Comprehensive WOMEN'S HEALTHCARE

Patient Information Record

Patient will be responsible for all charges if form is not entirely complete.

Patient Name _____ (Last / First / M.I.) Nickname _____

Age _____ Gender ☐ M ☐ F Gender Identity _____ Marital Status S M W D Sep. DP

DOB _____ SS# _____ Sexual Orientation _____ Race/Ethnicity _____

Mailing Address _____ City State Zip

Email _____ Home Phone _____

Cell Phone _____ Work Phone _____

Preferred Phone ☐ Cell ☐ Home ☐ Work Preferred Method for Reminder Calls VM Text Email

Employer _____ Occupation _____

Patient's Primary Care Doctor _____ Phone _____

How did you hear about our office? _____

Emergency Contact _____ Relationship _____ Phone _____

Spouse or Parent (if minor) _____ Phone _____

Primary Insurance Company _____ Name of Insurance

Claims Address _____ City State Zip

Phone _____ Effective Date _____ Co-Pay _____

ID/Policy # _____ Group # _____

Policyholder's Name _____ Relationship to Patient _____

Date of Birth _____ Policyholder's SS# _____ Phone _____

Policyholder's Employer _____

Other Insurance Company _____ Name of Insurance

Claims Address _____ City State Zip

Phone _____ Effective Date _____ Co-Pay _____

ID/Policy # _____ Group # _____

Policyholder's Name _____ Relationship to Patient _____

Date of Birth _____ Policyholder's SS# _____ Phone _____

Policyholder's Employer _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize payments of medical benefits to the provider for services rendered, or to be rendered in the future, without obtaining my signature on each claim submitted, and understand the signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary, I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedures.

_____ Responsible Party Signature

_____ Date

COMPREHENSIVE WOMEN'S HEALTHCARE

INSURANCE AND FINANCIAL POLICY

Welcome to Comprehensive Women's Healthcare. We are committed to providing you with the best possible care and treatment that may or may not be covered by your insurance.

We currently participate with most major insurance plans. Insurance is a contract between you and your insurance company. **It is your responsibility to know your benefits.** If you are unsure of your benefits, you will need to contact your insurance company for clarification of your benefits.

1. We will bill your insurance company for any services rendered. You must present your insurance card at the time of your visit. **Without your insurance card, your appointment will be rescheduled. Co-payments are due on the day of service and must be paid on the day of the appointment. We accept cash, personal checks, checks, debit cards, VISA, Mastercard, Discover and American Express.**

   If you do not have insurance, payment in full is due on the day of service or your appointment will be rescheduled.

   If your insurance company requires a referral from your primary care physician for your appointment, you must contact their office prior to your appointment. **We cannot see you without a valid referral for your appointment.**

2. Our office will bill your insurance company(s) based on the information you provided. Upon conclusion of the insurance billing process, you may be responsible for a co-pay, a balance owed after insurance or a deductible. If an amount is due, we will send you a courtesy billing statement. If the bill is not paid within thirty (30) days, we reserve the right to assign the past-due amount to our outside collection agency. You hereby agree to pay any imposed collection charge fee up to 33% of the amount owed in the event the account is referred to our outside collection service.

3. If you are unable to keep your appointment, please notify our office as soon as possible. We would like to offer an available appointment to another patient. **"No-Show"** appointment will be subject to a **$50 fee.** If you are going to be more than 15 minutes late, we must receive a phone call to confirm we can keep your appointment, otherwise your appointment will need to be rescheduled.

4. A NSF, non-sufficient, fee of $35 will be applied to each returned check.

5. Request for medical records, for personal use, to other physicians, insurance companies etc. can take up to two weeks to process. There will be a $25 fee to patients after the first request for additional copies. To avoid this fee, patients will need to make additional copies for their personal file.

6. Procedure cancellations require 72 hours' notice. If notice is not provided, a $100 fee will be charged.

I have read the above Insurance and Financial Policy and agree to these terms.

