The Womens Centre

John F. Dulemba, MD Suhas D. Mantri, MD
Amy Dean, WHNP-BC

Patient Info

Patient Name: First _____ M ____ Last _____ (former last name:_____)
Preferred Name (If different from above) _____
Address: _____ Home Phone: _____
City/State: _____ Work Phone: _____
Zip: _____ Cell Phone: _____
Email: _____ Driver Lic # & State: _____
SS#: _____ Marital Status: **S M D W** DOB: ____/____/_____
Employer: _____ Address: _____
Nearest Relative not living with you: _____
Primary Physician: _____ Phone: _____
Bill Patient Charges to (if other than patient): _____ SS#: _____
Address: _____ Phone: _____
Emergency Contact: _____ Phone: _____

Spouse

Spouse Name: _____ DOB: ____/____/_____
Spouse SS#: _____ Driver Lic # & State: _____
Employer: _____ Employer Phone: _____
Employer Address: _____

Insurance

Insurance Company: _____ Phone: _____
Policy ID/Subscriber #: _____ Group #: _____
Claims Address: _____
Subscriber Name: _____ Relationship to you: _____
Subscriber SS#: _____ Subscriber DOB: ____/____/_____

NOTE: "Subscriber" refers to the primary account holder on the insurance policy.

2nd Insurance

Insurance Company: _____ Phone: _____
Policy ID/Subscriber #: _____ Group #: _____
Claims Address: _____
Subscriber Name: _____ Relationship to you: _____
Subscriber SS#: _____ Subscriber DOB: ____/____/_____

It is the policy of our office that all visits must be paid for at the time of services; this will include all co-payments and deductibles. Your insurance will be verified at the time of your appointment.

I understand and agree that (regardless of my insurance status,) I am ultimately responsible for the balance of my account for any professional services rendered. I will notify this office of any changes in my information.

I consent to and authorize The Womens Centre to treat any conditions that I might have and seek treatment for.

I authorize The Womens Centre to release any medical information to my insurance company needed to process claims.

I acknowledge I have access to a copy of this office's Notice of Privacy Practices.

Patient Signature: _____ **Date:** _____

Personal Medical Information

Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Who are you here to see? John Dulemba, MD, Suhas Mantri, MD, Amy Dean,WHNP-BC, Sara Muskopf, RDMS

Race: Caucasian/Non-Hispanic Caucasian/Hispanic African American Native American Asian Pacific Islander

List any ALLERGIES you may have: _____

Check if YOU have had the following:

- ☐ Breast Cysts / Tumors / Discharge
- ☐ Ovarian Cyst / Uterine Tumors
- ☐ Pelvic Infections (Uterus, Tubes, Ovaries)
- ☐ Chronic Pelvic Pain
- ☐ Chronic Vaginal Infections
- ☐ Endometriosis
- ☐ Dyspareunia (Painful Intercourse)
- ☐ Bleeding After Intercourse
- ☐ Abnormal Pap Smear Date: _____
  How was it treated? _____
- ☐ STD (Herpes, Gonorrhea, Syphillis, Trichomonas Chlamydia, Genital Warts, HPV Virus)
- ☐ HIV+ / AIDS
- ☐ Chronic Bladder Infections
- ☐ Urinary Incontinence (leaking)
- ☐ Interstitial Cystitis
- ☐ Osteopenia / Osteoporosis
- ☐ Stroke/Blood Clot/Blood Clotting Disorder
- ☐ Heart Attack
- ☐ Heart Problems (Murmurs)/Arrythmia
- ☐ High Cholesterol
- ☐ Lung Problem (short of breath, asthma, tuberculosis)
- ☐ High Blood Pressure
- ☐ Gall Bladder Problems/Stones
- ☐ Kidney Disease
- ☐ Cancer Type: _____
- ☐ Headaches/Migraine Headaches
- ☐ Depression / Anxiety
- ☐ Psychiatric Conditions/Mental Disability
- ☐ ADD / ADHD
- ☐ Diabetes / Type I / Type II
- ☐ Epilepsy / Seizures
- ☐ Thyroid Problems / Hypo / Hyper
- ☐ Varicose / Inflamed Veins
- ☐ Sickle Cell Disease /Trait
- ☐ Anemia
- ☐ Stomach Ulcers
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Gastrointestinal Problems (Colitis, Crohn's, Chronic Constipation, Chronic Diarrhea)
- ☐ Hepatitis
- ☐ Rheumatoid Arthritis / Osteo Arthritis

Are you being treated for anything or have you ever been treated for anything not listed? If so, what? _____

_____

Do you use recreational drugs? Yes / No If yes, what type? _____

Are you concerned about wrinkles or spider veins? Yes / No

Family Medical History

Please check all that apply to your mother, father, sister(s), or brother(s):

