Arcadia Well Woman

PATIENT REGISTRATION

(PLEASE PRINT CLEARLY)

NAME____ SOCIAL SECURITY NO.______________________
LAST FIRST MI

DATE OF BIRTH______________ GENDER_________ MARITAL STATUS ___________________

ADDRESS____
CITY STATE ZIP

HOME PHONE NO.______________________________ CELL PHONE NO.____________________________________

RACE______________ ETHNICITY ______________________ LANGUAGE _____________

EMAIL (required for online patient portal) ____

PREFERRED PHARMACY NAME _____________________PHONE NUMBER_______________CROSS STREETS __________________

OCCUPATION________________________ PLACE OF EMPLOYMENT____

MAY WE TEXT MESSAGE YOUR CELL PHONE? YES___ NO___ PREFERRED METHOD OF CONTACT: Cell ___ Portal ___ Home ___

HOW DID YOU HEAR ABOUT OUR OFFICE? ________________________________

INSURANCE INFORMATION

PLEASE PRESENT YOUR INSURANCE CARD DURING REGISTRATION

INS CO_____________________ CLIAMS ADDRESS ON BACK OF CARD ____

GROUP # OR NAME______________________________ INSURANCE ID NO.____________________________________

POLICY HOLDER/RESPONSIBLE PARTY_____________________________ RELATIONSHIP TO PATIENT_________________

POLICY HOLDER ADDRESS____ SSN_________________________

PLACE OF EMPLOYMENT______________________DAY PHONE NO.________________ EVENING PHONE NO.____________

DO YOU HAVE SECONDARY INSURANCE? YES____ NO_____

SECONDARY INS. CO___________________ SECONDARY INS. ADDRESS____

GROUP # OR NAME_____________________________ INSURANCE ID NO._____________________________________

POLICY HOLDER/RESPONSIBLE PARTY__________________________ RELATIONSHIP TO PATIENT___________________

POLICY HOLDER ADDRESS____ SSN_________________________

PLACE OF EMPLOYMENT________________________ DAY PHONE NO._______________ EVENING NO._____________

Emergency Contact

NAME_______________________________ RELATIONSHIP TO PATIENT_________________________________

ADDRESS____ BEST CONTACT NUMBER______________________

AUTHORIZATION TO PAY BENEFITS TO PHYSICAN AND TO RELEASE/ACQUIRE INFORMANTION: I HEREBE AUTHORIZE RELEASE OF MEDICAL INFORMATION AND DIRECT PAYMENT TO ARCADIA WELL WOMAN FOR SERVIES RENDERED IN THE COURSE OF MY EXAMINATION AND/OR TREATMENT. I ALSO AUTHORIZE ARCADIA WELL WOMAN TO ACCQUIRE INFORMATION RELATED TO MY MEDICAL AND MEDICATION HISTORY.

SIGNATURE OF PATIENT OR GUARDIAN____ DATE ____________________________

WOMEN'S HEALTH INTAKE FORM

TODAY'S DATE: _______/_______/_______ AGE: _____________

NAME: ____ BIRTH DATE: _______ /______/_______

HEIGHT: _____________________

PRIMARY CARE PROVIDER: ____

Are you here for a Well Woman Exam ☐ No ☐ Yes or a Problem Visit? ☐ No ☐ Yes

Anything you want to talk to your provider about:

____

____

ALLERGIES

Name	Reaction

MEDICATIONS

DRUG NAMES	DOSAGE	DRUG NAMES	DOSAGE

CURRENT VACCINES

NAME	DATE	NAME	DATE

GYN HISTORY

What is the first day of your last menstrual period? ______________
Do you have a monthly menses? Yes ☐ No ☐
How many days does your cycle last? _____________
(Circle one) Is your bleeding: light moderate heavy
What age did you start having menses? ______________
How many days apart are your menstrual cycles starting from the first day of one cycle to the first day of your next cycle?________

Are you currently using birth control? Yes ☐ No ☐ Trying to get pregnant? Yes ☐ No ☐
Current birth control: ___________________________ Are you satisfied with it? Yes ☐ No ☐

