Offices at Cranbrook ▪ 10111 East 21st Street North ▪ Suite 301 ▪ Wichita, KS 67206

316-634-0060 ▪ 316-634-0050 (fax) ▪ cwhwichita.com

PATIENT INFORMATION

Last Name:	**First Name:**		
Address:	City:	State:	Zip Code:
Phone Number:	Marital Status:	Social Security Number:	
Primary Care Provider:	DOB:	Preferred Name:	
Email Address:		Significant Other's Name:	
Place of employment:			
Please circle: Female Male Non-Binary		Primary Language:	
Preferred Pharmacy:			

INSURANCE INFORMATION:

Primary Carrier:	Policy Holder's Name/D.O.B.: ☐ Self
Member ID:	Group Number:
Medical Claims PO Box:	

CONSENT TO TREATMENT:

I hereby grant consent for treatment or services to be provided by the providers of Center for Women's Health. I also certify that no guarantee or assurance has been made regarding the result that may be obtained.

QUEST DIAGNOSTICS:

Center for Women's Health uses Quest Diagnostics as our in-office laboratory vendor. Laboratory services including blood draw, pap smears, cultures or biopsies done in our office will be sent to Quest Diagnostics.

It is your responsibility to know if Quest Diagnostics is your in-network laboratory vendor.

If you do not want your laboratory services to be sent to Quest Diagnostics, please write your preferred laboratory vendor name below. We may be able to schedule a pick up for this specimen, otherwise you will need to take the lab order to your designated laboratory vendor.

Preferred Laboratory Vendor:

By signing this form, you acknowledge that you have consented to treatment as stated above as well as to using Quest Diagnostics as your laboratory vendor, unless you listed an alternative vendor.

Patient Signature:	**Date:**
☐ Updated. Signature:	Date:
☐ Updated. Signature:	Date:
☐ Updated. Signature:	Date:
☐ Updated. Signature:	Date:

Offices at Cranbrook ▪ 10111 East 21st Street North ▪ Suite 301 ▪ Wichita, KS 67206

316-634-0060 ▪ 316-634-0050 (fax) ▪ cwhwichita.com

FINANCIAL POLICY

In the interest of good health care practice, it is desirable to establish a policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health, and we wish to spend our time and energy toward that end.

AGREEMENT:

- The patient is responsible for payment of all medical treatment and other related services covered by the treating provider at Center for Women's Health.
- As a service and out of consideration to our patients, this office will file insurance claims for all covered services. We will file up to two insurance companies. If you have additional coverage, you must file those yourself. We will not do 3rd party billing. This preparation is not a guarantee that we have a contractual relationship with your insurance plan, nor can we guarantee that your specific insurance policy covers the services that we have provided. It is a courtesy of CWH to provide an estimate of charges for procedures, surgeries, etc. but it is the patient responsibility to deal with insurance company.
- Self pay patients are responsible for all medical treatment and other related services covered by the treating provider at Center for Women's Health. While CWH will try to estimate services in advance, the patient agrees in advance to pay for all services, tests and fees the providers feel are necessary for the patient's care.
- We do not have a way to access the terms and conditions of your insurance policy and therefore are unable to speak on your behalf to your insurance company about contract disputes that you might have. If you believe that your insurance company has not paid your medical costs correctly, you should contact your company directly to negotiate a solution.
- This office will accept your insurance company's maximum allowable reimbursement. The patient will be responsible for any deductible, co-insurance and co-payment amount. The patient is 100% responsible for payment of any non-covered services at the time of service.
- Patient is responsible for all charges during their care; including laboratory charges, sonograms, and referrals to outside clinics for advanced testing and screening if necessary.
- Patients with insurance, which require a referral, must have a referral prior to receiving treatment. It is the patient responsibility to obtain all necessary referrals from the primary care physicians. Patients without proper referrals and electing to receive service from the office will be required to make full payments in advance of the time of service.
- Patients normally receive a statement from our clinic after the insurance company has processed the claims. This will include all charges that the insurance company has not paid. **Payment is due upon receipt.**
- **An 18% APR will accrue on balances not paid within the specified billing cycle, with a $10 minimum charge. Rates are subject to change without notice.**
- An account is considered past due if not paid by due date listed on billing statement, unless prior arrangements have been made with our billing office. If no attempts at payment have been made, the account may be referred to a collection agency.
- Patients may be discharged from care due to nonpayment of account.
- Patients who reserve an appointment with a provider and fail to keep that appointment will be subject to a $50 no-show fee; $100 no show fee for a scheduled procedure. To avoid this charge, patients must cancel appointments 24 hours prior to their reserved time. Fees are subject to change without notice.
- We accept cash, check, Visa, MasterCard, Discover, and debit cards. There is a $50 returned check fee.
- CWH may send you a refund check for services rendered; if this check is lost, stolen, or not received there is a $35 stop payment fee to reissue the check. We will not reissue checks for services later than one year.
- A copy of this form is available upon request.

