7162 Liberty Centre Dr ste b
West Chester Township, OH 45069
PATIENT INFORMATION:

NAME: _____________________________

FIRST   MIDDLE   LAST

SS#: _____________________________  BIRTHDATE: _____________________________

SEX: M  F  MARITAL STATUS: ___________ DRIVERS' LICENSE #

ADDRESS: ________________________________________________________________

CITY, STATE & ZIP: _________________________________________________________

HOME PHONE: (   ) ________________ WORK PHONE: (   ) ______________________

EMPLOYER: ______________________________________________________________

EMERGENCY CONTACT PERSON: ______________________________________________

RELATIONSHIP: _____________________________ PHONE: (   ) __________________

RESPONSIBLE PARTY (IF OTHER THAN PATIENT):

NAME: _____________________________

FIRST   MIDDLE   LAST

SS#: _____________________________  BIRTHDATE: _____________________________

SEX: M  F  MARITAL STATUS: ___________ DRIVERS' LICENSE #

ADDRESS: ________________________________________________________________

CITY, STATE & ZIP: _________________________________________________________

HOME PHONE: (   ) ________________ WORK PHONE: (   ) ______________________

EMPLOYER: ______________________________________________________________

INSURANCE COVERAGE

PRIMARY CARRIER: __________________________________________________________

SUBSCRIBER NAME: _____________________________ EFFT DATE: _________________

ID#: ___________________________ GROUP #: __________________ COPAY AMT ______

CLAIMS ADDRESS: _________________________________________________________

SECONDARY CARRIER: _______________________________________________________

SUBSCRIBER NAME: _____________________________ EFFT DATE: _________________

ID#: ___________________________ GROUP #: __________________ COPAY AMT ______

CLAIMS ADDRESS: _________________________________________________________

I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physician or supplier for all services rendered. 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 also agree that I am responsible for any collection fees should my account be turned over to a collection agency.

RESPONSIBLE PARTY SIGNATURE ___________________________ DATE ___________________________
New Patient GYN Consult HPI

Date of visit: __________

Name: _______________________________ DOB: ___________ Age: ______

Referring Doctor: _____________________ Primary Doctor: ______________

What is the main reason for your visit? _______________________________________

How long have you had the problem? _________________________________________

What makes it better or worse? _______________________________________________

Please list all your bladder, bowel or GYN surgeries:

_________________________________________________________________________

When was your last urinary tract infection? __________

How often do you move your bowels? ________________________________

Do you have trouble moving your bowels? [Yes] [No] If so what is the trouble? ________________________________

How many children do you have? _________ How many vaginal deliveries? _________ How many C-Sections? _________

What difficulties did you have with labor and delivery? ________________________________

Contraception – Current Method: ________________

Menopause: ___ Hot Flashes ___ Vaginal Dryness ___ Night Sweats ___ Memory/Concentration

Sexual Problems: ___ Libido ___ Orgasmic Dysfunction ___ Painful Intercourse ___ Vaginismus

When was your last period? __________

When was your last PAP? _____________ Was it normal? [Yes] [No]

What was done to treat the abnormality? __________________________________________________________________

When was your last mammogram? _____________ Was it normal? [Yes] [No]

What was done to treat the abnormality? __________________________________________________________________
New Patient GYN Consult

Medications


Drug Allergies

Medical Problems


Surgeries


Serious medical problems in your family


Social History

Have you ever been a smoker? _______ Sexual Problems:

How often and how much do you drink? 

Marital status?

Are you sexually active? _______ Any problems?

What is your occupation?

Are you depressed or do you have a history of depression?


PHARMACY:

NAME ___________________ CITY/STATE/ZIP CODE ________________________________

PHARMACY PHONE NUMBER ______________________________

Name ___________________________ Date __________________
## REVIEW OF SYSTEMS

Have you had any problems related to the following systems in the past 6 months? Circle Yes or No

