Camelback Women's Health

PATIENT INFORMATION

Patient Name: Last, First, MI			Maiden Name:	Date of Birth:
Address:	City:	State:	Zip:	Social Security #:
Home Phone: ( )	Work Phone & Ext. ( )		Cell Phone: ( )	
E-mail Address:			Marital Status: S M D W	
Occupation:	Employer Name:			
Contact Preference: ___ Home ___ Work ____ Cell ____ E-mail	Race: __ White __Hispanic __ African/American ____ Other		Ethnicity/Nationality:	

Spouse/ Significant Other or Parent Name: Last, First, MI		Date of Birth:
Work Phone & Ext. ( )	Cell Phone: ( )	
Occupation:	Employer Name:	

Emergency Contact: (Other than spouse/significant other)		Relationship:
Home Phone: ( )	Work Phone & Ext. ( )	Cell Phone: ( )

Primary Care Physician:	Phone Number:
Preferred Pharmacy:	Phone Number/Location:

How were you referred to Camelback Women's Health? ____ Yellow Pages ____ Advertisement _____Internet
____ Friend/Family Member _____ Primary Care Physician _____ Insurance Booklet ____Other: Please Explain:

My **PRIMARY** insurance policy is through: ---- THE EMPLOYEE IS THE POLICY HOLDER---
____ My Employer ____ Spouse's Employer _____ Mother's Employer _____ Father's Employer ____ State/Federal

Insurance Company Name:	Policy Holder Name:			Policy Holder DOB:
ID #:	Group #:		Social Security # of policy holder:	
Claims Address:	City:	State:	Zip:	
Insurance Phone: ( )	Relationship to Policy Holder:			

My **SECONDARY** insurance policy is through: ---- THE EMPLOYEE IS THE POLICY HOLDER---
____ My Employer ____ Spouse's Employer ____ Mother's Employer ____ Father's Employer ____ State/Federal

Insurance Company Name:	Policy Holder Name:			Policy Holder DOB:
ID #:	Group #:		Social Security # of policy holder:	
Claims Address:	City:	State:	Zip:	
Insurance Phone: ( )	Relationship to Policy Holder:			

I hereby certify the above information is correct and I understand I am ultimately responsible to assure payments are made on my account:

Patient Signature: _____ Date:_____

Parent/Guardian Signature: _____ Date: _____

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I, hereby, acknowledge that I have received a copy of Camelback Women's Health's **NOTICE OF PRIVACY PRACTICES** pamphlet.

_____
Printed Name of Patient

_____ _____
Signature of Patient/Guardian Date

If applicable:

Patient Name: _____ has declined to sign this document.

_____ _____
Staff Member Signature Date

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FINANCIAL AGREEMENT

By placing my signature on this page, I agree to the following:

- I am consenting to treatment and services ordered by my Physician or Nurse Practitioner to be performed by Camelback Women's Health and/or it's associates.
- I understand I am financially liable for all services performed, including those, which, are not covered by my health insurance company or if my coverage is not effective at the time services are rendered.
- I understand I am responsible for confirming and understanding my insurance company's coverage limitations and policies, including my obligation for deductibles, co-insurance, and co-payments.
- I understand any referrals or authorizations needed for the visit or services to be rendered are MY responsibility to obtain prior to my visit. I realize I may not be seen if these are not in place or I accept full responsibility for payment.
- I authorize my insurance company to make payment directly to Camelback Women's Health for services provided.
- I understand all payments are due at the time of service, including co-pays, deductible balances, and co-insurance.
- I understand and agree to pay $25 fee for all returned checks.
- I understand any returned checks are subject to further collections by the County Attorney's office if I do not forward payment upon request.
- I agree if my account is turned over to an outside collections agency for non-payment, to pay the fees of the collection agency equal to the maximum of 50% of our outstanding balance at the time the account is placed with the collection agency. Interest of 10% per year will be accrued on the principal balance placed with the agency. Should legal action become necessary to collect on the outstanding account balance, I agree to pay attorney's fees and court costs incurred for collection. I understand any outstanding bad debts, which I am not making consistent monthly payments for will be reported to the national credit reporting agencies/bureaus.
- I authorize Camelback Women's Health to disclose all or part of my medical and/or financial records to my insurance company or third party payor, which may be needed to assist in payment of services rendered per HIPAA regulations. This may include utilization review organizations, hospital, or medical service companies, governmental agencies, or the employer for the insured (for self-funded plans only). I understand this may be revoked by me in writing at any time, except to the extent to which action has taken in reliance upon it. The authorization will stay in effect as long as the need for information exists.

I understand and I agree to the above mentioned:

Signature: _____ Date:_____

Signature of Parent or Guardian, if applicable: _____

Camelback Women's Health

Authorization to Share Personal Protected Information

Camelback Women's Health WILL NOT release information to anyone other than patients without specific authorization to do so. This includes spouses & parents in accordance with state and federal laws.

If you **do not** wish to have ANY information shared with anyone other than yourself, please sign below:

Patient Signature Date:

However;

If you **do** wish to have information shared, please read the following:

I hereby certify the following people have complete access to the following protected information, which is including, but not limited to: laboratory results, radiology results, physician notes, assessments and opinions, and financial information relating to account status, collection states, and payment history:

Camelback Women's Health may disclose any or all of the above to the following individuals:

Name: _____ Relationship: _____ SS# or DOB _____

Name: _____ Relationship: _____ SS# or DOB _____

Name: _____ Relationship: _____ SS# or DOB _____

I understand this authorization will be in effect indefinitely unless a specific date is indicated here: _____. I understand this authorization may be revoked AT ANY TIME by me in writing. I understand the office cannot be responsible for information released under this agreement prior to the receipt of the written revocation/cancellation and will not hold the office responsible for such disclosures.

