Women's Health Care – Patient Information

Account No._____ (office use only) **Date _____**

Patient Name _____
Last First

Address _____ Apt. No._____

City _____ State _____ Zip code _____

County _____

Email address_____Nationality/Race _____

Home # _____Work # _____Cell #_____

Social Security # _____ - _____ - _____ Date of Birth _____ / _____ / _____

Marital Status: circle one Single Separated Married Divorced Widowed

Employer's Name _____ Occupation _____

Employer's Address _____
Address City/State Zip code

Spouse's Name _____ Date of Birth _____

Spouse's Employer _____ Cell # _____

NAME AND PHONE # OF RELATIVE/FRIEND NOT LIVING WITH YOU WHOM WE MAY CONTACT IF WE ARE UNABLE TO REACH YOU OR YOUR SPOUSE: (IF YOU ARE A MINOR, PLEASE LIST A PARENT OR GAURDIAN WE MAY CONTACT.)

Name:_____ Name:_____
Phone # _____ Relation: _____ Phone# _____ Relation: _____

PLEASE PROVIDE YOUR INSURANCE CARD AND ID TO BE COPIED

SELF-PAY (NO INSURANCE) YES ____

Policy Holder _____Social Security #_____
Date of Birth _____Relation to Patient: circle one Self Spouse Dependent Other

Does your insurance require that your PCP refer you to our office? YES/NO
****If yes, have you obtained your referral or any medical records from your PCP? YES/NO**

How did you hear about Women's Health Care? _____

WE GLADLY ACCEPT CASH,CREDIT/DEBIT CARDS (VISA,MC)FOR PAYMENT
*****CHECKS ARE NOT ACCEPTED*****

Women's Health Care Health History Intake Form

Allergies: ◯ **NKA** ◯ **Other**:_____ **Name**:_____

Medications: _____ **DOB:** _____

Pharmacy: _____

Past Medical History (mark all that apply):

Abnormal Pap	◯	**Diabetes**	◯	**Lupus**	◯
Abnormal bleeding	◯	**Deep vein blood clot**	◯	**Osteoporosis**	◯
No menses	◯	**Painful periods**	◯	**Ovarian cyst**	◯
Anemia	◯	**Painful sex**	◯	**PCOS**	◯
Anxiety	◯	**Endometriosis**	◯	**PID**	◯
Asthma	◯	**Fibroids**	◯	**Rheumatoid arthritis**	◯
Blood transfusion	◯	**Genital warts**	◯	**Spina Bifida**	◯
Breast problems	◯	**Heart murmur**	◯	**Sexually transinfections**	◯
Cancer	◯	**HIV/AIDS**	◯	**Stroke**	◯
Chronic pain	◯	**Hormone problem**	◯	**Substance abuse**	◯
Clotting disorder	◯	**High blood pressure**	◯	**Thyroid disease**	◯
Heart disease	◯	**Infertility**	◯	**Trauma/violence**	◯
Depression	◯	**Kidney disease**	◯	**Urinary incontinence**	◯
DES exposure	◯	**Liver disease**	◯	**Uterine anomaly**	◯
Other	◯				

Surgical history:

Abdominal surgery	◯	**Cystocele/rectocele repair**	◯	**Hysteroscopy**	◯
Appendectomy	◯	**Colposcopy**	◯	**Laser conization**	◯
Bladder suspension	◯	**Cosmetic surgery**	◯	**LEEP**	◯
Breast enlargement	◯	**D&C**	◯	**Oophorectomy**	◯
Breast surgery	◯	**Endometrial ablation**	◯	**Laparoscopy**	◯
Cesarean	◯	**GYN cryosurgery**	◯	**Tubal ligation**	◯
Colon surgery	◯	**Hysterectomy**	◯	**Other**	◯

Menstrual history:

Age at first menstrual period: _____ **Menstrual cycle every** _____

Last menstrual period:_____ **Duration:** _____

Menstrual pattern: **Regular** ◯ **Irregular** ◯

Flow: **Light** ◯ **Moderate** ◯ **Heavy** ◯ **Clots** ◯

Type of sanitary protection:

