PLATINUM
women's health and wellness

Today's Date:_____

Patient Information:

Patient Name:_____ **DOB:**_____ **Age:**____

Mailing Address:_____ **City:** _____

State:____ **Zip Code:** _____ **Email Address:**_____

Home Phone:_____ **Cell Phone:**_____

Which number is best to contact you? (Circle preference): Home Cell **Last 4 digits of SS #** _____

Can we leave messages regarding your care on this phone? (Circle One): Yes No

Social Security Number:_____ **Marital Status:**_____

Employer:_____ **Occupation:**_____

Employment Status: (Circle One) **Occupation:** _____

Full Time Part Time Retired Self Active Duty Not Employed Student

Students:____ **Full Time** ____ **Part Time** **Name of School:**_____

Emergency Contact (Someone Not Living With you):

Name:_____ **Phone Number:**_____

Relationship to patient:_____

How did you hear about us? (Circle One) Internet - Ins Co.- Phone Book – Advertisement- Friend - Other

Spouse/Significant Other/Parent Information:

Name:_____ **DOB:**_____**SSN:**_____

Address:_____**City:** _____ **State:**_____

Zip:_____ **Apt#:**_____

Home Phone#:_____ **Cell #:**_____ **Work #:**_____

Employer Name:_____

Patient name_____

Primary Insurance Information:

Name of Insurance: _____ **(Circle one)**: HMO PPO

If HMO name of Medical Group:_____ **Insurance phone number**:_____

Name of Insured: _____ **DOB**:_____ **SSN:**_____

Relationship to patient: (Circle One) Self Spouse Child Other

Member Id#:_____ **Group#**_____ **Plan#**_____

Secondary Insurance Information:

Name of Insurance:_____ **(Circle one)**: HMO PPO

If HMO name of Group:_____ **Insurance phone number**:_____

Name of Insured:_____ **DOB**:_____ **SSN:**_____

Relationship to patient: (Circle One) Self Spouse Child Other

Member Id#:_____ **Group#**_____ **Plan#**_____

I authorize treatment for the person named on this information form. I authorize all insurance benefits to be paid directly to Platinum Women's Health and Wellness. I further expressly agree to acknowledge that my signature on this document authorized by my physician to submit claims for services rendered without obtaining my signature on each and every claim submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

Note: If you do not have insurance coverage, full payment is expected at the time of your visit.

I accept financial responsibility for any medical fees incurred at Platinum Women's Health and Wellness. I further agree to pay all finance charges, collection cost, attorney fees and any other cost that may be incurred to enforce collection of any amount outstanding. I also authorize the release of any information required by an insurance company to process a claim.

Signature:_____ **Date**:_____

PLATINUM
women's health and wellness

Medical Information:

Today's Date:_____

Patient Name:_____ **DOB:**_____

Reason for visit:_____

Name of primary care physician:_____

Preferred Pharmacy Information:

Name:_____ **Ph #:**_____

Location:_____

Allergies:_____ **Reaction:**_____
_____ _____
_____ _____

Last menstrual period:_____ **Last Pap:**_____ Normal:_____
Marital Status:_____

Sexual History: **Are you sexually active? Yes or No (circle)**

How many sex partners in the last 6 months _____Last year _____Last 2 years _____Life time_____

Do you have or have you ever had: (Please circle any that apply)

Genital Warts Herpes Chlamydia Gonorrhea Trichomonas Syphilis

Current birth control method used: _____

Last Mammogram: _____ **Normal:** _____**Last Colonoscopy:**_____ **Normal:** _____

Last Dexa scan: _____**Normal:**_____

Menstruation History:

Age of 1st menses:_____ **Days between cycles:** _____ **Days you bleed:**_____
Flow (circle) Light Moderate Heavy How many tampons/pads/day/hour?:_____

Cramping/clotting/pain: (Circle One) Yes or No

Patient name_____

Obstetrical History:

How Many pregnancies have you had?:_____
How Many Births?:_____ **How Many Living Children?:**_____
How Many Full Term Births?:_____ **How Many Preterm Births?:**_____
How Many Miscarriages?:_____ **How Many Abortions?:**_____

