical History:

How Many pregnancies have you had?: _____

How Many Births?: _____ How Many Living Children?: _____

How Many Full Term Births?: _____ How Many Preterm Births?: _____

How Many Miscarriages?: _____ How Many Abortions?: _____

List All Deliveries:

Mo/Yr	Week @ birth	Vaginal Y/N	Weight	Gender	Complications

Comments: _____

Menopausal History:

Age of onset: _____ Are you experiencing any menopausal symptoms?: _____

Are you currently on hormone replacement therapy?: _____ Type: _____

List any medical treatments you are currently being treated for: ie: asthma, hypertension, high cholesterol...

List any current medications you are taking, including supplements/vitamins:

INCLUDE STRENGTH AND TIMES TAKEN DAILY

Surgical History:

Date: _____ Type: _____
List any past surgeries: _____

Social History:

Do you smoke? _____ Have you ever smoked? _____ When did you quit? _____

How many years smoker? _____ Type? _____ How many per day? _____

Patient Name: _____

Do you drink alcohol? _____ (Circle) Wine Beer Hard alcohol How much? _____

How much caffeine per day? _____

Do you exercise? _____ What type of exercise? _____ How often? _____

Have you ever been sexually abused, threatened, or hurt by anyone? _____

Occupation: _____

Medical/Family History:

Were you adopted? (Circle One): Yes or No

Please check any of the following medical conditions you, parents, grandparents or siblings have:

Disorder	Self	Father	Mother	Grandparent	Sister	Brother
Alcohol						
Anesthesia complications						
Asthma						
Autoimmune Disorder						
Breast Problems						
Cancer: Type						
Depression						
Diabetes						
Heart Disease						
Hepatitis/Liver Disorder						
Hx of Abnormal Pap						
Hx of Blood Transfusion						
Hypertension						
Infertility						
Kidney Disease						
Latex Allergies						
Lung Disease/Disorders						
Neurological Disorder						
Possible Exposure to TB						
Psychiatric Disorder						
Recreational Drugs						
Rh Sensitized						
Seasonal Allergies						
Seizure Disorder						
Thyroid Dysfunction						
Tobacco						
Trauma/Niolen						
Uterine Abnormalities						
Varicosities/Phlebitis						

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**GENETIC SCREENING/TERATOLOGY COUNSELING
INCLUDES PATIENT AND HER FAMILY FATHER OF
BABY AND HIS FAMILY**

Condition	Yes	No
1. Patients age > 35 years as of estimated date of delivery		
2. Thalassemia (Italian, Greek, Mediterranean or Asian)		
3. Meningomyelocele, Spina Bifida or Anenceph		
4. Congenital heart defect		
5. Down Syndrome		
6. Tay-Sachs (eq. Jewish, Caiun, French Canadian)		
7. Canavan disease		
8. Sickle Cell Disease or trait (African American)		
9. Hemophilia or blood disorders		
10. Muscular dystrophy		
11. Cystic Fibrosis		
12. Huntington's Chorea		
13. Mental retardation/autism		
14. Other inherited genetic or chromosomal disorders		
15. Maternal metabolic disorder (eq. Tvoe I Diabetes, PKU)		
16. Patient or baby's father had a child with other birth defects.		
17. Recurrent pregnancy loss or stillbirth		
18. Medication (including supplements, vitamins, herbs or OTC druqs/illicit/recreational drugs/alcohol since LMP		
19. Exposure to chemicals or radiation (work hazards)		
20.		
21.		
22.		

Financial Policy

Insurance - Your insurance policy is a contract between you and your insurance company. The doctor is not involved in this contract. You are contractually responsible for your co-payment, co-insurance or any balance unpaid at the time of service. We accept Cash, Check, Visa/Mastercard and Care Credit.

No Insurance - Patients who are self-pay are responsible for the entire balance at the time of service .

Regarding Insurance - We may accept assignment of insurance benefits. We will bill your insurance company upon receipt of your current insurance information. If your insurance company has not paid your account in full within 45 days, the balance may automatically be billed to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Non-covered services will be billed to the patient.

Medicare Medical Necessity - Medicare will pay only for services that is determines to be "reasonable and necessary" under the Medicare laws. If Medicare determines that a particular services, although it would otherwise be covered, is not reasonable and necessary, Medicare will deny payment for that service. If Medicare denies payment, you are personally and fully responsible for payment.

FMLA Forms, Disability Forms and Insurance Forms - Forms completion is not a covered benefit under any plan. There will be a charge for the completion of all FMLA, Short-term and Long-term Disability forms. Completion of insurance forms is not a covered benefit; there will be a \$15.00 charge for completion of insurance forms.

No-Show/Late Cancellation - If you must cancel your appointment, you will be required to cancel 24 hours before our a ointment time. "No show" patients and cancellations with less than 24 hours notice will be charged a \$25 .00 fee. If you "no show" 3 appointments you will be dismissed from practice.

Children - The parent seeking medical attention of a child/children is responsible for their co-payment and/or coinsurance at the time of service. The financial arrangement between you and the child/children's parent does not include our practice.

Returned checks - There is a \$30.00 fee if your check is returned unpaid. In addition, any future services will require cash or credit card payments.

Statements - Charges shown on statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing date.

Collections - Should it be necessary to place your unpaid account with a outside collection agency, you must communicate directly with them. Additionally, you will be responsible for all fees of 40% to collect a debt.

Non-covered Services - It is the patient's responsibility to know their insurance coverage benefits and present their care at each visit. We ask that you contact your insurance carrier to review your benefits prior to being seen. Although you may receive a pre-authorization number from your insurance company, this does not guarantee that your insurance company will pay for the services.

Co-payments/Co-Insurantee - Are due at the time of service .

I have read, understand and agree to abide by the financial policy of Platinum Women's Health and Wellness.

Patient or Responsible Party Signature

Date