Today's Date: _____

platinumwomen's HEALTH

Medical Information:

Patient name: _____ DOB:_____

Reason for visit: _____

Name of primary care provider: _____

Preferred Pharmacy Information:

Name: _____ Phone #:_____

Address: _____

Allergies:

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

Medications: Please list any current medications you are taking including supplements or vitamins. Include dosage and frequency.

_____

_____

_____

_____

_____

Last PAP: _____ Normal: YES / NO / N/A

Last mammogram: _____ Normal: YES / NO / N/A

Last colonoscopy: _____ Normal: YES / NO / N/A

Last DEXA scan: _____ Normal: YES / NO / N/A

Surgical/Procedure History (circle those which apply)

	Year		Year		Year
Amputation (list site)		Dental Implants		Hip Replacement Left / Right	
Aneurysm Repair		Esophagogastroduodenoscopy (EGD or stomach scope)		Hysterectomy, Partial	
Angioplasty/Angiogram		Eye Surgery (cataract, glaucoma, other)		Hysterectomy, Total	
Ankle Surgery		Bladder Surgery		Knee Replacement, Complete/ Partial	
Appendectomy		Caesarean Section		Knee Surgery (Meniscal, arthroscopic)	
Back Surgery		Carpal Tunnel Surgery		Lasik Eye Surgery	
Breast Augmentation		Cholecystectomy (gallbladder)		Neck Surgery	
Breast Lumpectomy/Mastectomy		Endometrial (Uterine) Biopsy		Weight Loss Surgery (sleeve, band, bypass)	
CABG (Open heart bypass)		Spinal Injection (i.e., pain shot)		**Other:**	
Colonoscopy		Hernia Repair			
Coronary Stent Placed		Vasectomy / Tubal Ligation			

Past Medical/ Family History:

Were you adopted? YES or NO

Please check any of the following medical conditions you or a family member may have:

DISORDER	SELF	FATHER	MOTHER	SISTER	BROTHER	PATERNAL GRANDPARENT	MATERNAL GRANDPARENT
ALCOHOL OR DRUG ABUSE							
ASTHMA							
BLEEDING DISORDER							
AUTOIMMUNE DISORDER							
CANCER TYPE:							
DEPRESSION OR ANXIETY							
DIABETES							
STROKE							
HEART DISEASE							
LIVER DISEASE							
HIGH BLOOD PRESSURE							
HIGH CHOLESTEROL							
HEADACHE/ MIGRAINE							
KIDNEY DISEASE							
LUNG DISEASE							
NEUROLOGICAL DISORDER							
SEIZURE DISORDER							
THYROID							

Additional past medical history (patient only): _____

_____

Social History:

Smoking Status (Tobacco)	Never	Former	Current	**Cigarettes Vape Pen Dip /Chew**
Smoking – How many tobacco cigarettes per day?	1 PPD (20)	1/2 PPD (10)	1/4 PPD (5)	*There are 20 cigarettes in 1 Pack *PPD = Packs per day
What age did you start?	**What age did you stop?**			
Alcohol intake	None	Occasional	Moderate (<2 daily)	Heavy (more than 2 drinks daily) # per week ____

Marijuana or CBD Use? (Smoke, edibles, etc.?)	Yes	No	**History of Drug Abuse/Addiction?** Yes No Please explain:
Illicit drugs (Cocaine, amphetamine, heroin, etc.)	Yes	No	
Chewing tobacco	Yes	No	
Caffeine intake (Coffee, Soda, Energy Drinks)	None	Occasional	Moderate (daily)

Sexual History:

Are you sexually active? YES or NO

Number of partners: _____ (circle) Male / Female / Both

History of STIs: (circle) Gonorrhea Chlamydia Herpes Syphilis Hepatitis HIV

Current birth control method used: _____

Menstruation History:

Last menstrual period: _____ Age of 1st menses: _____ Frequency: _____

Duration: _____ Pain/Cramping? _____ Flow: (circle) Light Moderate Heavy

Obstetrical History:

How many pregnancies have you had? _____ Age of 1st Pregnancy? _____

How many births? _____ How many living children? _____

How many full-term births? (37 weeks or beyond) _____

How many preterm births? _____

How many miscarriages? _____ How many abortions? _____

Ectopic? _____

List All Deliveries:

Date	Weeks @ birth	Vaginal Y/N	Weight	Gender	Complications

Menopausal History:

Age of onset: _____

Are you experiencing any menopausal symptoms? _____

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

Financial Policy

Insurance – Your insruance 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.

