

Medical History Form

Name _____

Date of Birth _____ Age _____

Reason for today's visit _____

Primary Care Physician _____

	Normal	Abnormal	Date	Please provide explanation if needed:
PapSmear	_____	_____	_____	_____
Mammogram	_____	_____	_____	_____
Colonoscopy	_____	_____	_____	_____
Bone Density	_____	_____	_____	_____
Gardasil	_____	_____	_____	_____

• Menstrual History

Age of first period: _____

Date of last period: _____

How many days between periods: _____

How many days do your periods last: _____

The flow is: (light/medium/heavy/clots) _____

Cramps: (mild/average/severe) _____

Medication used to relieve cramps: _____

If menopausal, are you on Hormone Replacement Therapy: _____

How long have you been on Hormone Replacement Therapy: _____

• Gynecologic History

Sexual Preference:

- ☐ Heterosexual
- ☐ Homosexual
- ☐ Bisexual
- ☐ Other

Are you sexually active? _____

yes _____ no _____ never _____

Have you had a new partner since your last exam? _____

_____ yes / no _____

Are you concerned about exposure to a sexually transmitted disease? _____

_____ yes / no _____

Have you ever had a sexually transmitted disease? _____

_____ yes / no _____

If yes, please mark below:

- _____ Chlamydia
- _____ Gonorrhea
- _____ Genital Herpes
- _____ HIV
- _____ Syphilis
- _____ Condyloma (Genital Warts)
- _____ Hepatitis C

• **Contraception- please check method/s of birth control that you use**

- | | |
|---|--|
| <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Nuva Ring/Anovera |
| <input type="checkbox"/> Condoms | <input type="checkbox"/> Natural Family planning |
| <input type="checkbox"/> Contraception Patch | <input type="checkbox"/> Partner with vasectomy |
| <input type="checkbox"/> Essure | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> IUD (Mirena/Paragard, Skyla, Kyleena, Liletta) | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> None |

• **Gynecologic Issues/Concerns**

Have you ever had an abnormal pap? _____ yes / no _____

If yes, Date: _____

Diagnosis: _____

Treatment/follow up: _____

Have you had any of the following procedures:

Colposcopy	_____ yes / no _____	date: _____
LEEP	_____ yes / no _____	date: _____
Laser/Conization	_____ yes / no _____	date: _____
CryoSurgery	_____ yes / no _____	date: _____

Please check if you've had any of the following:

Fibroids	_____ yes / no _____	date: _____
Ovarian Cysts	_____ yes / no _____	date: _____
Endometriosis	_____ yes / no _____	date: _____
Lichen Sclerosus	_____ yes / no _____	date: _____
PCOS	_____ yes / no _____	date: _____

• **Obstetrical History**

Number of pregnancies: _____

Terminations: _____

Miscarriages: _____

Living Children: _____

<u>Date of Delivery:</u>	<u>Gestational Age:</u>	<u>Vaginal/C-Section Forceps/Vacuum:</u>	<u>Male/Female:</u>	<u>Weight:</u>	<u>Complications (if any):</u>
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_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

• **General Medical**

Name _____ DOB _____

Have you ever been diagnosed with any of the following,
if yes please provide dates:

Date of Diagnosis:

Stroke	___ yes / no ___	_____
Seizures	___ yes / no ___	_____
Epilepsy	___ yes / no ___	_____
Migraines	___ yes / no ___	_____
Depression	___ yes / no ___	_____
Anxiety	___ yes / no ___	_____
Breast Cancer	___ yes / no ___	_____
Breast Cysts/Nodules	___ yes / no ___	_____
Cancer (other than breast)	___ yes / no ___	_____
Diabetes	___ yes / no ___	_____
Hypothyroidism	___ yes / no ___	_____
Hyperthyroidism	___ yes / no ___	_____
Thyroid Nodules	___ yes / no ___	_____
High Cholesterol	___ yes / no ___	_____
Hypertension	___ yes / no ___	_____
(High Blood Pressure)	___ yes / no ___	_____
Heart Attack/Heart Disease	___ yes / no ___	_____
Mitral Valve Prolapse	___ yes / no ___	_____
Pulmonary Embolism	___ yes / no ___	_____
Asthma (date of onset)	___ yes / no ___	_____
Interstitial Cystitis	___ yes / no ___	_____
Kidney Disease	___ yes / no ___	_____
Liver Disease	___ yes / no ___	_____
Anemia	___ yes / no ___	_____
Sickle Cell	___ yes / no ___	_____
Blood Clotting Disorder	___ yes / no ___	_____
Deep Vein Thrombosis	___ yes / no ___	_____
(DVT or blood clots)	___ yes / no ___	_____
Blood Transfusion	___ yes / no ___	_____
Arthritis	___ yes / no ___	_____
Chicken Pox	___ yes / no ___	_____
Other:	_____	_____

• **Surgical History**

Have you ever had surgery? _____ yes / no _____

If yes, please list any and all surgeries
(including non-gyn related surgery)

<u>Date</u>	<u>Surgery:</u>	<u>Reason for Surgery</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- Immediate Family History**

Do you have a family history of any of the following?