_____ _____

Patient/Responsible Party Signature Date

Patient Printed Name: _____

Initial if you have received a copy of policy/agreement. _____

Comprehensive
WOMEN'S HEALTHCARE

ACKNOWLEDGEMENT OF RECEIPT OF COMPREHENSIVE WOMEN'S HEALTHCARE'S NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the opportunity to review a current copy of Comprehensive Women's Healthcare's "Notice of Privacy Practices". My signature means that I understand the terms of this notice. Please return this acknowledgement of receipt of notice to Comprehensive Women's Healthcare. I understand that I may refuse to sign this acknowledgement.

_____ _____

Printed name of patient or legally authorized individual Date & Time

_____ _____

Signature of the patient or legally authorized individual Date & Time

_____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

_____

For Office Use Only

_____

Comprehensive Women's Healthcare could not obtain a written acknowledgement of receipt of our Notice of Privacy Practice due to:

_____ Individual refused to sign

_____Communication barrier prohibited it

_____An emergency situation prevented us

_____Other (please specify)

_____

_____

Comprehensive Women's Healthcare
1760 E. Pecos Road, Ste. 235
Gilbert, AZ 85295
Phone: (480) 813-0944
Fax: (480) 813-0038

Medical Information Authorization

Patient Name: _____

DOB: _____

I understand that my information will only be shared with those involved with the maintenance of my care and individuals that I provide the office permission to speak with regarding results or my medical information. Please list all names and phone numbers of individuals you allow our office to release information to if needed:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

This authorization is valid from _____ to _____
(Start Date) (End Date)

☐ I decline to list any authorized individuals to receive information about my care/results.

Please indicate which information can be disclosed:

☐ Pap Smear Reports	☐ Operative Reports	☐ HIV
☐ Pathology Reports	☐ Pre-Natal Records	☐ H&P
☐ Medication Log	☐ Labs/X-Ray/Ultrasound Reports	☐ Discharge Summary
☐ Progress Notes		☐ **ALL RECORDS**

☐ Other: _____

_____ _____
Patient Signature Date

_____ _____
Comprehensive Women's Healthcare Staff Witness Date

Comprehensive
WOMEN'S HEALTHCARE

Patient Name:_____ DOB:_____ Today's Date:_____

Patient Office Policy Agreement

We, at CWH strive for excellent patient care in a positive and caring environment. We want to maintain a healthy atmosphere for both staff and patients that is safe, clean and enjoyable. **Please read the following established office policies and *initial each indicated line, acknowledging your understanding.***

_____ **Initial – Cell Phones**
Please be courteous of the other patients and staff. Please turn off all cell phones and/or pagers during your visit with the doctor. Individual uninterrupted attention is very important when it comes to your health.

_____ **Initial – Treatment of Staff**
Any inappropriate treatment of staff will be a cause for discharge from our practice, this includes but is not limited to aggressive or threatening behavior towards the staff, use of foul/bad language towards staff and/or any other behavioral, verbal, or written communication, which is deemed inappropriate towards staff.

_____**Initial – Good communication/Appointment Reminder**
Good communication is crucial between patient and doctor. We have an automated courtesy reminder system that will send an initial text or email at the time of scheduling, a 2-day reminder via the method you choose (text/call/email) prior to your appointment. **Do not depend on automated reminder system; you are still responsible for keeping your appointments when scheduled.**

_____ **Initial – Constructive Criticism**
Constructive criticism of our practice is welcome. We do reserve the right to discharge anyone from the practice in the event of patient non-compliance of care, the breakdown in communication and/or willful slander/putting derogatory comments about our practice in person or on social media.

_____ **Initial – Office Appearance**
Please be courteous when in the lobby, using the restrooms or while in an exam room to be sure all trash is thrown away in a receptacle. Please don't leave a mess, leave it as tidy as it was before.

By signing this form, you acknowledge that you are aware of this policy and understand your responsibilities.

Patient Name (print): _____

X_____ Date: _____
Signature of the patient or responsible party

Please fill in all information on front and back of form **PLEASE USE BLACK INK ONLY**

Today's Date_____

Name_____ Date of Birth ____/____/_____

Referred by _____ Primary Care Doctor _____

Reason for today's visit _____ Pharmacy Address & Phone # _____

Menstrual History

First day of last period ____/____/____ Age at first period _____

Your periods occur every _____days and last for _____days

Any problems with your periods? ☐ No ☐ Yes

☐ Heavy flow ☐ Clots ☐ Pain/Cramping ☐ Irregular periods ☐ Discharge

☐ Bleeding between periods ☐ Other_____

If menopausal

Age/year began_____ Any Postmenopausal bleeding? ☐ No ☐ Yes

Did you/are you taking hormones? Yes No

Gynecological History

Have you had any of the following? (Check all that apply)

