**New Patient Demographics - Website Form**

MOTHERHOOD TO MENOPAUSE MIDWIFERY CARE

## Patient Demographic Information

**Patient Name** (Last, First, Middle) _____ **Nickname** _____

**Birth Date** _____ **Age** _____ **Sex** _____

**Address** _____ **City, State, ZIP** _____

**Home Phone** _____ **Cell Phone** _____

**Email Address** _____

**Emergency Contact Name** _____ **Emergency Contact Phone** _____

**Marital Status** _____ **Race** _____ **Ethnicity** _____

**Preferred Language** _____ **Employer** _____

**Primary Care Physician** (Name, Address, Phone Number) _____

**How did you hear about us:** *Select one*

☐ Patient Referral ☐ Provider referral:_____ ☐ Insurance referral ☐ Web search

☐ Social Media ☐ Event ☐ Direct Mail or Magazine ☐ Radio/TV ☐ Billboard ☐ Other:_____

## Responsible Party Information (if different than above or if patient is a minor)

**Guarantor Name** (Last, First) _____ **Relationship** _____

**Birth Date** _____ **Sex** _____

**Address** _____ **City, State, ZIP** _____

**Home Phone** _____ **Cell Phone** _____

**Email Address**

## Insurance Information

| | | | |
|---|---|---|---|
| **Primary Insurance** | | **Secondary Insurance** | |
| **Policy Holder Name** | | **Policy Holder Name** | |
| **Relationship to Patient** | | **Relationship to Patient** | |
| **Policy Holder DOB** | | **Policy Holder DOB** | |
| **Policy # / Member ID** | | **Policy # / Member ID** | |
| **Group #** | | **Group #** | |

PLEASE INCLUDE A CURRENT COPY OF YOUR INSURANCE CARD.

**Patient / Guarantor Signature** _____ **Date** _____

MOTHERHOOD TO MENOPAUSE MIDWIFERY CARE

# WOMEN'S HEALTH MEDICAL HISTORY

PAGE 1

Name: _____ DOB: ___/___/_____ Today's Date: ___/___/____

Primary Care Physician: _____ Pharmacy Name/Phone #_____

**REASON FOR YOUR VISIT TODAY:** _____

_____

BLOOD PRESSURE

At what age did menstruation begin? _____

HEIGHT:

What was the first day of your last menstrual period? ___/___/_____

Is your period usually: ❑ light ❑ moderate ❑ heavy (Please check)

WEIGHT:

Is your period regular or irregular? _____ How often? _____

OCCUPATION:

How many days does your period last? _____

If you have begun menopause at what age did you start? _____

## PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS:

| | | | | |
|---|---|---|---|---|
| ❑ Anemia | ❑ Asthma | ❑ Stroke | ❑ Thyroid Problems | ❑ Depression/Anxiety |
| ❑ Mental Illness | ❑ High Blood Pressure | ❑ Heart Problems | ❑ Kidney Problems | ❑ Blood Clots |
| ❑ Diabetes Type 1 | ❑ Migraines | ❑ Osteoporosis/PENIA | ❑ Kidney Stones | ❑ Hypertension |
| ❑ Diabetes Type 2 | ❑ Hepatitis Type: _____ | | ❑ Other: _____ | |

DEPRESSION, ANXIETY PTSD PMS/PMDD ADHD/ADD/OCD

| | DATE | WHERE | RESULTS |
|---|---|---|---|
| Pap Smear | | | |
| Bone density scan | | | |
| Colonoscopy | | | |
| Mammogram | | | |

## PLEASE CHECK IF YOU HAVE HAD ANY OF THE BELOW SURGERIES:

| | | | |
|---|---|---|---|
| ❑ Bladder Surgery | ❑ Appendectomy | ❑ Thyroidectomy | ❑ BSO |
| ❑ Breast Surgery/Mastectomy | ❑ Ovarian Cyst Removal | ❑ Tubal Ligation | ❑ C-Section |
| ❑ Breast Augmentation/REDUCTION | ❑ Lap Hysterectomy | ❑ Gallbladder | ❑ Laparoscopy |
| ❑ Total Abdominal Hysterectomy | ❑ Total Vaginal Hysterectomy | ❑ LEEP/Conization | ❑ D&C |

