OFFICE POLICY

Womens Health Professionals is currently participating in numerous managed care plans. While we are pleased to participate with these plans, it is impossible for our office staff to be aware of each plan's specific requirements. Each plan may have limitations regarding frequency of services performed, where services may be performed (e.g., laboratory work or diagnostic testing). Some plans may require a referral from your primary care physician as well.

Unfortunately, if you do not inform us of special limitations which your contract stipulates, and we subsequently order services, these services may be considered non-covered and will not be paid by the insurance company. **Payment for non-covered services will be your responsibility.**

In the event that services are provided and it is determined that your coverage was not in effect at the time of service, fees submitted and denied by the carrier will become your responsibility.

To ensure that we file your claims correctly, we require that you present your valid insurance card(s) at each visit and note which is primary. It is also important that you inform us of any name, address, telephone number or other demographic changes. This is important in the event we need to reach you regarding a clinical or other reason.

If you have had an insurance change and have not received your card, or if you have lost your card, you must bring with you the following information from your employer:
Patient Name (as will be on card):
Subscriber's (policy holder's) Name:
Subscriber's Date of Birth:
Subscriber's SSN: **Relationship to Patient: Spouse, Parent or Other**
Policy Number: **Group Number:**
Telephone Number for Verification: **Office Copay:**

If you do not have an insurance card or the above information OR if it is determined that you are not eligible under the information that you present, you need to be prepared to pay at time of service. In addition, you will receive a separate bill from Quest, LabOne or Phytest for laboratory services performed.

I have read and understand the above office policy and agree to accept responsibility as described.

_____ _____
Patient Signature Date

Women's Health Professionals, Patient Information Form

For Office Use Only

DR: DB LL RB

LIST ANY DRUG or LATEX ALLERGIES_____

Last Name	First	Middle Initial

Street Address	City	State	Zip
Billing Address (if not the same as above)	City	State	Zip

Home Telephone # ( )	Work Telephone # ( )	Alternative Telephone # ( )

Birthdate	Sex	M	F	Social Security #	Driver's License #

E-mail Address	Single	Married	Divorced	Widowed	Separated	Other

Employer	Employer Address
Spouse(or if Minor/Parent Name)	Birthdate / Social Security #
Employer	Employer Telephone #
Employer Address	

IN CASE OF EMERGENCY, NEAREST RELATIVE/FRIEND NOT RESIDING AT THE SAME RESIDENCE AS YOURS:

Name	Telephone # ( )		
Address	City	State	Zip

INSURANCE INFORMATION

Name of Insurance Company	Policy Holder's Name	Birthdate	Social Security #
Member ID Number	Group Number		Employer
Name of Additional Insurance Company	Policy Holder's Name	Birthdate	Social Security #
Member ID Number	Group Number		Employer

HOW DID YOU HEAR ABOUT US?

Referred By	Ins. Directory	Friend	Yellow Pages	Radio	Direct Mail	WHP Website	Physician
Referral's Name							

AUTHORIZATION FOR RELEASE OF INFORMATION - I hereby authorize this practice to furnish any medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment of my care.

ASSIGNMENT OF BENEFITS - I hereby authorize payment directly to this practice of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the charges for these services. I understand that I am financially responsible for charges not covered by this assignment.

GUARANTEE OF ACCOUNT - For services furnished by Women's Health Professionals I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Michigan and agree to pay, if necessary, all costs of collection, including attorney's fee.

Signature_____ Date_____

Women's Health Professionals

Date_____ **CONFIDENTIAL MEDICAL QUESTIONNAIRE**

FOR OFFICE USE ONLY

Age_____ WT_____ BP_____ PCV_____ W/P_____ U/A_____ UPT_____ G_____ P_____ TAB_____ SAB_____ L_____

Name: _____ Social Security # _____

Main reason seeking medical attention: ☐ Routine Physical ☐ Problem

Describe Problem:_____

_____

A. GYNECOLOGICAL HISTORY

1. Age at first period_____ Date of last menstrual period_____Previous Period_____
2. When not on birth control pills, the interval between first day of one period to first day of next period ranges from_____to_____days. Duration of flow is _____ days.
3. Menstrual flow is usually ☐ light ☐ moderate ☐ heavy ☐ excess flow with clots
4. Do you ever have bleeding between periods or after intercourse? ☐yes ☐no
5. Do you have pain with periods? ☐yes ☐no At other times? ☐yes ☐no If yes, when?_____
6. When was your last Pap smear?_____ Was it normal? ☐yes ☐no
7. When was your last mammogram? Was it normal? ☐Yes ☐No
8. What are you using for birth control? ☐ Birth Control Pill _____ ☐ Condoms ☐ IUD ☐ Depo-Provera ☐ Injections ☐ Rhythm Method ☐ Diaphragm ☐ Sterilization ☐ None ☐ Other