Medicare Medical Necessity – Medicare will pay only for services that are determined to be "reasonable and necessary" under the Medicare laws. If Medicare determines that a particular service is not reasonable and necessary, Medicare will deny payment for that service. If Medicare denies payment, you are personally and fully responible for payment.

FMLA Forms, Disability Forms and Insurance Forms – Form completion is not a covered benefit under any plan. There will be a *$20.00* charge per form for the completion of all FMLA, Short-term, Long-term disability, and insurance forms.

Children – The parent seeking medical attention of a child/children is responsible for their copayment and/or coinsurance at the time of service. The financial arrangement between the parent and the child/children does not include our practice.

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 guarentee that your insurance company will pay for the services.

Copayments/ Coinsurances – 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

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act — 45 CFR Parts 160 and 164)

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI") described below to my agent identified in my durable power of attorney for health care named _____.

2. Authorization for release of PHI covering the period of health care (check one)
   a. ☐ from (date) _____ - to (date) _____ OR
   b ☐ all past, present and future periods.

3. I hereby authorize the release of PHI as follows (check one):
   a. ☐ my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR
   b. ☐ my complete health record *with the exception of the following information* (check as appropriate):
      ☐ Mental health records
      ☐ Communicable diseases (including HIV and AIDS)
      ☐ Alcohol/drug abuse treatment
      ☐ Other (please specify): _____

4. In addition to the authorization for release of my PHI described in paragraphs 3 a and 3 b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

   Name _____ Relationship _____

   Name _____ Relationship _____

   Name _____ Relationship _____

5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This authorization shall be in force and effect until nine (9) months after my death or _____, (date or event) at which time this authorization expires.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date: _____

Signature of Patient

Keep original, and give copies to your health care provider, agent and family members

Patient Name: _____

DOB: _____

Today's Date: _____

Genetic Screening/ Teratology Counseling
Includes Patient, Maternal, and Paternal Family History

Condition	Yes	No
1. Patients age greater than 35 years as of estimated date of delivery		
2. Thalassemia		
3. Meningomyelocele, Spina Bifida		
4. Anencephaly		
5. Congenital heart defect		
6. Down Syndrome		
7. Tay- Sachs		
8. Canavan Disease		
9. Sickle Cell Disease or Trait		
10. Hemophilia or other blood disorders		
11. Muscular Dystrophy		
12. Cystic Fibrosis		
13. Huntington Chorea		
14. Autism		
15. Patient metabolic disorders (eq. Type 1 Diabetes, PKU)		
16. Recurrent pregnancy loss or stillbirth		
17. Exposure to chemicals or radiation (work hazards)		
18. Other inherited genetic or chromosomal disorders		
19. Patient or baby's father had a child with other birth defects		
20. Medication use/ changes since LMP (including supplements, vitamins, herbs or OTC/ illicit/ recreational drugs)		
21. Alcohol use since LMP		

platinumwomen's HEALTH

Zero Tolerance Policy

At **Platinum Women's Health,** we are committed to providing the highest quality of care and a safe, respectful environment for all patients and staff. To ensure this, we have implemented a **Zero Tolerance Policy** for certain behaviors. This policy applies to all individuals, including patients, their family members, and visitors.

Policy Overview:

Zero Tolerance for the following behaviors include but are not limited to:

- **Verbal Abuse**: Threatening or abusive language, including yelling, swearing, or making inappropriate comments toward any staff member or other patients.
- **Physical Abuse**: Any form of violence, including hitting, pushing, or threatening physical harm.
- **Harassment**: Unwelcome or inappropriate behavior, including sexual harassment, racial comments, or discriminatory actions.
- **Intimidation**: Attempts to intimidate, bully, or coerce any staff member or patient.
- **Disruptive Behavior**: Actions that disturb the normal operation of the office, including loud outbursts, threats, or refusal to follow reasonable instructions.
- **Substance Abuse**: Being under the influence of alcohol or illegal drugs during appointments.

Consequences:

- Any patient or visitor who engages in any form of verbal or physical abuse, harassment, or disruptive behavior will immediately be asked to leave the premises.
- **Repeated violations** of the Zero Tolerance Policy may result in the patient being **discharged** from the practice and refusing future services.
- If a patient's behavior is threatening or violent, **law enforcement** may be contacted, and criminal charges may be pursued.

Acknowledgement:

- By signing below, I acknowledge that I have read and understand the Zero Tolerance Policy. I understand that failure to adhere to these guidelines may result in termination of care and potential legal consequences. I agree to treat all staff members, other patients, and visitors with respect and kindness.

Patient Name: _____

Patient Date of Birth: _____

Signature: _____

Date: _____