List All Deliveries:

Mo/Yr	Weeks @ birth	Vaginal Y/N	Weight	Gender	Complications

Comments:

_____

Menopausal History:

Age of onset:_____ **Are you experiencing any menopausal symptoms?:**_____
Are you currently on hormone replacement therapy?:____ **Type:**_____

List any medical treatments you are currently being treated for: ie: asthma, hypertension, high cholesterol…

_____ _____
_____ _____

List any current medications you are taking, including supplements/vitamins:
INCLUDE STRENGTH AND TIMES TAKEN DAILY

_____ _____
_____ _____
_____ _____

***Surgical History: List any past surgeries*:**

Date:_____ **Type:**_____
_____ _____
_____ _____

Social History:

Do you smoke?_____ **Have you ever smoked?**_____ **When did you quit?**_____
How many years smoker?____**Type?**_____ **How many per day?**_____
Do you drink alcohol?_____ **(circle) Wine Beer Hard alcohol How much?**_____

How much caffeine per day?_____

Do you exercise?_____ What type of exercise?_____How often?_____

Have you ever been sexually abused, threatened or hurt by anyone?_____

Occupation: _____

Patient name_____

Medical/Family History: **Were you adopted? (Circle one): Yes No**

Please check any of the following medical conditions you, parents, grandparents or siblings have:

Disorder	*Self*	*Father*	*Mother*	*Grandparent Maternal/Paternal*	*Sister*	*Brother*
Alcohol						
Anesthesia complications						
Asthma						
Autoimmune Disorder						
Breast Problems						
Cancer: **Type**						
Depression						
Diabetes						
Heart Disease						
Hepatitis/Liver Disorder						
Hx of Abnormal Pap						
Hx of Blood Transfusion						
Hypertension						
Infertility						
Kidney Disease						
Latex Allergies						
Lung Disease/Disorders						
Neurological Disorder						
Possible Exposure to TB						
Psychiatric Disorder						
Recreational Drugs						
Rh Sensitized						
Seasonal Allergies						
Seizure Disorder						
Thyroid Dysfunction						
Tobacco						
Trauma/Violence						
Uterine Abnormalities						
Varicosities/Phlebitis						

FINANCIAL POLICY

- **Insurance** - Your insurance 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.

- **Regarding Insurance** - We may accept assignment of insurance benefits. We will bill your insurance company upon receipt of your current insurance information. **If your insurance company has not paid your account in full within 45 days, the balance may automatically be billed to you.** Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Non-covered services will be billed to the patient.

- **Medicare Medical Necessity** - Medicare will pay only for services that is determines to be "reasonable and necessary" under the Medicare laws. If Medicare determines that a particular services, although it would otherwise be covered, is not reasonable and necessary, Medicare will deny payment for that service. If Medicare denies payment, you are personally and fully responsible for payment.

- **FMLA Forms, Disability Forms and Insurance Forms** - Forms completion is not a covered benefit under any plan. There will be a charge for the completion of all FMLA, Short-term and Long-term Disability forms. Completion of insurance forms is not a covered benefit; there will be a $15.00 charge for completion of insurance forms.

- **No-Show/Late Cancellation** - If you must cancel your appointment, you will be required to cancel **24 hours before your appointment time**. "No show" patients and cancellations with less than 24 hours notice will be charged a $25.00 fee. **If you "no show" 3 appointments you will be dismissed from practice.**

- **Children** - The parent seeking medical attention of a child/children is responsible for their co-payment and/or co-insurance at the time of service. The financial arrangement between you and the child/children's parent does not include our practice.

- **Returned checks** - There is a $30.00 fee if your check is returned unpaid. In addition, any future services will require cash or credit card payments.

- **Statements** - Charges shown on statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing date.

- **Collections** - Should it be necessary to place your unpaid account with a outside collection agency, you must communicate directly with them. Additionally, you will be responsible for all fees of 40% to collect a debt.

- **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 guarantee that your insurance company will pay for the services.

- **Co-payments/Co-Insurance** - 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.

X_____ _____

Patient or Responsible Party Signature Date