WERE YOUR OVARIES REMOVED OTHERS:

MOTHERHOOD TO MENOPAUSE MIDWIFERY CARE

# WOMEN'S HEALTH MEDICAL HISTORY



## HAS ANYONE IN YOUR FAMILY EVER HAD ANY OF THE FOLLOWING?

| | Mother | Father | Sibling | Child | Other |
|---|---|---|---|---|---|
| Osteoporosis/PENIA | | | | | |
| Heart Problems/DISEASE | | | | | |
| Stroke | | | | | |
| Uterine Cancer | | | | | |
| Bladder Cancer | | | | | |
| Breast Cancer | | | | | |
| Diabetes Type 1 | | | | | |
| Diabetes Type 2 | | | | | |
| High Cholesterol | | | | | |
| Alzheimer's | | | | | |
| Ovarian Cancer | | | | | |
| Thyroid Problems | | | | | |
| High Blood Pressure | | | | | |
| Colon Cancer | | | | | |

Other: _____

Would you be interested in a genetic screening that tests for breast, colon and ovarian cancer? ❑ Yes ❑ No

Have you received the Gardasil vaccine series? ❑ Yes ❑ No

If so, when did you receive the last vaccine? _____ What series are you on? Please circle. 1 2 3

Have you received the Flu Vaccine? ❑ Yes ❑ No If so, when? _____

**SOCIAL/REPRODUCTIVE HISTORY:** Check all that apply.

### General:

Marital status: ❑ Married ❑ Divorced ❑ Widowed ❑ Single ❑ Domestic Partner

Exercise amount per week: _____

Do you perform self-breast exams? ❑ Yes ❑ No If yes, how often? _____

Are you currently sexually active? ❑ Yes ❑ No

What do you currently use for birth control? Please check all that apply.

❑ IUD-date inserted ___/___/_____ ❑ Vasectomy ❑ Depo Provera ❑ Tubal Ligation ❑ Pills

IUD Type: _____ ❑ Condoms ❑ Nuva Ring ❑ None

MOTHERHOOD TO MENOPAUSE MIDWIFERY CARE

# WOMEN'S HEALTH MEDICAL HISTORY



Have you ever been pregnant? ❑ Yes ❑ No

How many living children do you have? _____

Have you had? ❑ Twins ❑ Triplets ❑ More ❑ N/A

How many of the following have you had?

Ectopic pregnancies _____ Abortions _____

Full term births _____ Premature births _____

Miscarriages _____

## Substance Use:

Smoking and/or tobacco use: ❑ Past/Date quit: _____ ❑ Present Packs per day: _____ ❑ Never

Alcohol use: ❑ Never ❑ Occasionally/Socially ❑ Regular use- Drinks per day_____

Drug use (ex. cocaine, marijuana, meth, narcotics, and prescription drugs): ❑ Past ❑ Present ❑ Never

If yes, what type of drugs? _____ If yes, how often? _____

Caffeine use: ❑ Yes ❑ No How many drinks per day: _____

| History of Abuse: | Yes | No | Past |
|---|---|---|---|
| Do you ever feel like you are verbally or emotionally abused? | ❑ | ❑ | ❑ |
| Are you in a relationship where you are being slapped, hit or kicked? | ❑ | ❑ | ❑ |
| Are you ever forced to have sex when you do not want to? | ❑ | ❑ | ❑ |

## GYN HISTORY: Check all that apply.

Have you ever had any of the following?

❑ Abnormal pap ❑ Fibroids ❑ Endometriosis

❑ Infertility ❑ Ovarian Cyst ❑ Cancer Type: _____

Have you ever had any sexually transmitted diseases?

❑ Chlamydia ❑ Gonorrhea ❑ Trichomonas ❑ Genital Warts ❑ Pelvic Inflammatory Disease

❑ HPV ❑ HIV ❑ Hepatitis C ❑ Syphilis

Are you allergic to any medications? If yes, please list the medication as well as your reaction.