If yes, please indicate which family member:

Breast Cancer _____ yes / no _____
 Uterine Cancer _____ yes / no _____
 Ovarian Cancer _____ yes / no _____
 Colon Cancer _____ yes / no _____
 Diabetes _____ yes / no _____
 Heart Disease _____ yes / no _____
 High Blood Pressure _____ yes / no _____

Relative / Age Diagnosed: _____
 Relative / Age Diagnosed: _____
 Relative / Age Diagnosed: _____
 Relative / Age Diagnosed: _____
 Relative / Age Diagnosed: _____
 Relative / Age Diagnosed: _____
 Relative / Age Diagnosed: _____

Please list all medications you are currently taking:

Please list all known allergies (medication and seasonal):

- Social History**

- | | |
|--|---------------------------------|
| <input type="radio"/> Single | <input type="radio"/> Separated |
| <input type="radio"/> Married | <input type="radio"/> Divorced |
| <input type="radio"/> Domestic Partner | <input type="radio"/> Widowed |

Do you drink alcohol? _____ yes / no _____
 If yes, how much _____

Do you use tobacco products? _____ yes / no _____
 If yes, how much _____

Do you use street drugs? _____ yes / no _____
 if yes, what type and frequency _____

Do you exercise? _____ yes / no _____
 If yes, what type and frequency _____

Do you have any religious or cultural beliefs that would interfere with you receiving blood or blood products? _____ yes / no _____

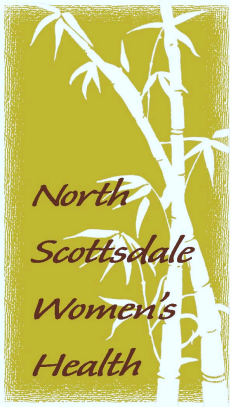
Do you see a naturopath? _____ yes / no _____

Name: _____

Date of Birth: _____

Signature: _____

Today's Date: _____



Patient Information

Please Print

Last name _____ First Name _____ Middle Initial _____

Date of Birth _____ Age _____ Social Security Number _____

Address _____ City _____ State _____ ZipCode _____

Home Phone _____ Cell Phone _____

Occupation _____ Employer _____

Emergency Contact (include phone number) _____

Whom may we thank for referring you? _____

Name of Primary Insurance Company _____

Primary Cardholder Name _____ Date of Birth _____

Policy/Member ID# _____ Group # _____

Name of Secondary Insurance Company _____

Policy/Member ID# _____ Group # _____

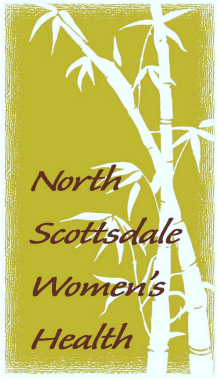
I certify that I, and or my dependent (s) have coverage with the above named Insurance Company(ies) and assign directly to North Scottsdale Women's Health all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am finally responsible for all charges whether or not paid by insurance. I authorize my signature on all insurance submissions.

The above named office may use my health care information and may disclose such information to the above named

Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of patient or Legal Guardian _____ Date _____

Printed Name or Legal Guardian _____ Relationship to patient _____



Notice of Privacy Practices

This Notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a copy of our most up-to-date Notice upon request to our offices or online. Under federal law your patient health information is protected and confidential.

Patient health information (PHI) includes all information related to your past, present, or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by North Scottsdale Women's Health, PLLC in spoken, written, electronic, or any other form. Your health information also includes billing, payment, and insurance information. North Scottsdale Women's Health (NSWH) takes the security and privacy of your PHI seriously.

How We Use Your PHI

NSWH may use your health information for treatment, to obtain payment, and for health care operations; including evaluation of the quality of care you receive. Under some circumstances we may be required to use or disclose information without your permission.