☐ Abnormal Pap Smear ☐ Breast Pain ☐ Chronic Pelvic Pain

☐ DES Exposure ☐ Endometriosis ☐ Genital Warts

☐ Infertility ☐ Ovarian Cysts ☐ Pain with Intercourse

☐ PID ☐ PMS ☐ Recurrent Miscarriage

☐ Recurrent Vaginitis ☐ STD _____

☐ Urinary Incontinence ☐ UTI (chronic) ☐ Uterine Fibroids

☐ **None of the above** *(additional medical history on the back of form)*

Contraceptive History

Are you currently sexually active? ☐ Yes ☐ No ☐ Never been

How many life time partners? _____ How many in the last year?_____

Current method of birth control (Include tubal or vasectomy)_____

Any problems with current method? ☐ No ☐ Yes _____

Previously used methods (Check all that apply)

☐ Birth Control Pill ☐ Condoms ☐ Diaphragm ☐ Depo Provera ☐ IUD

☐ NuvaRing ☐ Implanon ☐ Nexplanon ☐ Spermicide ☐ Sponge ☐ Other

☐ No previous birth control

Preventive Care History

Last WWE: _____

Last Pap Smear Date:_____ ☐ Normal ☐ Abnormal

Last Mammogram Date: _____ ☐ Normal ☐ Abnormal

Last Colonoscopy Date:_____ ☐ Normal ☐ Abnormal

Last DEXA (Bone Scan) Date: _____ ☐ Normal ☐ Abnormal

Last Cologuard Date: _____ ☐ Normal ☐ Abnormal

Vaccinations (year) Gardasil _____ Flu _____

Hepatitis B _____ TDAP (Tetanus) _____

Total Pregnancies	Full Term Deliveries	Premature Deliveries	Elective Terminations	Miscarriages	Ectopics	Multiples	Living

Date MM/DD/YYYY	Gestation Age #Wks@Delivery	Hours in Labor	Birth Weight	Sex	Type of Delivery	Type of Anesthesia	Early Labor	Comments/Complications Gestational Diabetes	Hospital

Your age at first delivery:

Surgical History (Please list all surgical procedures) ☐ None

Surgery_____ Date_____

Surgery_____ Date_____

Surgery_____ Date_____

Surgery_____ Date_____

Surgery_____ Date_____

Allergy History (List all medication allergies and reaction) ☐ None

Allergy_____ Reaction_____

Allergy_____ Reaction_____

Allergy_____ Reaction_____

Allergy_____ Reaction_____

Allergy_____ Reaction_____

Current Medication History

(Please include current prescriptions and medications ONLY) ☐ None

Drug name_____ Dose_____

Drug name_____ Dose_____

Drug name_____ Dose_____

Drug name_____ Dose_____

Drug name_____ Dose_____

Drug name_____ Dose_____

Social & Lifestyle History

Marital Status_____ Occupation_____

Tobacco Smoker ☐ Never ☐ Former ☐ Current - Amt/Day_____

Alcohol Use ☐ No ☐ Yes If yes, Amt/Wk_____

Caffeine Use ☐ No ☐ Yes Street Drugs/Marijuana use ☐ No ☐ Yes

Domestic Abuse ☐ No ☐ Yes If yes, ☐ Current or ☐ Past

Regular Exercise ☐ No ☐ Yes Type_____ Amt/Wk_____

Monthly Breast Exam ☐ No ☐ Yes Have you had Chicken Pox ☐ No ☐ Yes

Do you have a Health Care Directive (living will) ☐ No ☐ Yes

Past Medical History

Indicate Relationship

Anemia	☐ Self	☐ Family ->
Anxiety	☐ Self	☐ Family ->
Asthma	☐ Self	☐ Family ->
Blood Clotting Disorder	☐ Self	☐ Family ->
Cancer; Breast	☐ Self	☐ Family ->
Cancer; Cervical	☐ Self	☐ Family ->
Cancer; Colon	☐ Self	☐ Family ->
Cancer; Ovarian	☐ Self	☐ Family ->
Cancer; Skin-type:_____	☐ Self	☐ Family ->
Cancer; Uterine	☐ Self	☐ Family ->
Cancer; Other ->	☐ Self	☐ Family ->
Cardiac Arrhythmia	☐ Self	☐ Family ->
Coronary Artery Disease	☐ Self	☐ Family ->
Crohn's Disease	☐ Self	☐ Family ->
Cystic Fibrosis	☐ Self	☐ Family ->
Deep Vein Thrombosis (DVT)	☐ Self	☐ Family ->
Depression	☐ Self	☐ Family ->
Diabetes-type:_____	☐ Self	☐ Family ->
Eating Disorder-type:_____	☐ Self	☐ Family ->
Gastric Ulcer	☐ Self	☐ Family ->
Gastroesophageal Reflux Disease	☐ Self	☐ Family ->
Gestational Diabetes	☐ Self	☐ Family ->
Hepatitis-type:_____	☐ Self	☐ Family ->
Hyperlipidemia (High Cholesterol)	☐ Self	☐ Family ->
Hypertension (High Blood Pressure)	☐ Self	☐ Family ->
Irritable Bowel Syndrome	☐ Self	☐ Family ->
Kidney Stones	☐ Self	☐ Family ->
Lupus	☐ Self	☐ Family ->
Migraines	☐ Self	☐ Family ->
Multiple Sclerosis	☐ Self	☐ Family ->
Osteoporosis	☐ Self	☐ Family ->
Parkinson's Disease	☐ Self	☐ Family ->
Pulmonary Embolism	☐ Self	☐ Family ->
Rheumatoid Arthritis	☐ Self	☐ Family ->
Scoliosis	☐ Self	☐ Family ->
Seizures	☐ Self	☐ Family ->
Sickle - Cell Disease	☐ Self	☐ Family ->
Sleep Apnea/Disorder	☐ Self	☐ Family ->
Stroke	☐ Self	☐ Family ->
Thyroid Disorder-type:_____	☐ Self	☐ Family ->
Tuberculosis	☐ Self	☐ Family ->
Ulcerative Colitis	☐ Self	☐ Family ->

Other Medical History we should know about -> _____

Are there any other problems that are important to you today?

☐ No ☐ Yes _____

_____

_____

Patient Signature:_____

Experiencing Today / Recently

Review of Systems - You are currently having any of the following:

Constitutional	Fever	☐ Yes	☐ No
	Chills	☐ Yes	☐ No
	Sweats	☐ Yes	☐ No
	Weight loss	☐ Yes	☐ No
	Weight gain	☐ Yes	☐ No
	Fatigue	☐ Yes	☐ No
Eyes	Impaired Vision	☐ Yes	☐ No
Head, Ears, Nose, & Throat	Headaches	☐ Yes	☐ No
	Sinus Congestion	☐ Yes	☐ No
Breast	Lumps	☐ Yes	☐ No
	Tenderness	☐ Yes	☐ No
	Swelling	☐ Yes	☐ No
	Nipple Discharge	☐ Yes	☐ No
Cardiovascular	Chest pain	☐ Yes	☐ No
	Loss of Consciousness	☐ Yes	☐ No
Respiratory	Shortness of breath	☐ Yes	☐ No
	Wheezing	☐ Yes	☐ No
	Cough	☐ Yes	☐ No
Gastrointestinal	Nausea	☐ Yes	☐ No
	Vomiting	☐ Yes	☐ No
	Diarrhea	☐ Yes	☐ No
	Constipation	☐ Yes	☐ No
	Blood in stools	☐ Yes	☐ No
Genitourinary	Urinary urgency	☐ Yes	☐ No
	Urinary frequency	☐ Yes	☐ No
	Urinary Incontinence	☐ Yes	☐ No
	Blood in urine	☐ Yes	☐ No
Integument (Skin)	Rash	☐ Yes	☐ No
	Change in moles, lesions	☐ Yes	☐ No
	Change in hair growth/loss	☐ Yes	☐ No
Neurologic	Muscular weakness	☐ Yes	☐ No
	Incoordination	☐ Yes	☐ No
	Tingling or numbness	☐ Yes	☐ No
Musculoskeletal	Joint pain	☐ Yes	☐ No
	Muscle pain	☐ Yes	☐ No
Endocrine	Excessive thirst	☐ Yes	☐ No
	Excessive urination	☐ Yes	☐ No
	Temperature intolerance	☐ Yes	☐ No
Psychiatric	Anxiety	☐ Yes	☐ No
	Depression	☐ Yes	☐ No
	Feeling Confused	☐ Yes	☐ No
	Difficulty Sleeping	☐ Yes	☐ No
	Excessive Anger	☐ Yes	☐ No
Heme-Lymph	Easy bleeding	☐ Yes	☐ No
	Easy bruising	☐ Yes	☐ No
	Swollen lymph glands	☐ Yes	☐ No
Allergic-Immunologic	Sinus allergy symptoms	☐ Yes	☐ No
	Frequent illnesses	☐ Yes	☐ No