Past birth control methods:

Condoms	☐	Birth control pills	☐	Withdrawal	☐	Tubal Ligation	☐
Diaphragm	☐	Patch	☐	Rhythm	☐	Vasectomy	☐
Nexplanon	☐	Vaginal Ring	☐	IUD	☐	Essure	☐

When was your last PAP smear? _________________________
Have you ever had an abnormal Pap smear? Yes ☐ No ☐ When? _____________
What abnormality? _____________________________________
Have you had a Colposcopy? Yes ☐ No ☐ When? _____________
Did you have the HPV vaccine? Yes ☐ No ☐

Most recent Mammogram? ____________________
Most recent Bone Density? ______________________
Most recent Colonoscopy? ______________________

Are you currently sexually active? Yes ☐ No ☐ Never ☐
Do you practice protected sex? Yes ☐ No ☐
Have you had more than 5 sexual partners in your lifetime? Yes ☐ No ☐
Did you begin sexual activity before 16 years old? Yes ☐ No ☐
Do you have any sexual problems? Yes ☐ No ☐

Sexual Partner Preference (Circle One): Men Women Both Prefer not to Answer

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Have you ever been treated for: ☐ Chlamydia ☐ Gonorrhea ☐ Genital Warts
☐ Herpes ☐ Trichomonas ☐ Syphilis

Have you ever tested positive for HIV? Yes ☐ No ☐

PREGNANCY HISTORY

	Number		Number		Number
Total times pregnant		Full term deliveries		Premature deliveries	
Abortions		Miscarriages		Ectopic	
Multiple births (i.e. twins)		Living children		Cesarean sections	
Deliveries before 37 weeks		Forceps or vacuums			
Describe any special pregnancy problems:					

FAMILY HISTORY

	YES		YES		YES
Diabetes		Heart Disease		Anxiety	
High Blood Pressure		High cholesterol		Depression	
GI Reflux Disease		Hepatitis		Seizures	
Other GI disease		Liver problem		Asthma	
Fibroids		Kidney infections/stones		Lung disease	
Endometriosis		Arthritis		Tuberculosis	
Osteopenia		Joint pain		Thyroid disease	
Osteoporosis		ADHD		Clotting disorder	
Cancer (Type)					
Add others/Explain:					

PERSONAL SOCIAL HISTORY

Tobacco Smoking: Yes ☐ No ☐ Packs/day ________ Years ________ Quit when: ________
Smokeless Tobacco Smoking: Yes ☐ No ☐ Years ________ Quit when: ________
E-Cigarette/Vape Smoking: Yes ☐ No ☐ Years ________ Quit when: ________
Alcohol Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
Caffeine Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
Recreational Drugs: Yes ☐ No ☐ Type: ________________________________

Occupation: ____

Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner ☐
Education Level: High School ☐ College ☐ Graduate Degree ☐ Other ☐
Exercise Level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
Special Diet: Yes ☐ No ☐ Type: ____

Do you routinely use seatbelts? Yes ☐ No ☐
Do you routinely use sunscreen? Yes ☐ No ☐
Do you have an advance directive on file? Yes ☐ No ☐
Do you have a gun in your home? Yes ☐ No ☐ If yes, is it in a secure location? Yes ☐ No ☐

Yes ☐ No ☐	Has anyone, including you partner, every forced you to have sex?
Yes ☐ No ☐	Are you ever afraid of your partner?

Do you live alone? Yes ☐ No ☐

Do you have pets? Yes ☐ No ☐ What kind? ___________________________

Do you feel safe at home? Yes ☐ No ☐

Did your mother take the drug DES when she was pregnant with you? Yes ☐ No ☐

SURGICAL HISTORY

SURGERY	YEAR	SURGERY	YEAR

PERSONAL PAST MEDICAL HISTORY

	YES		YES		YES
ADHD		Cancer		Herpes	
Abuse/Domestic Violence		Coronary Artery Disease		High Cholesterol	
Acid/GI Reflux disease		Depression		Hypertension	
Acne		Diabetes		Infertility	
Anemia		Eating Disorder		Kidney/Bladder Issues	
Anxiety		Eczema		Liver Disease	
Arthritis		Endometriosis		Lung Disease	
Asthma		Fibromyalgia		Osteoporosis	
Birth Defect/Inherited Disease		GI Problems		Ovarian Cancer	
Blood Clotting Disorder		Headaches/Migraines		PCOS	
Blood Transfusions		Heart Disease		Pre-Eclampsia	
Breast Cancer		Heart Problems		Stroke	
Breast Problem		Hepatitis		Thyroid Issues	
Add others/Explain:					