**General:**
- Fever: Y N
- Weight change: Y N
- Tired easily: Y N
- Other:

None of these above ___

**Skin/Breast:**
- Breast Lumps: Y N
- Skin Rash: Y N
- Other:

None of these above ___

**Eyes:**
- Change in Vision: Y N
- Cataracts: Y N
- Glaucoma: Y N
- Other:

None of these above ___

**Musculoskeletal:**
- Weakness: Y N
- Limited Range of Motion: Y N
- Joint Pain: Y N
- Other:

None of these above ___

**Neurological:**
- Seizures: Y N
- Burning or Shooting Pain: Y N
- Numbness: Y N
- Other:

None of these above ___

**Respiratory:**
- Chronic Cough: Y N
- Asthma: Y N
- COPD: Y N
- Other:

None of these above ___

**Hematological:**
- Easy Bruising: Y N
- Bleeding: Y N
- Swollen Glands: Y N
- Other:

None of these above ___

**Cardiovascular:**
- Shortness of Breath: Y N
- Chest Pain: Y N
- Other:

None of these above ___

**Endocrine:**
- Thyroid Problems: Y N
- Diabetes: Y N
- Other:

None of these above ___

**Gastrointestinal:**
- Nausea/Vomiting: Y N
- Reflux: Y N
- Diarrhea: Y N
- Bloody Stool: 
- Other:

None of these above ___

**Psychiatric:**
- Depression: Y N
- Anxiety: Y N
- Other:

None of these above ___

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**NAME** __________________________

**DATE** __________________________
CONSENT TO TREATMENT/TESTING: I hereby consent to the administration of treatment and testing as is considered therapeutically necessary for my condition.

RELEASE OF RECORDS: I authorize the release of medical record information (including, but not limited to information concerning drug related conditions, alcoholism, psychiatric conditions, HIV testing, AIDS diagnosis/related conditions) to insurance carriers, third-party payers or to their representatives, review organizations, or surveyors for accreditation, regulatory and/or licensing purposes, as necessary to determine benefits entitlement and to process payment claims for healthcare services provided. This authorization shall be valid only for the period of time necessary to process payment claims.

In consideration of admission and all facility services, the undersigned agrees to the following:

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Advanced Pelvic Surgery, LLC of all insurance benefits, otherwise payable to me.

GUARANTEE OF ACCOUNT: I unconditionally guarantee the payment in full to the facility of the total amount due them for said admission and/or facility services. I understand that I am financially responsible to the facility and/or physician for the charges not covered by the above assignment. I am also responsible for charges even if determined by my employer or insurance company to be unnecessary in their judgement.

I have read and do understand this form.

________________________________________  __________________________
Signature of Responsible Party               Date

________________________________________  __________________________
Relationship to Patient                      Witness
WAIVER OF FINANCIAL RESPONSIBILITY

ADVANCED PELVIC SURGERY, LLC
R. GREGORY OWENS, M.D. F.A.C.O.G.

PATIENT NAME: ________________________________

PHYSICIAN NAME: R. Gregory Owens, M.D.

DATE OF SERVICE: ______________________________

I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR SERVICES IN THE EVENT THAT MY INSURER DOES NOT COVER EXPENSES. IF YOU HAVE A DEDUCTIBLE AND IT HAS NOT BEEN MET, PAYMENT FOR SURGERY OR PROCEDURES WILL HAVE TO BE PAID BEFORE SERVICES ARE RENDERED. AN INTEREST CHARGE OF 1 1/2 % PER MONTH WILL BE ASSESSED FOR ANY OUTSTANDING PATIENT BALANCE AFTER THE FIRST STATEMENT IS SENT.

TO ASSIST YOU WITH YOUR MEDICAL CARE, WE PROVIDE THE FOLLOWING PAYMENT OPTIONS:

1. CASH – INCLUDES PERSONAL CHECKS
2. VISA, MASTERCARD, DISCOVER, DINERS CLUB, JBC, AMEX
3. CareCredit – Patient payment plans that allow you to pay over time with convenient low minimum payments. With CareCredit, you enjoy these benefits:*  
   • Flexible Financing options  
   • No annual fees or prepayment penalties  
   • Quick and easy application  
   • Receive a credit decision almost immediately  
   • Start your recommended treatment immediately

SIGNATURE: ________________________________

RELATIONSHIP IF OTHER THAN PATIENT: ____________

DATE: ________________________________
CONSENT TO DISCUSS

I, __________________________, give my consent to Advanced Pelvic Surgery to discuss my medical condition with __________________________.

_________________________  _________________________
Patient Signature          Date