INSURANCE RELEASE:

I authorize payment of medical benefits to the treating provider at Center for Women's Health to release any information requested by my insurance carrier.

I have read and understood the above agreement and by my signature here below, agree to the terms.

Patient Signature	Patient Printed Name	Date of Birth
Responsible Party Signature	Responsible Party Printed Name	
Relationship to Patient	Date	

Medical Information Release Form

(HIPAA Release Form)

Name:______________________________________**Date of Birth:**______/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse____

[ ] Child(ren)____

[ ] Other____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:____________________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] ____

The best time to reach me is (day)______________________between (*time*)___________

Signed: ____ Date: ____/____/_____

Center For Women's Health

Offices at Cranbrook ▪ 10111 East 21st Street North ▪ Suite 301 ▪ Wichita, KS 67206
316-634-0060 ▪ 316-634-0050 (fax) ▪ cwhwichita.com

NAME: **DATE:**
DOB:

WELCOME:

Your accurate completion of this health history is greatly appreciated. This will allow us to more accurately address your health problems and make recommendations. This information enables us to spend more quality time evaluating your present concerns and less time on the collection process of your previous health history. Please let us know if you have any questions and thank you for your assistance.

Reason for today's visit? ______________________________

Would you like to be tested for sexually transmitted infections? *Y/N*

Age: ______________ Last Menstrual Period: _____/_____/_____

OBSTETRIC HISTORY:

Total Pregnancies: ______ Total Miscarriages: ______ Total Abortions: ______

Ectopic Pregnancy: ______ Children Living: ______

DATE	SEX	WEIGHT	TYPE OF DELIVERY	COMPLICATIONS

GYNECOLOGY HISTORY:

1. How old were you when your periods began? ______
2. Are your periods regular: *Y/N* How many days in a cycle? ______
3. How heavy is your bleeding? ______________ How many days of bleeding? ______
4. Do you have cramping? *mild / moderate / severe*
5. Are you sexually active? *Y/N* (if yes) Do you have pain with intercourse: *Y/N*
6. Age at first intercourse: ______ Total number of sexual partners: ______
7. Do you have a history of venereal disease such as gonorrhea, chlamydia, herpes, HPV, genital warts, or syphilis?
   ____
8. History of infection in the uterus and/or fallopian tubes? ______________________________
9. History of sexual abuse: __________ Or physical abuse: __________
10. Date of last Pap smear: ______________________
11. Have you ever had an abnormal Pap smear? ____________ When? __________
12. What is your birth Control Method: (please circle) none, condoms, spermicidal, foam, Depo-Provera, IUD(Mirena), IUD(Paraguard), IUD (Liletta/ Skyla), Nexplanon, birth control pills, birth control patch, birth control ring, tubal ligation, vasectomy. Natural Family Planning Are you satisfied with this method? *Y/N*
13. Do you have a history of breast disease? ______________________________
14. Do you perform monthly self breast exams? *Y/N*

PERSONAL MEDICAL HISTORY **Patient Name:________________ Date of Birth:________**

Please list any allergies to medications: ____

____

Please list any current medications /dosage you are taking (please include supplements and over the counter medications):

____

____

____

Have you ever had any unusual childhood illnesses such as rheumatic fever or seizures? ____________________

____

Who is your primary care physician? ____

PAST MEDICAL HISTORY:

Have you had any past history of medical problems in the following areas? If so, please describe:

1. Eye or visual problems: ____
2. Ear, nose or throat problems: ____
3. Thyroid disorder or diabetes: ____
4. Lung disease (such as pneumonia, bronchitis, asthma): ________________________________
5. Heart problems or high blood pressure: ____
6. Liver or gallbladder disease (such as hepatitis, jaundice, or gallstones): ____________________
7. Stomach disorders (such as ulcers, gastritis, hiatal hernia): ____________________________
8. Intestinal disorders (such as irritable bowel syndrome, colitis, polyps): ____________________
9. Urinary tract infections or kidney stones: ____
10. Anemia or blood clotting disorder: ____
11. History of DVT or other blood clot:____
12. Ever prescribed blood thinning medications: ____
13. Bone or joint disease (such as arthritis or osteoporosis): ________________________________
14. Neurological problems: ____
15. History of migraines; with or without Aura:____
16. Mental disorders (such as depression, anxiety attacks, eating disorders, nervous breakdown): ____________

SURGICAL HISTORY: Please list all surgery you have had and approximate dates:

1. ____ Date: ______________
2. ____ Date: ______________
3. ____ Date: ______________
4. ____ Date: ______________

