Women's Health & Wellness

Jeanette Pilotte MD, FACOG
Denise L. Gallus, PA

PATIENT REGISTRATION FORM

NAME (*last, first*) _____ DATE OF BIRTH: ____/____/_____

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed S.S #_____-_____-_____ *(for billing purposes only)*

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE (____) _____-_____ CELL: (_____) _____-_____ E-MAIL: _____

EMPLOYER: _____ PHONE: (_____) _____-_____ x_____

PCP (*Primary Care Physician*) Name: _____

INSURANCE INFORMATION

PRIMARY INS. COMPANY NAME: _____ MEMBER ID# _____ GROUP# _____

INSURED'S NAME (*policyholder*): _____ BIRTH DATE: _____ GENDER: _____

INSURED'S RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT

CLAIMS ADDRESS (*located on the back of the card*): _____

SECONDARY INS. COMPANY NAME: _____ MEMBER ID# _____ GROUP# _____

INSURED'S NAME (*policyholder*): _____ BIRTH DATE: _____ GENDER: _____

INSURED'S RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT

CLAIMS ADDRESS (*located on the back of the card*): _____

PRIVACY & COMMUNICATION PREFERENCES

How may we contact you? (*Please check ALL that apply*): ☐E-mail ☐Text Message ☐Home Phone ☐Cell Phone ☐US Mail

May we leave messages regarding NORMAL test results or appointments on your answering machine or voicemail? ☐YES ☐NO

Who May Receive Information Regarding Your Protected Health Information? (*check all that apply*)

☐SPOUSE	Name: _____	Date of Birth: ____/____/_____
☐CHILDREN	Name: _____	Date of Birth: ____/____/_____
	Name: _____	Date of Birth: ____/____/_____
	Name: _____	Date of Birth: ____/____/_____
☐PARENT/ GUARDIAN	Name: _____	Date of Birth: ____/____/_____

I have received a copy of the Privacy Policy from this provider and authorize the individuals listed above to receive my Protected Health Information. I may change or revoke this authorization at any time by providing written notification.

SIGNATURE: _____ **DATE:** _____/_____/_____

1000 Willow Creek Rd • Suite E • Prescott, Arizona 86301
928-583-7887 phone • 928-583-7886 fax
drp.womenshealthandwellness@gmail.com

New Patient Health Information

NAME:_____**DOB:**_____**TODAY'S DATE:**_____

MEDICAL HISTORY: *PLEASE LIST ALL MEDICAL CONDITIONS (past and present):*

_____

_____

_____

SURGICAL HISTORY:

_____

_____

GYNECOLOGICAL HISTORY

LAST MENSTRUAL PERIOD:_____ DURATION(DAYS):_____ FLOW:_____
AGE WHEN YOU STARTED YOUR PERIOD? _____IF POSTMENOPAUSAL, AGE AT MENOPAUSE:_____
LAST PAP SMEAR:_____ RESULTS:_____
HISTORY OF ANY ABNORMAL PAP SMEARS? _____ RESULTS:_____
ARE YOU SEXUALLY ACTIVE? *Y N* IF YES, WITH (CIRCLE): *MALE FEMALE BOTH*
DO YOU HAVE ANY SEXUALITY ISSUES YOU WISH TO DISCUSS? _____
DO YOU HAVE A HISTORY OF ANY STD'S? *Y N* TYPE:_____
ARE YOU CURRENTLY USING ANY FORM OF BIRTH CONTROL?_____ TYPE:_____
LAST MAMMOGRAM:_____ RESULTS:_____ BONE DENSITY SCAN:_____RESULTS:_____
COLONOSCOPY:_____ RESULTS:_____ ROUTINE BLOOD TESTS:_____
HAVE YOU EVER HAD A PELVIC ULTRASOUND?_____ IF SO, WHAT WERE THE RESULTS?_____
HAVE YOU EVER HAD AN ENODMETRIAL BIOPSY?_____ IF SO, WHAT WERE THE RESULTS?_____

OBSTETRICAL HISTORY

HOW MANY TIMES HAVE YOU BEEN PREGNANT? ____ _ AGE AT FIRST CHILD:____
WERE YOU ON BIRTH CONTROL WHEN YOU BECAME PREGNANT? *Y N*
HOW MANY DELIVERIES HAVE YOU HAD? VAGINAL_____ C-SECTION_____
HOW MANY MISCARRIAGES? _____TERMINATIONS?:_____
HAVE YOU EVER HAD AN ECTOPIC (TUBAL) PREGNANCY? *Y N*

Has anyone in your family suffered from any of the following conditions?
(*Please Indicate relationship)*

__Diabetes	__Heart Disease	__Substance Abuse	__Ovarian Cancer
__ Stroke	__High Blood Pressure	__Breast Cancer	__Colon Cancer
__Cervical Cancer	__Uterine Cancer	__Osteoporosis	__Depression/Anxiety

SOCIAL HISTORY:

What is your marital status? _____ Do you live alone or with others?_____

Any concerns of emotional or physical abuse?_____ Are you currently employed?_____

What is your occupation?_____ Highest education level:_____

DO YOU USE:

Tobacco (smoke or chew)?	Y	N	Years?_____	Packs per day?_____
Recreational drugs?	Y	N	What kind and how often?_____	
Alcohol?	Y	N	What kind and how often?_____	
Caffeine?	Y	N	What kind and how often?_____	
Do you exercise?	Y	N	What type and how often?_____	