SCREENING

Over the last two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed, or hopeless?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

REVIEW OF SYSTEMS (Please Mark any Current Symptoms)

1. CONSTITUTIONAL		NOTES
Fever	☐	
Chills	☐	
Fatigue	☐	
Weight Loss	☐	
Weight gain	☐	
2. EYES		
Changes in vision	☐	
Double vision	☐	
3. ENT/ MOUTH		
Ear aches / Ringing	☐	
Sinus problems	☐	
Sore throat	☐	
Mouth sores	☐	
Dry Mouth	☐	
4. CARDIOVASCULAR		
Chest pain	☐	
Difficulty breathing on exertion	☐	
Swelling of legs	☐	
Palpitations	☐	
Heart Murmurs	☐	
5. RESPIRATORY		
Wheezing	☐	
Spitting up blood	☐	
Shortness of breath	☐	
Cough	☐	
6. GASTROINTESTINAL		
Diarrhea	☐	
Constipation	☐	
Nausea/vomiting	☐	
Bloody stool	☐	
Abdominal pain	☐	
Indigestion	☐	
Bloating	☐	
Liver problem/Hepatitis	☐	
7. GENITOURINARY		
Blood in urine	☐	
Pain with urination	☐	
Urgency / Frequency	☐	
Urinary Incontinence	☐	

7. GENITOURINARY		NOTES
Abnormal Bleeding	☐	
Vaginal discharge/ odor	☐	
Vaginal itching/ burning	☐	
Pelvic pain	☐	
Menstrual cramps	☐	
Painful intercourse	☐	
Genital lump	☐	
Fertility concerns	☐	
Menopausal concerns	☐	
8. MUSCULOSKELETAL		
Joint stiffness	☐	
Joint pain	☐	
Joint swelling	☐	
9. SKIN/ BREAST		
Breast pain	☐	
Nipple discharge	☐	
Breast lumps	☐	
Rash	☐	
Ulcers	☐	
11. PSYCHIATRIC		
Depression	☐	
Mood swings	☐	
Anxiety	☐	
Suicidal thoughts	☐	
Homicidal thoughts	☐	
12. ENDOCRINE		
Abnormal thirst	☐	
Hot flashes	☐	
Tremors	☐	
Cold/ Heat intolerance	☐	
13. HEMATOLOGIC		
Frequent bruising	☐	
Cuts do not stop bleeding	☐	
Enlarged lymph nodes	☐	

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: ____________________________________

Date of Birth: ____________________________________ **Date completed**:____________________________________

Instructions: This is a screening tool for the common features of hereditary cancer syndromes. If you circle Y (yes) for any statement below, you may be appropriate for hereditary cancer testing. Please note all 1st, 2nd and 3rd degree relatives.