TRAUMA HISTORY: Please list any broken bones, concussions, or injuries you may have had in the past:

1. ____
2. ____

HOSPITALIZATIONS:

1. ____
2. ____

Patient Name:______________________________ **Date of Birth:**____________________

FAMILY HISTORY: Please list any family members with the following illnesses (parents, grandparents, aunts, or uncles):

1. Heart disease: ____
2. High Blood Pressure: ____________________________________
3. Diabetes: ____
4. Clotting Disorder: ______________________________________
5. Cancer (please list type of cancer): ____________________________
6. Endometriosis: ____

SOCIAL HISTORY:

Cigarette smoking: ***Y / N*** Amount: _____ per day For how long? _______________

If no, have you ever smoked: ***Y / N*** Amount: _____ per day For how long? __________

Do you drink alcohol: ***Y / N*** Amount: ____________________

History of drug use: ***Y / N*** If yes, which drug? ________________________________

Occupation or type of employment: ____

Do you exercise regularly? ***Y / N***

Language you speak: _________________ Your race: ____________ Your ethnicity: ___________

HEALTH/ RISK BEHAVIOR:

Do you wear sunscreen? ***Always / Usually /Sometimes / Never***

Are you exposed to occupational or recreational hazards? ***Y / N***

Do you wear your seatbelt while riding or driving in a car? ***Always / Usually /Sometimes / Never***

TESTING:

Date of last pap smear: ___________ Normal: ***Y / N*** if no, results _______________

Date of last Mammogram: ___________ Normal: ***Y / N*** if no, results _______________

Date of bone density: _____________ Normal: ***Y / N*** if no, results _______________

Have you had any blood work, labs or x-rays in the past year? ***Y / N*** If so, please list: ____________________

____

For those over 45, when did you have your last sigmoidoscopy / colonoscopy: ____________________

IMMUNIZATIONS:

When was your last Tetanus vaccine? __________

Have you had the HPV vaccine? ***Y / N*** Hepatitis B vaccine? ***Y / N***

ADDITIONAL QUESTIONS OR COMMENTS:

____

____

____

____

Patient Name:______________________________ **Date of Birth:**____________________

REVIEW OF SYSTEMS: Check only those symptoms you experienced in the past 6 months.

General
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fever / Chills
- ☐ Fatigue / Weakness

Skin
- ☐ Nail Changes
- ☐ Hair Changes
- ☐ Mole Changes
- ☐ Skin Rashes
- ☐ Itchy Skin

Eyes
- ☐ Blurred / Double Vision
- ☐ Glaucoma / Cataracts
- ☐ Dry or itchy eyes
- ☐ Eye glasses or contacts

Ears
- ☐ Hard of Hearing
- ☐ Hearing changes / Deafness
- ☐ Ringing in ears
- ☐ Ear Discharge
- ☐ Earache
- ☐ Dizziness

Nose
- ☐ Sinus Congestion
- ☐ Runny Nose
- ☐ Post Nasal Drip

Mouth
- ☐ Bleeding Gums
- ☐ Oral sores/ulcers
- ☐ Dental Problems
- ☐ Loss of Taste

Throat
- ☐ Difficulty swallowing
- ☐ Throat pain
- ☐ Hoarseness

Neck
- ☐ Stiffness
- ☐ Soreness
- ☐ Pain
- ☐ Masses

Breast
- ☐ Nipple Discharge
- ☐ Lumps/ Nodules
- ☐ Pain/ Tenderness
- ☐ Breast Masses
- ☐ Nipple Bleeding

LUNGS
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing

HEART
- ☐ Murmur
- ☐ Irregular Heartbeat
- ☐ Palpitations
- ☐ Chest pain

GASTROINTESTINAL
- ☐ Change in appetite
- ☐ Difficulty swallowing
- ☐ Abdominal Pain
- ☐ Nausea / Vomiting
- ☐ Bloating/Gas
- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Rectal Bleeding

☐ **Genitourinary**
- ☐ Urgency
- ☐ Incontinence
- ☐ Urinary frequency
- ☐ Pain with urination
- ☐ Bloody urine
- ☐ Urination at night

Blood
- ☐ Anemia
- ☐ Prolonged Bleeding
- ☐ Swollen Lymph Nodes
- ☐ Painful Lymph Nodes

Gynecologic
- ☐ Break through Bleeding
- ☐ Labial Sores
- ☐ Labial lumps/nodules
- ☐ Vaginal Discharge
- ☐ Vaginal Itching
- ☐ Painful Intercourse
- ☐ Menstrual Cramps
- ☐ Pain between periods
- ☐ Postmenopausal Bleeding
- ☐ Irregular menses
- ☐ Loss of Sexual Desire
- ☐ Night Sweats
- ☐ Vaginal Odor
- ☐ Pelvic Pain
- ☐ Infertility Problems