- ☐ Stroke
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ History of Other Cancer Type: _____
- ☐ Diabetes / Type I / Type II
- ☐ Sickle Cell Disease / Trait
- ☐ Elevated Cholesterol
- ☐ Genetically Inherited Abnormalities: _____
- ☐ Other: _____

Menstrual History

Have you gone through menopause? Yes / No If yes, what age? _____

Have you had a hysterectomy? Yes / No If yes, what was the reason? _____ Abdominal / Vaginal

(If you answered yes to the above, then skip down to Reproductive history)

Age periods began: ____ **First day of last NORMAL period:** _____

Pain/Cramping with periods? Yes / No If yes: Severe / Moderate / Mild

Period every _____ days **Period lasts _____ days** **Number of pads/tampons used per day:** _____

Bleeding between periods? Yes / No

Contraceptive History

Are you interested in a Birth Control Method at this time? Yes / No

Have you had unprotected intercourse since your last period? Yes / No

Please check which birth control methods you have used:

- ☐ Abstinence
- ☐ Virgin
- ☐ IUD Kind: _____
- ☐ Nexplanon/Implanon
- ☐ Condoms
- ☐ Birth Control Pills Kind: _____
- ☐ Fertility Awareness
- ☐ Sterilization You / Partner
- ☐ Withdrawal
- ☐ Nuva Ring
- ☐ Ortho Evra Patch
- ☐ Same Sex Relationship
- ☐ Other: _____
- ☐ None

Current Method: _____ **How long have you used this method?** _____ **Problems?** _____

Do you wish to continue this method? Yes / No

Reproductive History

Total number of pregnancies including any miscarriages & abortions: _____

Number of full term babies: _____ **Number of abortions:** _____ **Number currently living:** _____

Number of miscarriages: _____ **Number of premature babies:** _____

Pregnancy	Vag, C/S, AB Miscarriage	Delivery Date	Complications
1			
2			
3			
4			
5			

Surgical History

List date, surgeries (even as a child): _____

_____

General Information

Usual Weight: _____ **Height:** _____

Date of last pap smear: _____ Normal / Abnormal **Date of last mammogram:** _____ Normal / Abnormal

List all medications you are currently taking: _____

_____

Do you use alcohol? Yes / No If yes, amount per day/week: _____ **Do you smoke?** Yes / No If yes, amount per day: _____

Do you use caffeine? Yes / No If yes, amount per day: _____

Who referred you to our office? _____ **For what problem / reason are you here today?** _____

The Womens Centre

Patient Name: _____ **Patient #:** _____

Social Security# (last 4 digits): _____ **Date of Birth:** _____

Patient Privacy Directive

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPPA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

_____

Please provide an email address that this office may communicate health information to you with:

_____

Please provide a cell phone or home number that we may leave a message or text health information to:

_____

Please provide us with the name and number of your emergency contact:

_____

Please provide us with the name(s) and phone number(s) that we may share the following information:

(Check all that apply)

☐ **Appointments** ☐ **Treatments/Test Results/Prescriptions** ☐ **Billing**

_____ _____

Name *Phone Number*

_____ _____

Name *Phone Number*

I acknowledge that everything above is accurate.

_____ _____ _____

Signature *Printed Name* *Date*

I acknowledge I have seen or been offered a copy of the "Notice of Privacy Practices."

_____ _____ _____

Signature *Printed Name* *Date*

_____ _____

Relationship if Patient Representative *Physician Office Representative*

_____

Family History Questionaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____
Date of Birth: _____ Date Completed: _____

Instructions: Please circle **Y** to those that apply to **YOU and/or YOUR FAMILY**. Then please list the relationship of the individual diagnosed (such as **Self, Uncle, Aunt, Grandmother**) & their age at diagnosis. This is a screening tool for **Hereditary Cancer Syndromes**, if you circle **Y** to any statement below, you MAY be appropriate for genetic testing.

		BREAST & OVARIAN CANCER (BRCA)	**Relationship**	**Mother's Side**	**Father's Side**	**Age Diagnosed**
Y	**N**	Breast Cancer		**Y**	**Y**	
Y	**N**	Ovarian Cancer		**Y**	**Y**	
Y	**N**	Breast Cancer in both breasts or multiple primary Breast Cancers		**Y**	**Y**	
Y	**N**	Male Breast Cancer		**Y**	**Y**	
Y	**N**	Pancreatic Cancer		**Y**	**Y**	
Y	**N**	Prostate Cancer		**Y**	**Y**	
Y	**N**	Triple Negative Breast Cancer		**Y**	**Y**	
Y	**N**	Are you of Jewish descent?		**Y**	**Y**	
Y	**N**	Family member with known BRCA mutation		**Y**	**Y**	
		COLON & UTERINE CANCER (COLARIS)	**Relationship**	**Mother's Side**	**Father's Side**	**Age Diagnosed**
Y	**N**	Uterine (Endometrial) Cancer		**Y**	**Y**	
Y	**N**	Colon Cancer		**Y**	**Y**	
Y	**N**	Ovarian, Stomach, Kidney/Urinary Tract, Pancreatic, Brain or Small Bowel		**Y**	**Y**	