_____

_____

_____

Are you allergic to any of the following? ❑ Latex ❑ Iodine ❑ Nickel

MOTHERHOOD TO MENOPAUSE MIDWIFERY CARE

# WOMEN'S HEALTH MEDICAL HISTORY



**MEDICATION LIST:** ***Please list all medications including over-the-counter***

| Name of Medication | Dosage | Times per day | Prescribing Doctor |
|---|---|---|---|
| Example: Lasix | 20 mg | Twice a day | Dr. Jones |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**REVIEW OF SYSTEMS:** Please check all that you are ***currently*** experiencing.

### Genital/Urinary:

- ❑ Breakthrough Bleeding
- ❑ Urinary Urgency
- ❑ Heavy Vaginal Bleeding
- ❑ Pain/Burning with Urination
- ❑ Vaginal Dryness
- ❑ Urinary Leakage
- ❑ Irregular Vaginal Bleeding
- ❑ Urinary Tract Infections
- ❑ Painful Intercourse
- ❑ Painful Periods
- ❑ Frequent Urination at Night
- LOW LIBIDO

### Endocrine:

- ❑ Hot Flashes
- ❑ Night Sweats
- ❑ Absense of Menstrual Periods
- ❑ Fatigue
- ❑ Hair Loss

### Skin/Breasts:

- ❑ Changes in Mole
- ❑ Nipple Discharge
- ❑ Breast Lumps
- ❑ Breast Tenderness

### Neurological:

- ❑ Frequent Headaches
- ❑ Muscle Weakness
- ❑ Poor Coordination
- ❑ Trouble Sleeping
- ❑ Moodiness

### Digestive:

- ❑ Rectal Bleeding
- ❑ Diarrhea
- ❑ Constipation
- ❑ Significant Weight Gain _____ lbs
- ❑ Heart Burn
- ❑ Bloody Stool
- ❑ Black/Tarry Stool
- ❑ Significant Weight Loss _____ lbs
- ❑ Vomiting

### Cardiac:

- ❑ Fainting/Dizziness
- ❑ Irregular Heartbeat
- ❑ Chest Pain

### Respiratory:

- ❑ Shortness of Breath
- ❑ Coughing Up Blood
- ❑ Wheezing

### Eyes:

- ❑ Changes in Vision

MOTHERHOOD TO MENOPAUSE
MIDWIFERY CARE

# PATIENT CONSENT FORM & AUTHORIZATION TO BILL INSURANCE

**Please read and initial by each item below, then sign at the bottom, please. Thank you.**

_____ I certify that I am requesting the services of Motherhood to Menopause Midwifery Care for myself.

_____ I agree to advanced practice nursing students may be present as observers.

_____ I request payment of authorized insurance benefits or subsidies made, on my behalf, and payment made to Motherhood to Menopause Midwifery Care for any services provided to me. I authorize any holder to release to my insurance company my medical information that may be needed to determine benefits or the benefits payment for related services, regulatory compliance, status audit or quality assurance purposes.

_____ I understand that Motherhood to Menopause Midwifery Care will submit insurance claims and that I will be responsible for any deductibles, co-payments, co-insurance or client fees at the time services are rendered. I understand that there is 4% surcharge cost for using a credit card, Benefits card or similar.

_____I understand that I will receive a statement if my account has a balance due. I understand that Motherhood to Menopause Midwifery Care cannot accept responsibility for collection of my insurance claim or for negotiating a settlement on a disputed claim and that I am responsible for payment of my account.

_____ I understand that there is a 24-hour cancellation policy and if I fail to appear at the time of a scheduled appointment, I will be responsible for payment of that missed appointment.

_____ I understand that my services and/or treatment with Motherhood to Menopause Midwifery Care may be terminated in the case of non-compliance. This includes non-adherence regarding prescribed medications, and treatment plans; repeatedly missing appointments, or failure to pay the fees for services rendered and determined as obligatory by my insurance and the guidelines of the practice.

**CLIENT'S PRINTED NAME**_____**DOB**_____

**CLIENT'S SIGNATURE**_____**DATE SIGNED**_____

MOTHERHOOD TO MENOPAUSE
MIDWIFERY CARE

# HIPAA PRIVACY PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e., my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA.

I understand that I have the right to request restrictions on how my protected health information is used and disclose to carry out treatment, payment, and health care operations, but that you are not required to agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoked this content is not affected.

**CLIENT'S PRINTED NAME**_____**DOB**_____

**CLIENT'S SIGNATURE**_____**DATE SIGNED**_____