Musculoskeletal
- ☐ Muscle Pain/ Cramps
- ☐ Weakness
- ☐ Joint Pain/Swelling

Neurological
- ☐ Seizures
- ☐ Vertigo
- ☐ Paralysis
- ☐ Tingling/Numbness

Psychiatric
- ☐ Depression
- ☐ Irritability
- ☐ Anxiousness
- ☐ Alcohol Abuse
- ☐ Suicidal Thoughts
- ☐ Sexual Difficulties
- ☐ Panic Attack
- ☐ Drug Addition
- ☐ Physical Abuse

☐ **Endocrine**
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Loss of Hair
- ☐ Extreme Thirst
- ☐ Excessive Hair Growth
- ☐ Hypoglycemia/Low Blood Sugar

Patient Name:______________________________ **Date of Birth:**____________________

Do you have any concerns that this update did not cover? ____

Thank you for taking the time to provide this information!

Family History Screening Form

Patient Name: ____________________________ Date of Birth: _________ Age: ____ Height: ______ Weight: ______
Your age at First Period: _____ Your age at First Childbirth (if applicable): _______ Are you Menopausal: Yes or No
If yes, your age at Menopause: ____ Have you ever used Hormone Replacement Therapy? Yes or No If yes, for how long? _____
Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? Yes or No

Please indicate if you have a **personal or family history** of any of the following cancers. If yes, then **write family relationship** and **AGE at diagnosis**. **Consider parents, children, brothers, sisters, half- siblings, grandparents, aunts, uncles, nieces, nephews.**

BREAST AND OVARIAN CANCER (HBOC)

			You (age of diagnosis)	Siblings / Children (age of diagnosis)	Mother's Side (age of diagnosis)	Father's Side (age of diagnosis)
(Y)	N	EXAMPLE: *Breast Cancer*	———	———	*Aunt 53*	*Grandmother 45*
Y	N	Breast Cancer				
Y	N	Breast Cancer in both breasts OR multiple primary breast cancers				
Y	N	Ovarian cancer *(Peritoneal/Fallopian Tube)*				
Y	N	Male breast cancer				
Y	N	Are you of Ashkenazi Jewish descent?				

COLON AND UTERINE CANCER (LYNCH)

			You (age of diagnosis)	Siblings / Children (age of diagnosis)	Mother's Side (age of diagnosis)	Father's Side (age of diagnosis)
Y	N	Endometrial (uterine) cancer				
Y	N	Colon/Rectal cancer				
Y	N	Ovarian, stomach, kidney, brain OR small bowel cancer **Please specify relatives, type of cancer & their age at diagnosis.*				
Y	N	10 or more colon polyps in a lifetime *(Specify #)*				

Y	N	Prostate Cancer (HBOC)				
Y	N	Melanoma (HBOC)				
Y	N	Pancreatic Cancer (HBOC/Lynch)				
Y	N	Other Cancers **Please specify relatives, type of cancer & their age at diagnosis.*				

Patient's Signature: ____ Date: ______________

For Office Use Only:
Patient offered hereditary cancer testing? HEALTH CARE PROVIDER SIGNATURE: ____________________
☐ YES ACCEPTED DECLINED
☐ NO

1st degree: self, parents, siblings, children. 2nd degree: grandparents, grandchildren aunts/uncles, nieces/nephews, ½ siblings. 3rd degree: great grandparents, great aunts/uncles, 1st cousins.

HBOC - Personal or Family History

One person with: (out to 2nd degree)
-Breast (diagnosed <50)
-Ovarian, ANY age
-Male breast, ANY age
-Breast with Ashkenazi Jewish heritage, any age
-Bilateral breast at ANY age
-Triple Negative breast (diagnosed ≤60)
-Metastatic Prostate or Pancreatic at ANY Age
-Metastatic Breast at ANY age (personal history only)

Two persons with: (out to 3rd degree)
-Breast cancer (1 diagnosed ≤ 50)
-Breast & Ovarian Cancer, any age

Three Persons with: (out to 3rd degree)
-Breast and/or Pancreatic and/or Prostate, any age

Lynch*- Personal or Family History

One or Two persons with: (out to 2nd degree)
-Endometrial or Colorectal cancer (1 diagnosed ≤50)
-Endometrial or CRC cancer (1 ≤50) & another Lynch* cancer, any age

Three persons with: (out to 2nd degree)
-Lynch* cancers with 1 being Endometrial or Colorectal, any age

*Lynch cancers: endometrial, CRC, ovarian, stomach, brain, pancreas, small bowel, ureter/ renal pelvis, biliary tract, sebaceous adenomas