Panty liner	◯
Thin pad	◯
Maxi pad	◯
Hospital pad	◯
Tampon	◯
Tampon and pad	◯
Other	◯

Change pad/protection every _____

Pain with menstrual cycle:

None	◯
Mild	◯
Moderate	◯
Severe	◯

Family History:

	Mark if deceased	Breast cancer	Colon cancer	Ovarian cancer	Diabetes	Heart disease	High cholesterol	High blood pressure	Deep vein clot	Migraines	Lupus	Rheumatoid disease	Osteoporosis	Seizures	Stroke	Thyroid disease	Other
Patient																	
Mother																	
Father																	
Brother																	
Sister																	
Paternal grandmother																	
Paternal grandfather																	
Maternal grandmother																	
Maternal grandfather																	
Paternal aunt																	
Paternal uncle																	
Maternal aunt																	
Maternal uncle																	

Obstetrical History:

Total number of pregnancies: _____ Number of term deliveries: _____ Number of preterm deliveries: _____ Number of miscarriages: _____

Number of abortions: _____ Number of twin pregnancies: _____ Number of living children: _____ Number of ectopic/tubal pregnancies: _____

Date of birth	Gestational age	Birth weight	Sex	Baby's name	Type of delivery	Anesthesia	Mark if preterm labor	Mark if living	Place of birth	Length of labor

Genetic History (OB patients only):

	Mark if deceased	Patient >35	Anesthesia problems	Ashkenazi Jewish	Autism	Birth Defects	Canavan's disease	Clotting disorders	Congenital heart defect	Cystic Fibrosis	Down syndrome	Eclampsia	Huntington's disease	Mental retardation	Two or more miscarriage	Muscular dystrophy	PKU disease	Preterm birth	Preterm labor	Sickle cell disease	Sickle cell trait	Spina bifida/Neural tube defect	TaySach's disease	Thalassemia	Other
Patient																									
Mother																									
Father																									
Brother																									
Sister																									
Paternal grandmother																									
Paternal grandfather																									
Maternal grandmother																									
Maternal grandfather																									
Paternal aunt																									
Paternal uncle																									
Maternal aunt																									
Maternal uncle																									
Father of baby																									
Father of baby family																									

Social history:

Tobacco use:
- Never user ○
- Everyday user ○
- Someday user ○
- Former user ○
- Heavy user ○
- Light user ○
- Passive exposure ○

If yes, number of packs per day: _____

Alcohol use: Yes ○ No ○

_____ glasses of wine per week
_____ beers per week
_____shots per week
_____mixed drinks per week

Drug use: Type:_____
Number of times per week:_____

Sexually active: Yes ○ No ○
_____number of partners in last year
Male ○ Female ○

Birth control method:

Abstinence	○	IUD	○
Withdrawal	○	Pills	○
Condoms	○	Patch	○
Diaphragm	○	Natural family planning	○
Implant/Nexplanon	○	Spermicide	○
DepoProvera	○	Sponge	○
Inserts	○	Tubal/vasectomy	○

Mark if yes:

- On a special diet ○
- Lost >5-10 lbs unintentionally ○
- Difficulty swallowing ○
- Refuse blood transfusions ○
- Homeless/housing problems ○
- In drug/alcohol treatment ○
- Domestic violence/abuse ○
- Feel would be better off dead ○
- Need help walking ○
- Transportation problems ○
- Separated from father of baby ○
- History of forced sex/coercion ○
- Thoughts of self- harm ○
- Live alone ○
- Fallen in the past year ○
- History of abuse/violence ○
- Recent death of loved one ○

Occupation: _____

Partner/spouse name:_____

Notice of Information Practices

This notice describes how medical and other personal information about you may be used and disclosed. It also describes how you can get access to this information. Please review the notice carefully.

You entrust us with individually identifiable personal health and financial information (referred to as "personal health information" in the rest of this notice). You are our best and most important source of information about you.

We may also collect personal information about you from others.
For example, we may collect personal health information from other health care providers, employers, educational entities, and the judicial system, insurance companies or other community referral sources or partners.

