Complete Women's Wellness
GYNECOLOGY

PATIENT INFORMATION SHEET

Patient Name (last, first, MI)	Date of Birth	Social Security Number
Mailing Address	Home Telephone	Work Telephone
City State Zip Code	Cell Phone	Marital Status
Email	Driver's License Number	
Primary Care Physician	Primary Care Physician's Phone Number	
Patient's Employer	Patient Employer's Address	
Emergency Contact: Name & Number	Relationship of Contact to You:	
Spouse's Name	Spouse's Telephone	
Spouse's Social Security	Spouse's Date of Birth	

INSURANCE INFORMATION

Primary Health Plan		Secondary Health	
Group #	ID#	Group#	ID#
Name of Policy Holder (last, first, MI)		Name of Policy Holder (last, first, MI)	
Telephone Number	Date of Birth	Telephone Number	Date of Birth

Race American Indian African Indian Caucasian Other:_____	**Ethnicity** Hispanic or Latino Not Hispanic or Latino Other: _____
	Preferred Pharmacy:
Signature of Patient or Responsible Party (must be at least 18 years of age)	Date (Month/Day/Year)

New Patient Questionnaire

Today's Date:_____ Name:_____

Date of Birth:_____ Age:____

Drug Allergies (*type of reaction*):_____

Reason for Visit: Annual Problem:_____

Date of last Pap Smear:_____Was it normal? *Yes No*

Gynecological History: 1st day of last period:_____# of days bleeding:_____days

Is your flow: heavy medium light Do you have pain with your period? *Yes No*

Type of Birth Control:
Pill Patch DepoProvera Injection Nexplanon IUD Vasectomy Tubal Ligation Essure Hysterectomy Condoms Natural Family Planning

Have you had the HPV vaccine? *Yes No*

Are you sexually active? *Yes No* Would you like to be checked for STDs? *Yes No*

Are you post-menopausal? *Yes No* If yes, what age?____

Have you had a hysterectomy? *Yes No* If yes? Abdominal Vaginal Laparoscopic

Do you have your ovaries? *Yes No* Reason for Hysterectomy?_____

Do you take hormones? Present Past No

Reproductive History: # of pregnancies:____ #of children___ #of miscarriages:___ #of abortions

Date of delivery	Weight	Sex	Type of delivery	Complications (diabetes, high blood pressure,etc)
_____	_____	___	c-section/vaginal	_____
_____	_____	___	c-section/vaginal	_____
_____	_____	___	c-section/vaginal	_____
_____	_____	___	c-section/vaginal	_____

Breast History: Have you had a Mammogram? *Yes No* If yes: *Normal Abnormal*

When?_____ Where? ACC STRIC MAP HCMH (Fredericksburg) Avestee

Do you do regular *self-breast* exams? *Yes No* Do you or your family have a history of Breast Cancer? *Yes No*

If yes, Who?_____

Surgical History: (Include type of procedure and date.)

_____

_____

Social History:

Illegal drug use?	*Never Former Yes*	What and how much? _____
Do you smoke?	*Never Former Yes*	Amount:_____
Do you drink alcohol?	*Never Former Yes*	Amount:_____
Do you drink caffeine?	*Never Former Yes*	Amount:_____
Do you exercise?	*Yes No Active*	Amount:_____

Bone Health: Have you had a Bone Density Scan? *Yes No* Was it normal? Yes No When?_____
Any self or family history of Osteoporosis? *Yes No* Who?_____

Digestive History: Have you had a colonoscopy? Yes No If yes When?_____
Was it normal? *Yes No* Do you have a history of: *hemorrhoids rectal bleeding*

Any self or family history of Colon Cancer? *Yes No* if yes Who?_____

Personal or Family History: *Self,* Mother, Father, Sister, Brother, Aunt, Uncle, Maternal (grandmother, grandfather), Paternal) grandmother, grandfather)

High Blood Pressure:_____ Diabetes:_____

High Cholesterol:_____ Thyroid Disease:_____

Heart Disease:_____ Stroke/DVT:_____

Migraines:_____ Cancer:_____

Other History:_____

Primary Care Physician:_____

List any recent labs done (Which lab do you use) :

_____

Have you had a flu shot? Y/N When?_____Have you had a pneumonia shot? Y/N When?_____
Pharmacy (local): HEB #1 HEB #2 CVS Wal-Mart Wal-greens Kerr Drug Med Stop MAP Pharmacy Apothecary Frontier Other:_____Location:_____

Do you take a Multivitamin? *Yes* *No* Calcium Supplement *Yes* *No*

PLEASE INCLUDE A COPY OF VITAMINS, PRESCRIPTION, AND OVER-THE-COUNTER MEDICATIONS YOU TAKE, OR YOU MAY WRITE THEM BELOW.

Medications	**Dose Given**	**Frequency (How many times given)**	**Time (AM/PM)**

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Financial Policy

Thank you for choosing Hill Country Health and Hormones as your wellness provider. We are committed to providing you the best available medical care. Our personnel will be pleased to discuss our fees and this policy with you at any time. We ask that all patients read and sign our financial policy as well as complete our Patient Information form prior to seeing the practitioner.

Payment for services is **DUE** at the time services are rendered. We accept **cash, check, Visa, and MasterCard**.

In special instances, we may accept the assignment of insurance benefits. However, you must understand:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, coverage charges, secondary insurance, and "usual and customary" charges. We are, however, contracted with certain managed care and preferred provider plans; we will follow the guidelines for patient care, reimbursement, and submission of claims for services rendered. Any contractual provider discounts will be deducted from your balance.
2. **All charges are your responsibility whether your insurance company pays or does not pay**. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. **Fees for these services, along with unpaid deductibles and copayments are due at the times of treatment**.
4. If your insurance company does not pay on your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. **You will be responsible for any unpaid claims**.
5. If your insurance company does not pay in full within 45 days, we require you to pay the balance by cash, check, Visa, or Mastercard.
6. Any patient balance **less than** $500.00 requires a **minimum of** $25.00 per month payment. Any patient balance **more than** $500.00 requires a **minimum** of $50.00 per month.
7. **Lab Billing**-Please remember, your lab billing is separate from our physician's billing, and you may receive a separate itemized bill from the laboratory, for which you are responsible. Please verify that you are being directed by our office to a lab that is a participating provider with your insurance plan.
8. Returned checks and balances older than 45 days may be subject to collection placement and collection fees.

Please note that if you must cancel or reschedule your appointment, **all cancellations must be made at least 24 hours in advance. If you fail to cancel your appointment, you may be charged at the rate of a normal office visit**. We encourage you to communicate with our business office any payment problems, so that we may assist you in the management of your account. Again, thank you for choosing Hill Country Health & Hormones as your healthcare provider. We appreciate your trust in us, and we appreciate the opportunity to serve you.

Patient's Signature _____ Date _____

Acknowledgment of Receipt of Notice of Privacy Practice

I have received a paper copy of W Gynecology and Women's Wellness Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

Signature of Patient or Personal Representative

_____

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

Our patient was handed a paper copy of our Notice of Privacy Practices and a good-faith effort to obtain written acknowledgment was made. This effort was declined at this time by the patient.

Employee of Hill Country Health & Hormones

_____

Date

The following people may have access to my medication records:

_____ _____

_____ _____