Special Uses and Other Disclosures:

We may use your information in an attempt to contact you with appointment reminders, provide you with information about alternative treatments or other health-related benefits and services that may be of interest to you. Subject to certain requirements, we are permitted to give out your PHI without consent for the following purposes:

- **Required by Law:** When required by law to report information to report information about abuse, neglect, or domestic violence to public authorities if a reasonable belief exists that you may be a victim of such abuse
- **Public Health Activities:**
- **Judicial & Administrative Proceedings:** We may disclose PHI in response to an appropriate subpoena or court order.
- **Law Enforcement Purposes:** We may disclose PHI when required by law enforcement.
- **Deaths:** We may disclose information regarding deaths to coroners, medical examiners, and similar personnel.
- **Serious Threat to Health & Safety:** We may disclose PHI when necessary to prevent a serious threat to your health and safety, the health and safety of others.
- **Research:** Subject to certain conditions, we may use or disclose PHI for approved medical research.
- **Worker's Compensation:** We may disclose PHI for worker's compensation or similar programs. In all other situations we will ask for your written authorization before using or disclosing any identifiable health information. If you choose, you may authorize to disclose information which you may later revoke for any future uses and disclosures.

Initials _____

-Individual Rights

Your rights with regard to your PHI:

-Request Restrictions: You may request restrictions on certain uses or disclosures of your PHI.

-Confidential Communications: You may ask us to communicate with you confidentially, for example, by sending notices to a special address.

-Inspect & Obtain Copies: In most cases, you have the right to view and/or receive a copy of your PHI. There may be a fee associated with copies.

-Amend Information: If you believe information in your record is inaccurate or incorrect, you have the right to request that modify or amend information related to your PHI. This request does not guarantee a change will be made.

-Accounting of Disclosures: You have the right to request a list of certain disclosures of your PHI for reasons other than treatment, payment, or health care operations.

Our Legal Duty

We are required by law to protect the privacy of your health information. We are also required to provide you this notice about our legal obligations and privacy practices regarding your PHI, and to abide by the terms currently in effect.

Changes in Privacy Practices

We may change our privacy practices at any time. If a change occurs, we will update our Notice and make a revised copy available to you in our office and on our website. To request a copy please contact our office or visit our website.

Complaints

If you feel that we have violated your privacy rights, you may contact our office. You may also send a written complaint to the US Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

North Scottsdale Women's Health

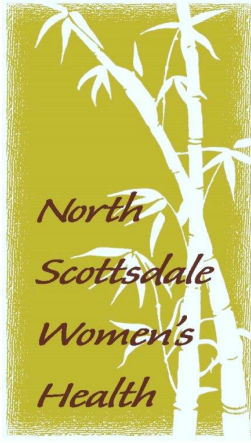
9745 N 90th Place
Scottsdale, AZ 85258
Ph: 480-661-1485 Fax: 480-661-1495

HH Office of Civil Rights

US Department of Health and Human Services
90 7th Street Suite 4-100
San Francisco, CA 94103
Ph: 415-437-8310 Fax: 415-437-8329

Printed Name_____

Signature_____Date_____



North Scottsdale Women's Health
9745 N 90th Place
Scottsdale, AZ 85258
ph 480-661-1485 fax 480-661-1495

Cell Phone Use Policy

Purpose: The purpose of this policy, limiting the use of cell phones and other electronic devices is for the protection and privacy of you and others.

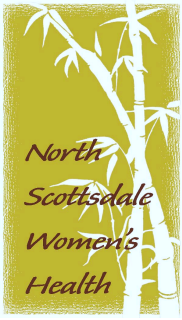
Policy and Procedure: Cell phones and similar devices shall be turned off completely or placed in silent mode and put away for the duration of your appointment. Patients can use personal cell phones, tablets or other devices while in the lobby, or exam room while waiting for the provider. We ask that once the provider or medical staff has entered the room you turn off and put away all electronic devices.

While we understand that your wait times can vary, we do ask that you keep your phone on silent in all waiting areas. If you need to take a phone call, please let the front office staff know and step outside to complete your call. We also ask that you complete all phone calls prior to checking in for your appointment. Failure to do so, could result in a delay in the check in process causing you to be late for your appointment.

My signature on this document confirms that I have read, understand, and agree to the cell phone use policy put forth by NSW. I understand that failure to comply with this policy could result in my appointment being canceled or rescheduled.

Signature: _____ Today's Date _____

Printed Name: _____ Date of Birth: _____



AGREEMENT REGARDING PAYMENT TERMS AND CONDITIONS

Payments (copays, balances and self pay fees) for professional services are due at the time of service. We accept cash, personal checks Visa, MasterCard, Discover Card and American Express.

- **FEE FOR SERVICE AND PAYMENTS:** All estimated prices quoted to you are quoted under a fee for service arrangement. Under the fee for service arrangement, you will be charged for all of the services provided by NSW. H.