Height:

Weight:

BP:

Reviewed by:_____

Family and Patient History
Does your family or the father of the baby's family have the following ethnic background:

Yes	No	
_____	_____	Southeast Asia, Taiwan, China, or the Philippines
_____	_____	Italy, Greece, or the Middle East

If yes to the previous two questions, have you or your partner been tested for thalassemia? Yes_____No_____

Yes	No	
_____	_____	Eastern European (Ashkenazi) Jewish
_____	_____	French Canadian

If yes to the previous two questions, have you or your partner been tested for Tay Sachs? Yes_____No_____

Yes	No	
_____	_____	African American, African, or Black

If yes to the previous question, have you or your partner been tested for sickle cell anemia? Yes_____No_____

Have you, the baby's father, or anyone in either of your families ever had any of the following?
If "yes", please explain at the bottom in the space provided:

Yes	No	
_____	_____	Down Syndrome
_____	_____	Other Chromosome Abnormalities
_____	_____	Neural Tube Defect (e.g. spina bifida, anencephaly)
_____	_____	Hemophilia or Other Bleeding Disorders
_____	_____	Cystic Fibrosis
_____	_____	Sickle Cell Anemia
_____	_____	Thalassemia(Mediterranean anemia)
_____	_____	Tay Sach's Disease
_____	_____	Muscular Dystrophy
_____	_____	Neurofibromatosis
_____	_____	Huntington's Disease
_____	_____	Other Nerve, Muscle or Seizure Disorder (e.g. epilepsy)
_____	_____	Phenylketonuria (PKU)
_____	_____	Kidney Disease
_____	_____	Heart Defect (from birth)
_____	_____	Cleft Lip and/or Cleft Palate

_____ _____ Limb Defects (extra or missing digits, malformed arms, legs, hands or feet)

_____ _____ Deafness / Early Onset Hearing Loss

_____ _____ Blindness / Early Onset Vision Loss

_____ _____ Diabetes

_____ _____ Cancer before age 50

_____ _____ Heart Attack before age 40

_____ _____ Do you or the baby's father have any relatives with mental retardation or developmental delay?

Yes **No**

_____ _____ Does anyone in either of your families have a genetic defect, or chromosome abnormality not listed above?

_____ _____ Have you or the baby's father had a baby that died shortly after birth or in the first year?

_____ _____ Have you or the baby's father had a stillborn child, or three or more first trimester miscarriages?

_____ _____ Are you and the baby's father blood-related in any way (i.e., cousins, uncle-niece, etc.)?

_____ _____ Is there any other family history that you have concerns about?

Pregnancy History

During this pregnancy, have you had any of the following? If "yes", please describe, including dates, if known, in the space provided at the bottom:

Yes **No**

_____ _____ Uterine cramping, vaginal bleeding (spotting) or vaginal leakage of fluid

_____ _____ Infections, rashes, or other illness, fever over 101 degrees

_____ _____ X-rays, hospitalizations, or surgery

_____ _____ Cigarettes, alcoholic beverages, or "street" drugs

_____ _____ Ultrasound ("sonogram")

_____ _____ Occupational, chemical, or other exposures

_____ _____ Prescription or non-prescription medications

_____ _____ Prenatal vitamins

Comments from above

_____

_____

_____

_____

_____

_____

My signature below indicates that the above family and pregnancy history information provided is complete and correct.

_____ _____

Signature of person completing form Today's date