		YES	NO	COMMENTS
9.	Are you satisfied with the present method of birth control?	☐	☐	_____
10.	Do you have any new sexual partners?	☐	☐	_____
11.	Do you ever have pain with intercourse (sex)?	☐	☐	_____
12.	Would you like testing for STD's?	☐	☐	_____
13.	Do you have any other sexual difficulties?	☐	☐	_____
14.	Do you have any vaginal discharge, irritation, or dryness?	☐	☐	_____
15.	Do you ever leak urine when you cough or sneeze?	☐	☐	_____
16.	Do you frequently have a sudden urgent need to urinate?	☐	☐	_____
17.	Do you have problems with urinating frequently at night or bed wetting?	☐	☐	_____
18.	Do you have painful urination or difficulty in starting urination?	☐	☐	_____
19.	Do you ever have a protrusion or bulging sensation from your vagina?	☐	☐	_____
20.	Have you ever had a herpes virus infection?	☐	☐	_____
21.	Have you ever had gonorrhea, Chlamydia, Syphilis, or venereal warts?	☐	☐	_____
22.	Have you ever had an abnormal Pap smear?	☐	☐	_____
23.	Have you felt any lumps or changes in your breasts?	☐	☐	_____
24.	Have you had any nipple discharge?	☐	☐	_____
25.	Do you have breast implants?	☐	☐	_____
26.	Do you do monthly self-breast examinations?	☐	☐	_____

CURRENT MEDICATIONS:_____

_____

DRUG ALLERGIES AND REACTIONS: _____

B. OBSTETRICAL HISTORY

I. How many times have you been pregnant?

2. Number of children living_____ Number of miscarriages_____Number of abortions _____

3. Were any of your babies born more than 3 weeks before their due date? ☐ Yes ☐ No

4. When were your babies born, and how much did they weigh?_____

5. Did you have any problems with your pregnancies, and if so, what were they?_____

C. HOSPITALIZATIONS - List all hospitalizations including operations you have had with date, reason, and name of hospital:

	Date	Hospital	Reason
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Have you ever had a blood transfusion? ☐Yes ☐ No

D. ILLNESSES

Have you or any blood relative ever had any of the following:

	YOU	FAMILY	(relationship)		YOU	FAMILY	(relationship)
Heart problems	☐	☐	_____	Breast Cancer	☐	☐	_____
High blood pressure	☐	☐	_____	Ovarian Cancer	☐	☐	_____
Stroke	☐	☐	_____	Uterine Cancer	☐	☐	_____
High cholesterol	☐	☐	_____	Colon Cancer	☐	☐	_____
Diabetes	☐	☐	_____	Other Cancers	☐	☐	_____
Blood clots	☐	☐	_____				
Bleeding disorder	☐	☐	_____	Depression	☐	☐	_____
Asthma or hayfever	☐	☐	_____	Epilepsy	☐	☐	_____
Liver or gall bladder problems	☐	☐	_____	Arthritis	☐	☐	_____
Colon polyps	☐	☐	_____	Downs Syndrome	☐	☐	_____
Kidney problems	☐	☐	_____	Birth defects	☐	☐	_____
Thyroid problems	☐	☐	_____	Other _____			

E. SYSTEMS REVIEW: - (Check any of the following that you have now or have had in the past six months.)

☐ Headaches, dizziness	☐ Shortness of breath	☐ Diarrhea, constipation, changes in stool
☐ Visual changes	☐ Chronic cough or coughing up blood	☐ Bloody or black stools
☐ Ringing in ears	☐ Hot flashes or night sweats	☐ Fatigue
☐ Loss of consciousness or fainting	☐ Varicose veins, easy bruising	☐ Weight gain or loss
☐ Numbness or tingling	☐ Changes in skin or hair	☐ Anxiety or depression
☐ Chest pain	☐ Abdominal pain, nausea, vomiting	☐ Infertility

Comments_____

When was your last Tetanus booster shot?_____ Are you immune to Rubella(German Measles) ☐ Yes ☐ No

When did you last have your cholesterol level checked? What was it? _____

F. SOCIAL HISTORY:

Occupation:_____Employer:_____

Marital status ☐ Single ☐ Married Husband's age:_____ ☐ Separated ☐ Divorced ☐ Widowed

Education - Grade last completed:_____ Religion:_____

Do you smoke? ☐ yes _____ Packs per day. ☐ No Do you drink alcohol? ☐ never ☐ occasionally ☐ socially ☐ daily

Have you ever used any other drugs? ☐ yes ☐ no If so, what? _____

Do you have any history of physical, emotional, or sexual abuse? ☐ yes ☐ no

Do you exercise regularly? ☐ yes ☐ no What type of exercise? _____

Do you wear seatbelts? ☐ always ☐ sometimes ☐ never

Patient Signature_____