Examples of Information We May Collect and Maintain Include:

Your name, address, telephone number, social security number, date of birth, marital status, income, email address, policy or account number, account balance, policy coverage, premium payment, claims history, medical information, motor vehicle reports, details about your transactions with state or federal agencies.

In the Following Situations, We May Use and/or Disclose Your Personal Health Information Without Your Authorization:

- To provide treatment.
- To obtain payment for treatment.
- To evaluate the quality of care that you receive.
- To an insurance authority.
- Performing mandatory licensing and regulatory compliance functions.
- For payment such as using details received from an insurance company to coordinate benefits.
- For payments such as to a health care provider to identify insurance coverage or benefits.
- For health care operations to detect or prevent criminal activity, fraud and material misrepresentation.
- For public health activities such as to prevent or control disease, injury, or disability.
- To health oversight agencies for compliance purposes.
- In response to a court or administrative order.
- In response to a subpoena, discovery request, or other lawful process by another person in a dispute.
- For law enforcement purposes.
- To avert a serious threat to health or safety to you, another person, or the public.
- To federal officials for intelligence, counterintelligence, and other national security activities.
- To worker's compensation or other programs that provide benefits for work-related injuries or illness.

Those who act on our behalf

Agencies who receive your personal information from Women's Health Care are required to keep your personal health information confidential. They are required to use the personal health information only to provide the services we have asked them to provide.

All Other Users and Disclosures of Personal Information

Women's Health Care will not disclose any of your personal health information for any marketing purposes. All other uses and sharing of personal health information, are not permitted or required by law, will be made only with your written authorization. You may revoke this authorization in writing. If you do, we will no longer use or share the information for the reason covered by the authorization-unless we have taken prior action based on the authorization. We are unable to withdraw any disclosures we have already made with your authorization.

Your Rights Regarding Your Personal Health Information:

- To inspect and obtain a copy of your personal health information. Copies will be provided for a fee.
- To request that we amend your personal health information. We will consider your request, but are not legally bound to accept your amendment.
- To receive details about our sharing of your personal health information.
- To request special accommodations on how your personal health information is communicated (such as alternative addresses and phones).

Security of Personal Information

We maintain physical, administrative, and technical safeguards to guard your information. We limit employee access to information based on essential job functions.

If there is ever a breach of your protected health information, we are required, by law, to notify you in writing, within 30 days of the breach.

We are required to keep your personal information private. We are providing this notice of our legal duties and privacy practices. We will abide by the terms of this notice as currently in effect.
If you believe that your privacy rights have been violated, you may send a written complaint to Women's Health Care. You may also write the Secretary of the Department of Health and Human Services. We will not take any action against you for filing this complaint.

We reserve the right to change the terms of our notice. We reserve the right to make the new notice apply to all personal information that we maintain. We will provide a new copy of any material change at your next office visit. We can also mail you a copy to your last known address.

Notice of Rights and Responsibilities

I certify by signing below that I have received, read, and understand the Notice of Information Practices and have had the opportunity to ask questions regarding the above, as well as, any questions regarding my registration with Women's Health Care.

Patient or Patient's Representative Date **Witness Date**

NOTICE TO OBSTETRIC PATIENT

(See Section 766.316, Florida Statutes)

I have been furnished information by Women's Health Care prepared by the Florida Birth-Related Neurological Injury Compensation Association (NICA), and have been advised that Women's Health Care is a participating facility in that program, wherein certain limited compensation is available in the event certain neurological injury may occur during labor, delivery or resuscitation. For specifics on the program, I understand I can contact the Florida Birth-Related Neurological Injury Compensation Association, P.O. Box 14567, Tallahassee, Florida, 32317-4567, 1-800-398-2129. I further acknowledge that I have received a copy of the brochure prepared by NICA.

Dated this _____ day of _____, 2015.

_____

Patient Signature

_____

Printed Name of Patient

Social Security # _____

Attest:

_____

Representative of Women's Health Care

Date: _____

***This form is informational only, and each person, participating physician or hospital should contact their own attorney to ensure compliance with Section 766.316, Florida Statutes.**