○ Information given to patient to review
○ Candidate
○ Patient offered genetic testing ○ Accepted ○ Declined
○ Follow up appointment scheduled

X_____ X_____

Patient Signature Date Healthcare Provider's Signature Date

THE WOMENS CENTRE

JOHN F. DULEMBA, M.D. SUHAS MANTRI, M.D.
AMY DEAN, WHNP-BC SARA MUSKOPF, RDMS

Patient Contract for Controlled Substance Prescriptions

Controlled substance medications (narcotics) can be very useful, but have high potential for misuse and abuse and are, therefore, closely controlled by the local, state and federal governments. Used properly, they are very effective pain medications. If used excessively, however, they can cause adverse effects such as vomiting, constipation, lethargy, or even death. To insure these medications are used properly, I agree to the following conditions:

1. I am responsible for my controlled substance medications. If the prescription or medication is lost, misplaced or stolen, or if I use it up sooner than prescribed, I understand that it will not be replaced or filled early.

2. I will not request nor accept controlled substance medication from any other physician, dentist or individual while I am receiving such medication from my doctor at The Women's Centre (except if I am a patient in a hospital). Medications received while in a hospital must be reported to our office. Besides being illegal to do so, it may endanger my health.

3. I agree to use only one pharmacy.

4. I understand that multiple telephone calls inquiring about my medication will only result in delaying that refill. The Womens Centre will make every effort to submit your prescription by 4:30pm the same day, but if not, you will be notified by our staff.

5. I understand that if I require chronic pain management, I will be required to be evaluated every 90 days and undergo a urine drug screening.

6. Refills of controlled substance medications will be made only during regular office hours of The Women's Centre. You should call your pharmacy to request the refill. Refills will not be made at night, on holidays, or weekends. Please plan at least 5 days in advance for renewal requests. **Do not request early refills of your medication. Your health is important to us and we will not dispense medications before they are due.**

3321 Unicorn Lake Blvd, Suite 121, Denton, TX 76210
Phone (940) 387-6248 Fax (940) 381-1881

7. No prescription request will be accepted by anyone other than the patient whom it is intended, whether via telephone or in our office.

8. No written prescriptions will be released to anyone not listed on the patient's privacy directive for treatment information. At time of prescription pick-up, a valid picture ID must be presented and in our file before the prescription will be released.

9. **I understand that if I violate any of the above conditions, my controlled substance prescriptions and treatment at The Women's Centre may be ended immediately.**

I have been informed by my physician about narcotic effects, including normal physiologic effects of tolerance (need for more medicine to achieve the same pain relief), dependence (withdrawal will occur if I stop the medicine abruptly), and addiction (abnormal psychological dependence), which is rare in patients with pain. Withdrawal can be a consequence of overuse, and often times can be unpleasant (nausea, vomiting, diarrhea, sweating, rapid pulse, etc.)

Patient Signature: _____ **Date:** _____

Patient Name: _____
Please Print

THE WOMENS CENTRE
PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name: _____ Date of Birth: _____
Last Name First Name

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to The Womens Centre or the physician individually for services rendered to my dependents, or me, by the physician or those under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that The Womens Centre is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my, or my dependent's records that these programs may request. I hereby direct that payment of my, or my dependent's authorized benefits be made directly to The Womens Centre or the physician on my behalf.

AUTHORIZED TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have read and been offered a copy of the The Womens Centre. "HIPAA Notice of Privacy Practices". I hereby authorize The Womens Centre. or the physician individually to release any of my, or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:
I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Womens Centre representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and diagnostic test results. I understand that I have the right to rescind this authorization at any time by notifying The Womens Centre to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by my Womens Centre physician or those under his/her supervision.

PATIENT SIGNATURE:_____ DATE:_____

GUARANTOR SIGNATURE:_____ DATE:_____
(if different from patient)

GUARANTOR NAME (Please Print):_____

The Womens Centre

John F. Dulemba, MD Suhas D. Mantri, MD
Amy Dean, WHNP-BC

Financial Policy

We appreciate the confidence that you have expressed in selecting our practice for your healthcare. If you have any questions about our services, fees, or other aspects of your care, please feel free to discuss your concerns with us.

Payment for your office visit is required at the time of your visit for:

- Patients without insurance
- Patients who do not provide us with a copy of their insurance card at the time of their visit.
- Patients who do not complete the insurance info on the update request along with a copy of their insurance card when requested.

We must be contracted with your insurance plan. If not, payment is required at the time of service.

