ADVANCED PELVIC SURGERY, LLC 7162 LIBERTY CENTRE DR., STE B, WEST CHESTER, OHIO 45069 (513) 942-7640

ESTABLISHED ANNUAL GYN EXAM **DATE OF VISIT**_____

NAME _____ DOB _____ AGE _____

Referring Doctor _____ Primary Doctor _____

What is the main reason for your visit? _____

_____

Please list all bladder, bowel, GYN or general surgeries _____

_____

Last urinary tract infection? _____ How often do you move bowels? _____

Do you have trouble moving bowels? YES NO If so what is the trouble? _____

_____

How many pregnancies? _____ How many vaginal deliveries? _____ C-Sections? _____

How many children? _____ Any difficulties with labor/delivery? _____

_____

PREVENTIVE HEALTH MAINTENANCE:

When was last PAP _____ Normal or Abnormal (Circle one) If not what was treatment?

_____

When was last Mammogram _____ Normal or Abnormal (Circle one) If not what was

Treatment? _____

When was last Dexa Scan _____ Normal or Abnormal (Circle one) If not what was

Treatment _____

When was last Colonoscopy _____ Normal or Abnormal (Circle One) If not what was

Treatment? _____

PHARMACY: _____ Address _____

City _____State _____ Zip _____ Phone _____

MEDICATIONS

Medication Dose

1._____

2._____

3._____

4._____

5._____

ALLERGIES TO MEDICATIONS:

If yes list medication and reaction? _____

MENSTRUAL HISTORY:

When was your last menstrual period? _____ Number of days ____

Are your periods: REGULAR or IRREGULAR (Circle One) How many days are between cycle? _____

Are your periods: LIGHT MODERATE HEAVY CLOTS (circle one) Do you spot in between? _____

Describe cramps: NONE MILD MODERATE SEVERE (circle one)

Are you sexually active? YES or NO? Are you on Birth control? YES or NO? Type:_____

POST MENOPAUSAL:

Do you have symptoms? YES or NO? What do you take? _____

Are you Sexually Active? YES or NO? Do you have any issues? _____

Vaginal dryness____ Night sweats ____ Painful intercourse____

SOCIAL HISTORY:

Do you drink alcohol? Rarely Occasionally Daily Never (circle one)

Have you ever smoked? YES or NO How long? _____ Current smoker? YES or NO Packs/day _____

Do you use ILLICIT Substances? YES or NO What type? _____

Marital Status: _____

Do you Exercise? REGULARLY DAILY OCCASIONALLY NEVER (Circle one)

Signature: _____ Date:_____

PATIENT REGISTRATION

PATIENT INFORMATION:

NAME:_____

SS#:_____ BIRTHDATE:_____

SEX: M F MARTIAL STATUS:_____ DRIVERS LICENSE#_____

ADDRESS:_____

CITY, STATE, & ZIP;_____

HOME PHONE: _____CELL PHONE:_____

EMPLOYER:_____

EMERGENCY CONTACT PERSON:_____

RELATIONSHIP:_____PHONE:_____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

NAME:_____

SS#:_____BIRTHDATE:_____

SEX: M F MARTIAL STATUS: _____DRIVERS LICENSE#: _____

ADDRESS: _____

CITY, STATE, & ZIP:_____

HOME PHONE:_____CELL:_____

EMPLOYER:_____

INSURANCE COVERAGE:

PRIMARY CARRIER:_____

SUBSCRIBER NAME:_____EFT DATE:_____

ID#_____GROUP#_____CO PAY:_____

CLAIMS ADDRESS:_____

I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits either to myself or to the other party who accepts assignment. I authorize payment of medical benefits to the physician for all services rendered. I understand and agree that regardless of my insurance status, I am responsible for the balance of my account for services rendered.

Signature:_____ Date:_____

REVIEW OF SYSTEMS

Have you had any problems related to the following in the past **6 months**?