This arrangement may not be modified by a verbal agreement. You will be financially responsible for all services provided, even if such services were not anticipated. Charges that are patient responsibility and remain unpaid after 30 days are subject to an administrative fee of \$15.00 per billing cycle. Finance charges will start to accrue after 90 days.

Patients are required to pay ALL estimated deductibles, co-payments, and co-insurance amounts at the time of the pre-operative appointment or at 32 weeks for pregnant patients. Should there be any cost difference resulting in an under or over payment of the provided estimate vs. the actual cost of services, the patient will be invoiced for any balances due or the account will be credited with any over payment amount. Refunds are made at the conclusion of all services with NSW. H.

- **LAB SERVICES:** Specimens will be sent out to your contracted lab for processing and billing. You will need to contact your insurance and the lab if there are any billing issues or questions
- **INSURANCE:** As the patient and contract holder with your insurance plan, you are ultimately responsible for payment of all charges not covered by your insurance. As the patient, it is your responsibility to know what your insurance covers and does not cover. If requested, our staff will assist you in providing a good faith estimate for your portion of the fee for services based on the information provided to us by your plan. However, we cannot guarantee what your insurance company will pay on a claim.. Please be aware that filing of claims is a *courtesy* our office provides to our patients, it does not guarantee payment to us. If we have received all of your insurance information at least 48 hours prior to the day of the appointment and we are able to confirm eligibility, we will be happy to file claims to contracted health plans on your behalf for covered services at North Scottsdale Women's Health. If you have insurance we are not contracted with or no insurance, our self pay rate is due at the time of service

BENEFITS ARE NOT DETERMINED BY OUR OFFICE Ultimately, it's your insurance company who decides what is applied to your deductible, what is considered your co-insurance or copay, and what your financial obligation is for each service you receive. You can see the break down on the Explanation of Benefits (or EOB) that your insurance company sends you after they process the insurance claims. If you ever have any questions about your bill or need help understanding how your insurance company has determined your financial responsibility, feel free to call our billing department at 1-888-963-9076

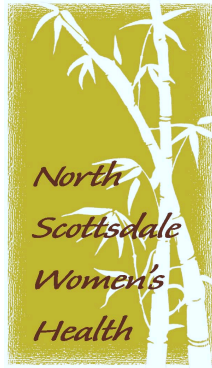
Benefits quoted by your insurance plan are not a guarantee of coverage or payment. Coverage and payment is determined by your insurance when the claim is actually processed. Some insurance plans limit the number of procedures/care they will cover. Some insurance plans also limit the type of services/care covered. Occasionally, unique patient situations sometimes require additional procedures. These additional procedures may not be announced to you as "additional" by our clinicians, as they are providing you with care based solely upon your individual needs.

- **ASSIGNMENT OF BENEFITS:** If I am entitled to benefits of any type whatsoever under any policy of insurance, the benefits are hereby assigned to NSW. H or to the provider group rendering service, for application on my bill. However, **I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF MY BILL.** In rendering treatment, NSW. H is relying on my agreement to pay the account. I have read and understand the NSW. H AGREEMENT REGARDING PAYMENT TERMS AND CONDITIONS and agree to be responsible for all charges incurred by me and to pay my account balance. If my account is sent to an attorney or collection agency, I agree to pay attorney's fees and/or collection agency expenses of up to a maximum amount of 40% of the debt, in addition to the original debt. The amount of the attorney's fee shall be established by the Court and not a jury in any court action. A delinquent account may be charged interest at the legal rate.
- **NO SHOW/CANCELLATION POLICY:** If you do not cancel your appointment within 24 hours prior to, the fee is \$50. If you no-show your appointment, the fee is \$50. If you reschedule or cancel your appointment more than 3 times, we will charge a fee of \$50. These fees will need to be paid prior to scheduling any future appointments.

My signature on this document confirms that I have read, understand, and agree to the NSW. H AGREEMENT REGARDING PAYMENT TERMS AND CONDITIONS.

Signature: _____ Date: _____

Printed Name: _____



Consent for Messages

Patient Name _____ Date of Birth _____

Email Address _____

Consent for Message:

It is ok to leave messages on my cell phone # _____

- ☐ Appointments
- ☐ Test Results
- ☐ Billing/Insurance

It is ok to leave messages on my home phone # _____

- ☐ Appointments
- ☐ Test Results
- ☐ Billing/Insurance

Personal Representatives (family members, other health professionals etc) I authorize North Scottsdale Women's Health and its employees to discuss, send and/or receive medical information to/with the following individuals, including leaving a message with them:

Name/Relationship _____

Name/Relationship _____

General Practitioner/Referring Physician _____

If you would like your health records shared with above named Physician, please let the staff know upon check out.

Patient Signature _____ Date _____