We will be glad to submit charges as per the requirements of your insurance company **IF** we are contracted with them. Labs are sent from our office according to your insurance plan. We are **not** responsible for the co-payment/deductible/coinsurance balance of lab work. Billing is done through your insurance's contracted lab facility.

Your co-payment must be paid at the time of your visit. **If you have an unmet deductible on your insurance policy, you will be required to pay any charges including lab work from your visit that apply to that deductible.** If your services are not covered by your insurance plan, you will be responsible for the charges for those services.

Our staff will do their best to make sure we obtain the correct benefits information, but please keep in mind that the information we receive is **not always** correct. If you have questions, please call your insurance company to verify your benefits. It is your responsibility to know and understand your coverage. If you need to use a specific lab or facility, please let us know. It is our sincere hope that this policy will be helpful and reduce any confusion.

No Show Policy: A failure to present at the time of a scheduled appointment will be recorded in our appointment scheduler as a "no show". The first time there is a "no show", a letter will be sent alerting you to the fact that you failed to show up for an appointment and did not cancel the appointment. If there is a second "no show" within 1 year, a fee of $50.00 will be billed to you, not your insurance company. The "no show" fee is required to be paid prior to scheduling your next appointment.

If you would like to receive email reminders/correspondence, please provide us with your email address:

_____

I have read and understand the above information. Payment of medical or surgical benefits are assigned directly to:

The Womens Centre

The patient is responsible for all court fees, attorneys' fees, or other fees necessary to collect unpaid balances.

Patient Signature: _____ **Date:** _____

3321 Unicorn Lake Blvd., Suite #121 • Denton, Texas 76210 • 940.387.6248 • Fax 940.381.1881

The Womens Centre

DISCLOSURE REGARDING ANCILLARY SERVICES/RESEARCH PROGRAMS

Ancillary Services

Your physician may refer you to one or more "Ancillary Services" in connection with your medical care. An "Ancillary Service" is a service relating to your medical care or treatment. The following types of services are Ancillary Services:

Magnetic Resonance Imaging (MRI)	Bone Density Imaging
Mammography	Nuclear Imaging
Ultrasound	Laboratory
Computer Tomography (CT)	Durable Medical Equipment (DME)
Positron Emission Tomography(PET)	Echo Cardiograph
X-Ray	Sleep Therapy
Infusion Therapy	Audiology

Your physician may have an economic interest in or a business relationship with the company or person who provides the Ancillary Services. You are not obligated to use the provider that your physician refers you to. You are free to use any provider you choose.

Research Programs

Your physician may ask if you would like to participate in a clinical trial or other research program. These programs may be sponsored by a drug or medical supply company or may be part of a governmental research program. Your physician may be compensated for services rendered in connection with these programs. You are not obligated to participate in any research program and your permission will be obtained prior to you participating in a program your physician believes may be appropriate for you.

Please feel free to ask your physician if you have any questions about a particular Ancillary Service or Research Program.

_____ _____

Date Patient (or Guarantor) Signature

_____

Printed Name

THE WOMENS CENTRE

JOHN F. DULEMBA, M.D. * SUHAS MANTRI, M.D.
AMY DEAN, WHNP-BC SARA MUSKOPF, RDMS

AFTER HOUR, WEEKEND & HOLIDAY GUIDELINES

The telephone is a great tool for interaction between the patient, office and provider, but it should not be abused. After hour and weekend calls are for emergencies that could not be addressed during business hours.

Prescription refills will not be made after hours or weekends. Pain medications, hormones and birth control medication refills must be called into your pharmacy and will be processed during business hours. Any prescriptions due to be refilled over a weekend or holiday should be called in on the 2 days before it is due. Do not wait until you run out of medication to call or we will not be able to guarantee you have your medication when needed. We will process all medication refills Monday thru Thursday 8:00am till 4:00pm and Friday 8:00am till 11:00am. Please do not make multiple calls concerning the same prescription for this will cause delays in processing for everyone. Any refill request received within the office hours listed above will be processed and filled if due by the end of the day.

There are times that the on-call provider may tell you to go to the ER since he or she are limited to what can be done over the telephone. In this case, go to the ER and they will notify your physician of your condition if needed.

Patients who are in the hospital, (post-operative or ER) are under the facility's care and should not call the provider or office for treatment until you are discharged. The hospital staff is well trained to handle your post-operative and/or medical problems. The staff will consult your physician if needed. If at any time you are not happy with the care you are receiving at a facility, ask to speak with a supervisor.

Be advised that there may be a $50.00 fee charged for any non-emergency calls made as addressed above. Also, be advised that you may also be dismissed from the practice if non-compliance to these guidelines persists.

I have read and acknowledge the after hour, weekend and holiday guidelines.

Name	Signature	Date

3321 Unicorn Lake Blvd, Suite 121, Denton, TX 76210
Phone (940) 387-6248 Fax (940) 381-1881