Describe your diet (circle one): Regular Vegetarian/Vegan Gluten-Free Diabetic Other

(If Other, please specify)_____

What is your general stress level? (circle one): High Moderate Low

DO YOU CURRENTLY HAVE ANY ABNORMALITIES OF:			***IF YES, PLEASE EXPLAIN:***
SKIN	Y	N	_____
ENDOCRINE SYSTEM (THYROID PROBLEMS, DIABETES)	Y	N	_____
NERVOUS SYSTEM	Y	N	_____
EYES	Y	N	_____
RESPIRATORY SYSTEM	Y	N	_____
ALLERGIES	Y	N	_____
BLOOD	Y	N	_____
EARS, NOSE AND THROAT	Y	N	_____
HEART OR VASCULAR SYSTEM	Y	N	_____
DIGESTIVE SYSTEM	Y	N	_____
MUSCLES OR JOINTS	Y	N	_____ _____
HAVE YOU HAD ANY PHSYCHOLOGICAL PROBLEMS?	Y	N	_____
URINARY SYSTEM*	Y	N	*(if yes, answer the following)*

Recent research indicates that 1 out of 4 women over the age of 18 experience some type of bladder leakage. Leakage typically affects 30-50% of childbearing women by age 40. Please answer the following: *(answer "Never, Rarely, Often or All The Time")*

- ☐ Do you leak urine (even small drops), wet yourself or wet your pad or undergarments when you jog, bend over, lift heavy objects, cough or sneeze?
- ☐ Do you get such a strong and uncomfortable need to urinate that you leak urine (even small drops) or wet yourself before reaching the toilet?
- ☐ Do you have to rush to the bathroom because you get a sudden, strong need to urinate?

Do you have a health care Power of Attorney? _____Do you have an Advance Directive? _____

Patient Signature:_____ Date:_____

MEDICATION LIST

PATIENT NAME:_____ DATE:_____/_____/_____

DRUG ALLERGIES REACTION

_____

_____

_____

_____

Are you allergic to latex? ___ yes ___ no

CURRENT MEDICATIONS

NAME DOSE TIMES PER DAY REASON

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

VITAMINS & SUPPLEMENTS

NAME DOSE TIMES PER DAY

_____

_____

_____

_____

_____

_____

_____

_____

PREFERRED PHARMACY:_____

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WOMEN'S HEALTH & WELLNESS

Symptom Checklist For Women

Name: _____ **Date:** _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Fatigue				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		

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HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice also contains a patient rights section describing your patient rights under the law. You have a right to review this notice before signing the consent. The terms of the notice may change, and if this should occur, you may receive a revised copy by contacting the office.

You have the right to restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment or healthcare operations. You have a right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in relation to you on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

1) Protected health information may be disclosed or used for treatment, payment or health care operations.
2) The practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice.
3) The practice reserves the right to change the notice of privacy practices.
4) The patient has the right to request restricted use of their information, but the practice does not have to agree with those restrictions.
5) The patient may revoke this consent in writing at any time and all future disclosures will then cease.

The Consent is signed by:

Please Print Name of Patient or Representative: _____

Signature: _____ Date: _____

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FINANCIAL RESPONSIBILITY AGREEMENT

The following is an explanation of our financial policies regarding patient accounts. **Please take the time to read these policies carefully; they describe your responsibilities for the handling of your account.** If you need a further explanation of these policies, our Patient Account Representative will be happy to meet with you.

It is your responsibility to know whether or not your insurance company requires a referral from your primary care provider (PCP). If your insurance does require a referral and we do not receive it by the time of your visit, it may be necessary to reschedule your appointment. You may potentially assume financial responsibility for the bill. You may be required to pay at the time of the visit.

If your insurance plan does not cover Well Woman Examinations (yearly female physical), you will be responsible for the cost of your visit. If you have health concerns, please let us know so we can submit the correct diagnoses for billing. Once your claim has been submitted we cannot change the diagnosis or re-file your claim. It is extremely important to know your benefits.

Please remember: an insurance contract is made between the patient and the insurance carrier, not the Physician. The ultimate obligation for payment rests with you. This office does not accept responsibility for collecting your insurance claim or for negotiating a disputed claim. You are responsible for payment of your account.

All lab charges are separate from your office visit. This includes pap smears, blood work, pathology, biopsies, and cultures. Your insurance may not cover lab charges; therefore you are responsible for these charges.

Co-payments are expected to be paid at the time of service unless previous arrangements are made and will be collected at time of check-in. Our office accepts all major credit & debit cards, checks and cash payments. Please note that there will be a $25 fee for all returned checks.

Please give 24 hour notice if you will be unable to keep your appointment. **Missed appointments and appointments not cancelled with a 24 hour notice are subject to a Late/Cancellation No Show Fee of $35.00. Three (3) no shows will result in you being discharged from our practice.**

PATIENT CONSENT

I have read the foregoing and hereby agree that I am fully responsible for all charges on my account, including any and all lab charges that will be separate from my office visit. Any and all remaining balances on my account shall be my responsibility.

Patient Signature _____ ***Date:*** _____

PLEASE PRINT NAME: _____

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