Mother/Father/Sister/Brother/Children = **1st Degree Relatives**

Aunt/Uncle/Grandparent/Niece/Nephew = **2nd Degree Relatives**

Cousin/Great Grandparent = **3rd Degree Relatives**

BREAST AND OVARIAN CANCER	**Maternal**	**Paternal**	**RELATIONSHIP**	**AGE AT DIAGNOSIS**
Y N - Breast Cancer at age 45 or younger (in self, 1st or 2nd degree relatives)	☐	☐	__________	______
Y N - Ovarian Cancer at **ANY AGE** (in self, 1st or 2nd degree relatives)	☐	☐	__________	______
Y N - Two Relatives with breast cancer on the same side of the family, one breast cancer	☐	☐	__________	______
occurring before age 50	☐	☐	__________	______
Y N - Three or more relatives with breast cancer on the same side of the family at **ANY AGE**	☐	☐	__________	______
Y N - Bilateral Breast Cancer at **ANY AGE**	☐	☐	__________	______
Y N - Triple Negative breast cancer under the age of 60 (receptor status negative for ER, PR, HER2)	☐	☐	__________	______
Y N - Male Breast Cancer at **ANY AGE**	☐	☐	__________	______
Y N - Breast or Ovarian cancer in Ashkenazi Jewish family members (**ANY AGE**)	☐	☐	__________	______
Y N - Pancreatic Cancer with 2 or more breast and/or ovarian cancers on the same side of the family	☐	☐	__________	______
Y N - A family member with a known BRCA Mutation (or in self)	☐	☐	__________	______

Are you Ashkenazi Jewish? ☐ Yes ☐ No

COLON AND UTERINE CANCER	**Maternal**	**Paternal**	**RELATIONSHIP**	**AGE AT DIAGNOSIS**
Y N - Uterine Cancer before age 50	☐	☐	__________	______
Y N - Colorectal Cancer before age 50	☐	☐	__________	______
Y N - Two or more of the following cancers on the same side of the family: colon,	☐	☐	__________	______
Uterine (endometrial), Ovarian, Stomach, Small bowel, Brain, Kidney/Urinary Tract,	☐	☐	__________	______
Ureter or Renal Pelvis **(ANY AGE)**	☐	☐	__________	______
Y N - A family member with a known Lynch Syndrome Mutation (or in self)	☐	☐	__________	______

☐ Patient meets criteria for genetic testing ☐ Patient offered genetic testing

☐ Patient does not meet criteria for genetic testing ☐ **Accepted** ☐ **Declined**

______________________________ ______________________________

Patient's Signature Date Health Care Provider's Signature Date

Arcadia Well Woman

PATIENT AGREEMENT: FOR WELL WOMAN/COMPLETE PHYSICAL EXAM VS. PROBLEM VISIT

Due to time constraints and insurance regulations, our office policy does not allow for both a
Well woman exam/Complete Physical Exam and a **problem visit** at the same time.

I understand that my appointment for today is for:

1.____**My well woman visit/Complete Physical Exam**. Insurance companies define this as a breast exam, pelvic exam, and a pap smear as indicated. It also includes an appropriate screening exam, review of current medical conditions and medications, and labs as included in my policy provisions. A well woman exam does **NOT INCLUDE DETAILED DISCUSSION OR DIAGNOSIS OF MEDICAL PROBLEMS.** I understand that I will need to schedule a problem visit for any problems I am experiencing at a later date.
2.____**My problem visit**. This will require my **well woman visit/complete physical** to be done at a later date, as insurance requires.

My Main Concern is: ____. If time permits I would also like to discuss ____.

Arcadia Well Woman wants to stress the importance of the annual well woman exam/complete physical exam. If you have chosen to see the provider for your problem today, our staff will assist you in making the appointment for your well woman exam/complete physical exam for a later date before you leave the office today. Arcadia Well Woman strongly urges you to keep this appointment and to check with your insurance to see what wellness and preventive benefits are available to you.

_____________________________________ _____________________
Patient's Signature Date

Patient Name: _________________________ DOB: __________________

Arcadia Well Woman

Dale Ann Dorsey, MSN WHNP-BC Mary Frazee, MSN WHNP ARDMS

PATIENT OFFICE POLICIES

Thank you for choosing **Arcadia Well Woman** for your Obstetrics and Gynecology care needs. We are committed to providing you with quality and affordable health care. We are pleased that you have placed your trust and confidence in us. In order to help acquaint you with our practice, we would like to make you aware of the following policies.

INSURANCE: We participate in many insurance plans, including some Medicare and Medicaid. We will attempt to bill whichever insurance you have advised us of as a courtesy. Please help us maintain accurate records by filling out forms legibly, and letting us know whenever there are important changes (like your address, telephone number[s], any changes in your name, your medical insurance, etc.). Contracts with insurances are constantly changing. It is the **patient's responsibility** to call the office prior to your appointment to verify that the office is contracted with your insurance.

