New Patient Health History

Name: _____ **DOB:** ___/___/___ **Age:** _____

LMP: ___/___/___ **Last Pap:** ___/___/___ **Last Mammo:** ___/___/___

Allergies: Medication Name & Reaction

☐ _____ **Reaction:** _____
☐ _____ **Reaction:** _____
☐ _____ **Reaction:** _____
☐ _____ **Reaction:** _____

Contraception: _____
Blood Transfusion: _____ **Year:** _____

Current Medications:

Please include Name, Strength, Quantity, Frequency

☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

Lifestyle/Habits:

Caffeine - Cups per day: _____
Smoking - Amount per day: _____
☐ Quit: m: _____ y: _____
Alcohol - oz per day: _____
☐ Quit: m: _____ y: _____
Street Drugs/Other:
Type: _____ Since: _____
☐ Quit: m: _____ y: _____
Type: _____ Since: _____
☐ Quit: m: _____ y: _____

Pregnant Patients ONLY:

Baby's Father's Name: _____
Age: _____ Ethnicity: _____

Family Health History:

☐ _____ Relation: **M P**
☐ _____ Relation: **M P**
☐ _____ Relation: **M P**
☐ _____ Relation: **M P**

Marital Status: _____
Occupation: _____

Past Gynecology History:

☐ Abnormal Uterine Bleeding (menstrual irregularities)
☐ Uterine Fibroids
☐ Pelvic Pain (endometriosis, PID, adhesions ect.)
☐ Pelvic Masses (tumors. cysts, ect.)
☐ STD's: (Gonorrhea, chlamydia, herpes, HPV, syphilis, trichomonas, ect.)
☐ Abnormal Pap: **Y N** Year: _____
☐ Abnormal Mammo: **Y N** Year: _____
☐ Infertility
☐ Other: _____

Menstrual History:

Age of first period: _____ Regular | Irregular
Length of period in days: _____
Length between period in days: _____
Post-coital bleeding? **Y N**
Intermenstrual Bleeding: **Y N**

How would you describe your periods?

☐ Heavy ☐ Moderate ☐ Painful ☐ Irregular ☐ Regular

Past Obstetric History:

of Pregnancies: _____
# of Miscarriages: _____
# of Living Children: _____
# of Abortions: _____

Past Surgical History:

☐ Tonsillectomy Year: _____
☐ Tubal Sterilization Year: _____
☐ Gallbladder Removal Year: _____
☐ Apendectomy Year: _____
☐ Hysterectomy Year: _____
☐ Removal of Ovaries Year: _____
☐ Mastectomy Year: _____
☐ Laparoscopy Year: _____
☐ D & C (dilation & curettage) Year: _____
☐ C-section Year: _____
☐ Breast Implant Year: _____
☐ Other: _____

Past Medical History:

☐ No Medical Problems
☐ High Blood Pressure
☐ Diabetes
☐ Coagulation Problems (Clots, bleeding, disorders)
☐ Heart & Vascular Disease Type: _____
☐ Gastrointestinal Problems Type: _____
☐ Kidney Problems Type: _____
☐ Thyroid Disease
☐ Pulmonary Problems Type: _____
☐ Birth Defects or Inherited Disease
☐ Sexual Abuse or Domestic Violence
☐ Autoimmune Disease Type: _____
☐ Cancer Type: _____
☐ Other Type: _____

Patient Insurance & Financial Responsibility

(Please Initial)

_____ I understand that I am expected to pay for services at the time services are rendered. Depending on my insurance plan, this may be payment in full, co payment, deductible amount and/or co-insurance.

_____ If i am a self-pay patient, I understand that payment is expected to be made in full for the services I receive. I understand that there may be other charges for ultrasounds, labs and any other testing. Ultrasounds done in office are to be paid in full at time of service. Any charges from lab testing will be billed to you separately by the laboratory company.

_____ If my insurance is a managed care plan, it is my responsibility to be sure that all necessary referrals or authorizations are obtained prior to my appointment. If NOT obtained, my appointment will be cancelled until to proper documentation is received.