I understand copies of this information will require written authorization by me; or the above party, before copies will be released.

I have read this agreement and understand my personal protected health information may be shared with the individuals I have indicated above.

Patient: _____Date: _____

Camelback Women's Health Representative _____

Camelback Women's Health **HEALTH HISTORY INFORMATION**

Today's Date:

Name: Last, First, MI

Date of Birth:

What is the reason you're being seen today?

PAST SURGERIES

Please list any surgeries/operations you've had:

Type: _____ Date: _____ Where: _____

Type: _____ Date: _____ Where: _____

Type: _____ Date: _____ Where: _____

Type: _____ Date: _____ Where: _____

CURRENT MEDICATIONS

Please list any medications/vitamins you're currently taking:

Name: _____ Mgs/units: _____ How often? _____

Name: _____ Mgs/units: _____ How often? _____

Name: _____ Mgs/units: _____ How often? _____

Name: _____ Mgs/units: _____ How often? _____

MEDICATION ALLERGIES

Are you allergic to any medications? **If none write none here:** _____

Name: _____ Type of reaction: _____

Name: _____ Type of reaction: _____

Name: _____ Type of reaction: _____

PAST MEDICAL HISTORY

Do you have any problems, diseases or disorders of the following?		
	No	Yes…… Please explain:
Anemia		
Bladder		
Bleeding/Clotting		
Blood Disorder		
Bowel		
Cancer		Type:
Depression		
Diabetes		
Fibromyalgia		

Headaches		
Hearing Problems		
Heart		
Hemorrhoids		
Hernia		
Kidney		
Liver/Hepatitis		
Mental Illness		
Neurological		
Osteoporosis		
Past Auto Accident		
Respiratory/Lung		
Seasonal Allergies		
Seizures		
STD's		
Skin		
Stomach/Intestines		
Thyroid		
Ulcers		
Vision		
OTHER:		

SOCIAL HISTORY: PLEASE CIRCLE

Marital Status	Single Married Divorced Separated Widowed Domestic Partner
Sexually Active	Yes No
Sexual Orientation	Heterosexual Homosexual Bisexual
Do you have a history of infertility?	Yes No
Education	Elementary High School Some College College Grad Post Grad
Occupation	
Stress Level	Low Moderate High
Exercise Level	None Occasional Moderate High
Diet	Regular Vegetarian Vegan Special:
Caffeine Intake	None Occasional Moderate Heavy
Smoking Status	Never Former Current How often? How long?
Alcohol Intake	None Occasional Moderate Heavy How long?
Illicit Drug Use	Never Former Current Type: How often?
Are there cats in your home?	Yes No
Do you work w/ chemicals or radiation?	Yes No
Have you had a LEEP or cone biopsy in the past?	Yes No If yes, when:

Do you routinely use seatbelts?	Yes No
Do you routinely use sunscreen?	Yes No
Is a blood transfusion acceptable in an emergency?	Yes No
Are you of Jewish ancestry?	Yes No
Are you of African American ancestry?	Yes No

FAMILY HISTORY:

Relationship	Problem	Onset Age	Died of Age
	___ Thyroid ___ Allergies ___ High Blood Pressure ___ Diabetes ____ Epilepsy ____ Stroke ___ Heart Disease ___ Mental Illness ___ Blood Disease ___ High Cholesterol ____ Cancer ___ Other:		
	___ Thyroid ___ Allergies ___ High Blood Pressure ___ Diabetes ____ Epilepsy ____ Stroke ___ Heart Disease ___ Mental Illness ___ Blood Disease ___ High Cholesterol ____ Cancer ___ Other:		
	___ Thyroid ___ Allergies ___ High Blood Pressure ___ Diabetes ____ Epilepsy ____ Stroke ___ Heart Disease ___ Mental Illness ___ Blood Disease ___ High Cholesterol _____ Cancer __ Other:		
	___ Thyroid ___ Allergies ___ High Blood Pressure ___ Diabetes ____ Epilepsy ____ Stroke ___ Heart Disease ___ Mental Illness ___ Blood Disease ___ High Cholesterol ____ Cancer ___ Other:		

GYN HISTORY:

Date of last period?	Approximate? Definite ?
How long does your period last?	
How many days between periods?	
How is the flow?	Light Moderate Heavy
Do you experience clotting?	
Are your periods painful?	Never Rare Occasionally Always
Age you began having periods?	
Do you have a history of abnormal paps?	
Were you treated for abnormal paps?	
Have you been treated for STD's?	
Are you currently sexually active?	
What are you using for birth control?	
Date of last mammogram	
Date of last pap smear	
Date of last bone mineral density screen	
Date of last cholesterol screen?	
Have you received the Gardasil injection?	
Age at first pregnancy?	
Planning future pregnancies?	
If menopausal, what age did it begin?	

OBSTETRIC HISTORY

Date of Delivery	Outcome? *(Full term, premature, miscarriage, termination)*	Length of Labor	Infant's weight	Infant's Sex	Delivery Type *(Vaginal, C/Section)*	Problems/Complications

Patient Signature: _____