Circle **Yes** or **No:**

General:

Fever	Y	N
Weight change	Y	N
Tire Easily	Y	N

Eyes:

Change in vision	Y	N
Cataracts	Y	N
Glaucoma	Y	N

Ears, Nose, Throat:

Sores	Y	N
Discharge	Y	N
Pain	Y	N

Respiratory:

Chronic Cough	Y	N
Asthma	Y	N
COPD	Y	N

Cardiovascular:

Shortness of breath	Y	N
Chest Pain	Y	N

Gastrointestinal:

Nausea/vomiting	Y	N
Reflux	Y	N
Diarrhea	Y	N
Bloody Stool	Y	N

Skin/Breast:

Breast Lumps	Y	N
Skin Rash	Y	N

Musculoskeletal:

Weakness	Y	N
Limited range of motion	Y	N
Joint Pain	Y	N

Neurological:

Seizures	Y	N
Burning or shooting pain	Y	N
Numbness	Y	N

Hematological:

Easy bruising	Y	N
Bleeding	Y	N
Swollen Glands	Y	N

Endocrine:

Thyroid problems	Y	N
Diabetes	Y	N

Psychiatric:

Depression	Y	N
Anxiety	Y	N

Please list details associated with any of the above _____

_____

Name:_____Date:_____

ADVANCED PELVIC SURGERY, LLC
R. Gregory Owens, M.D.

7162 Liberty Centre Dr.
West Chester, OH 45069
Phone: 513/942-7640
FAX: 513/755-4736

❖ **CONSENT TO TREATMENT/TESTING**: I hereby consent to the administration of treatment and testing as is considered therapeutically necessary for my condition.

❖ **RELEASE OF RECORDS**: I authorize the release of medical record information (including, but not limited to information concerning drug related conditions, alcoholism, psychiatric conditions, HIV testing, AIDS diagnosis/related conditions) to insurance carriers, third-party payers or to their representatives, review organizations, or surveyors for accreditation, regulatory and/or licensing purposes, as necessary to determine benefits entitlement and to process payment claims for healthcare services provided. This authorization shall be valid only for the period of time necessary to process payment claims.

In consideration of admission and all facility services, the undersigned agrees to the following:

❖ **ASSIGNMENT OF BENEFITS:** I hereby authorize payment directly to Advanced Pelvic Surgery, LLC of all insurance benefits, otherwise payable to me.

❖ **GUARANTEE OF ACCOUNT**: I unconditionally guarantee the payment in full to the facility of the total amount due them for said admission and/or facility services. I understand that I am financially responsible to the facility and/or physician for the charges not covered by the above assignment. I am also responsible for charges even if determined by my employer or insurance company to be unnecessary in their judgement.

❖ **I have read and do understand this form.**

_____ _____

Signature of Responsible Party Date

_____ _____

Relationship to Patient Witness

WAIVER OF FINANCIAL RESPONSIBILITY

ADVANCED PELVIC SURGERY, LLC
R. GREGORY OWENS, M.D. F.A.C.O.G.

PATIENT NAME: _____

PHYSICIAN NAME: R. Gregory Owens, M.D.

DATE OF SERVICE: _____

I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR SERVICES IN THE EVENT THAT MY INSURER DOES NOT COVER EXPENSES. IF YOU HAVE A DEDUCTIBLE AND IT HAS NOT BEEN MET, PAYMENT FOR SURGERY OR PROCEDURES IN THE OFFICE WILL HAVE TO BE PAID BEFORE SERVICES ARE RENDERED. AN INTEREST CHARGE OF 1 ½ % PER MONTH WILL BE ASSESSED FOR ANY OUTSTANDING PATIENT BALANCE AFTER THE FIRST STATEMENT IS SENT.

TO ASSIST YOU WITH YOUR MEDICAL CARE, WE PROVIDE THE FOLLOWING PAYMENT OPTIONS:

1. **CASH – INCLUDES PERSONAL CHECKS**
2. **VISA, MASTERCARD, DISCOVER, DINERS CLUB, JBC, AMEX**
3. **CareCredit – Patient payment plans that allow you to pay over time with convenient low minimum payments. With CareCredit, you enjoy these benefits:**
   - **Flexible Financing options**
   - **No annual fees or prepayment penalties**
   - **Quick and easy application**
   - **Receive a credit decision almost immediately**
   - **Start your recommended treatment immediately**

SIGNATURE: _____

RELATIONSHIP IF OTHER THAN PATIENT: _____

DATE: _____

CONSENT TO DISCUSS

I, _____ give my consent to Advanced Pelvic Surgery

to discuss my medical condition with _____

Family Member or Friend

_____ _____

Patient Signature Date