KNOW YOUR BENEFITS: Each and every insurance company and plan, including Medicare and Medicaid, has different plans, each with different benefits. Because your health insurance is an arrangement between you and your insurer, you should understand what services are covered under your specific plan. Some insurance companies require referrals or authorizations. It is your responsibility to acquire the appropriate referrals and authorizations prior to your appointment. Your insurer can assist you with any questions you have relative to your own benefits with them. **Arcadia Well Woman cannot be held responsible for informing patients whether a particular service is "covered" or not**. However, our staff will make every effort to try to assist you in understanding your health benefits or supply you with other health plan related resources.

PROOF OF INSURANCE/ID: All patients must complete our patient information form. We must also obtain a copy of your driver's license or photo ID, and current, valid insurance card. If you are unable to present an insurance card at the time of service, or if you are covered by an insurance company with which we are not contracted, we require that you pay in full for services in advance.

COPAYMENTS, COINSURANCE AND DEDUCTIBLES: All copayments, and patient balance of coinsurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure to do so may be considered a breach of your contract with your health plan. We may decline to see patients for non-emergent visits if copayments are not made at the time of the visit.

NONPAYMENT: In the event that your insurance does not pay your claim to us in sixty (60) days, we will transfer the remaining balance to you and will send you a statement. If the account becomes 90 days past due, then the unpaid balance may be turned over to a collection agency. Please be aware that all collection fees and/or legal fees will be owed in addition to the remaining balance.

NON-COVERED SERVICES: Your Arcadia Well Woman provider may provide services that may not be covered as a benefit of your specific plan with your insurer. Patients or Guarantors are financially responsible for any and all services provided that may not be covered by your insurance plan. It is your responsibility to know and understand your specific insurance plan and what benefits are provided.

Arcadia Well Woman

Dale Ann Dorsey, MSN WHNP-BC   Mary Frazee, MSN WHNP ARDMS

PRIVATE PAY/SELF PAY: Payment in full is due at the time of visit, without exceptions.

CANCELLATION POLICY: "NO SHOW" POLICY: Any patient that does not show for their scheduled **office visit** appointment, or fails to cancel prior to 24 hours of their appointment will receive a **$50 charge**. Continual missed appointments or rescheduled appointments with less than 24 hours' notice will be a cause for dismissal from the practice.

OUTSIDE PATHOLOGY, LAB FEES: Biopsy, Pathology and Lab samples sent outside of our office are billed independently of Arcadia Well Woman. You may receive a bill from the outside lab and will be responsible for payment to that facility.

TESTING/TREATMENT: The provider may send out specimens to the laboratory in order to properly diagnose and treat specific and ongoing issues. You may receive a bill from the outside lab and will be responsible for payment to that facility. Your signature at the bottom of this office policy authorizes our providers to treat you, and to recommend and/or order laboratory tests or other specialized tests as indicated for diagnosis for your medical condition.

RETURNED CHECKS: $30.00 Fee for returned checks. If your check is returned from the bank, we may NOT ACCEPT an additional check as payment on your account. Future payments must be made with cash, money order or credit card.

MINOR AGE PATIENTS: In accordance to Arizona state law, a young woman, aged 13 and older can access sexual and reproductive health services (such as STD testing and treatment, birth control and pregnancy testing, etc.) without parental consent. All other health issues do require consent from a parent or legal guardian if the child is under the age of 18. **The parent or legal guardian who brings the minor in for medical attention will be held responsible for payment at the time of services that are rendered**.

I have read and agree with the above Patient Office Policy. I understand the terms and conditions outlined herein as confirmed by my signature below.

____________________	____________________	__________
Patient Name (print)	Patient or Legal Guardian Signature	Date

I acknowledge that I have received and read a copy of Arcadia Well Woman's Notice of Patients Rights.

____

Patient Signature Date

____

Patient Printed Name Date

____

Parent, Guardian,
Responsible Party,
Legal Representative, if any

____

Patients Date of Birth