_____ I understand that even though services may be pre-authorized, not all services may be covered or paid by my insurance plan. These services may include but are not limited to: family planning, well woman exams, pregnancy and infertility.

_____ I understand that i am financially responsible for any charges incurred by me. I also understand that a 30% charge will be added to my account balance if Bella Women's Care if forced to send my account to an outside collection agency to collect payment.

Patient Name Printed: _____

Patient/Guardian Signature: _____

Bella Women's Care Practice Information

PHYSICIANS GROUP & COVERAGE

For those who have preferences for a male or female physician, please be advised the physicians of our practice share a call schedule. This means if your physician is NOT on call at the time of your delivery, one of our group physicians may perform your delivery. The same applies for gynecological patients receiving hospital care after office hours.

INSURANCE POLICY & BENEFITS

Bella Women's Care will verify my insurance for my appointment's date of service, but it is my responsibility to understand my insurance plan and it's coverage for: radiology, lab/blood work, family planning and preventative services, and obstetrical coverage. We cannot guarantee that any service provided to you will be covered by your insurance policy. Bella Women's Care will provide you with medical care deemed necessary by your provider.

REFERRALS & PRIOR AUTHORIZATION

Please allow 5-7 days for processing. If you have not heard from our office after 7 days, please contact us so we can further assist you.

FMLA, DISABILITY & MEDICAL RECORD REQUESTS

Please allow 5-10 days for the completion of all forms and medical records. There will be a $20 charge for completion of all forms or record requests. If you have not been seen in over two years, there will be an additional $35 charge to retrieve records.

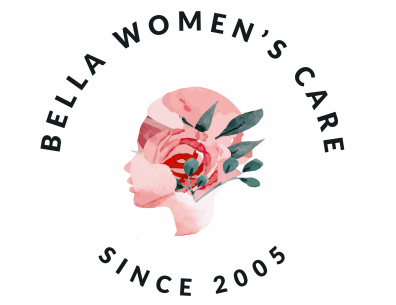
MEDICATIONS, PRESCRIBING & REFILLS

It is my responsibility to provide Bella Women's Care with my pharmacy information to ensure medications are received. I understand that I may be required to see a provider for certain medication requests. Please allow 48-72 hours for refill requests to be processed.

CANCELLATIONS/NO SHOWS

I understand that I may be assessed a fee of $25 for any appointments cancelled within 24 hours or no showed appointments.

Patient Signature:_____ **Date:**_____



IT IS OFFICE POLICY OF BELLA WOMEN'S CARE AND IT'S STAFF NOT TO DISCLOSE ANY CONFIDENTIAL AND/OR UNAUTHORIZED INFORMATION TO INDIVIDUALS OTHER THAN THE PATIENT.

I _____ AUTHORIZE BELLA WOMEN'S CARE AND/OR THEIR STAFF TO LEAVE MEDICAL INFORMATION PERTAINING TO MY CARE BY THE FOLLOWING METHODS OF COMMUNICATION. I ASSUME THE RESPONSIBILITY OF NOTIFYING BELLA WOMEN'S CARE WHEN ANY OF MY INFORMATION CHANGES.

Cell Phone	Yes	No	Leave Voicemail?	Yes	No
Home Phone	Yes	No	Leave Voicemail?	Yes	No
Work Phone	Yes	No	Leave Voicemail?	Yes	No

FAX MEDICAL RECORDS TO PCP OR OTHER MEDICAL PROVIDER? Yes No

NAME OF OFFICE: _____

NAME OF YOUR PROVIDER: _____

FAX NUMBER: _____

I AUTHORIZE MY INFORMATION TO BE RELEASED TO THE FOLLOWING:

_____ RELATION: _____

_____ RELATION: _____

_____ RELATION: _____

_____ RELATION: _____

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or was given the opportunity to receive a copy of Bella Women's Care Note of Privacy Practices. By signing below, I am only acknowledging that I have received or have the opportunity to receive the Notice of our Privacy Practices.

Patient Name (Printed): _____

Patient's DOB: _____

Patient/Guardian Signature: _____

Today's Date: _____