Med Center Health®
Women's Health Specialists

NEW GYNECOLOGICAL PATIENT PACKET

Dear New Patient:

Welcome to Women's Health Specialists. Your health and well-being are very important to us, and we are proud to be a part of your healthcare team.

At your appointment, we set aside time to devote our attention totally to you and to understanding your healthcare needs. We view good health as a partnership, which requires close involvement between you and your provider.

Early detection of any disease or illness usually means early treatment and a higher success rate. Thus, appointments that are not kept pose an increased risk to your health. If you are unable to keep an appointment, please notify us as soon as possible.

It is important you arrive on time for your scheduled appointment(s). Arriving late causes us to get behind schedule, which in turn makes all other patients' appointments run late. Therefore, **if you are late, we will require you to reschedule your appointment.**

Because of our concern with closely monitoring the health of all our patients, patients who fail to show up for an appointment or fail to call and reschedule more than two times may be discharged from the practice.

All co-pays, deductibles, lab collection/processing fees and other charges are due at the time of service.

Please complete the attached paperwork and bring it with you to your appointment along with your Insurance Card(s) and a Picture ID. Completing all paperwork will expedite your appointment. If you are unable to complete the enclosed paperwork, please arrive earlier than requested to receive assistance in completion / processing. If you have any questions or concerns, always feel free to contact our office.

It is a pleasure to serve you, and we look forward to seeing you in our office soon!

Appointment Date: _____

Time: _____

Provider: _____

Office Location: _____

Please plan to arrive 30 minutes early for processing of all paperwork!

Thank You

523 Park Street • Bowling Green, KY 42101 • 270.781.0075
Toll Free: 1.866.997.5784 • Fax: 270.781.0143 • MedCenterHealth.org

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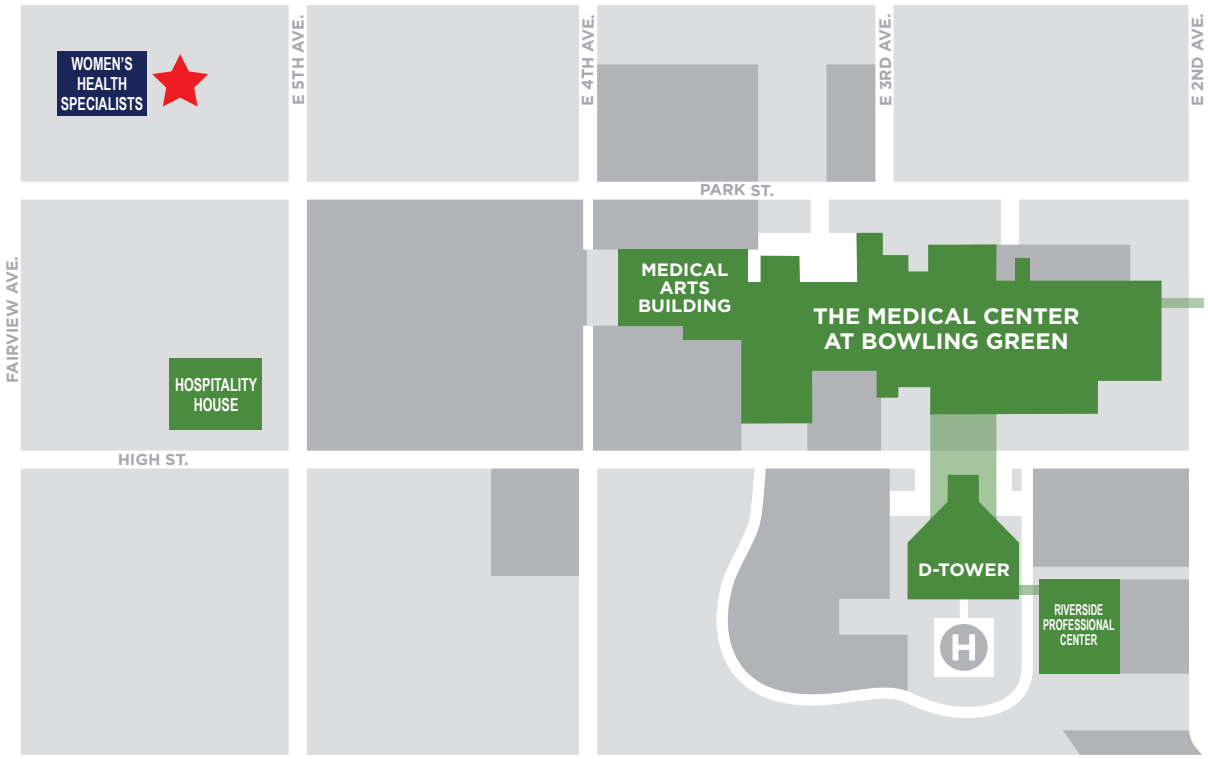
PARKING & ENTRANCE



Women's Health Specialists is located at 523 Park Street. If you have problems locating us, please feel free to call our office for directions.

Patients are also seen in Albany, Franklin and Scottsville on select days.

The Medical Center at Albany
723 Burkesville Road
Albany, KY 42602

The Medical Center at Franklin
Physician Specialty Clinics
Franklin Medical Pavilion
1100 Brookhaven Road
Suite 103
Franklin, KY 42134

The Medical Center at Scottsville
Physician Specialty Clinics
456 Burnley Road
Scottsville, KY 42164

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PATIENT INFORMATION (Please Print)

Patient Name _____
(Last, First, Middle Initial)

Date of Birth _____ Age _____ Social Security # _____

Marital Status (Please Circle) Single Married Widowed Divorced Separated

Mailing Address _____

_____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

E-mail Address: _____

Preferred Method to Confirm Appointments (Please Circle One) Text Home Phone Cell Phone Work Phone

Employer _____ Occupation (Indicate if a Student) _____

Name of Insured or Parent_____ Date of Birth_____
(Last, First, Middle Initial)

Social Security # _____ Relationship to Patient _____

Insured's Employer _____

Emergency Contact Name _____ Phone # _____

Relationship to Patient _____

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite Insurance Carrier payments. The patient is responsible for all fees, regardless of Insurance Coverage. Payment is due at the time services are rendered unless other arrangements have been made in advance. KRS 194A.505 requires every person to disclose all sources of Insurance Coverage, at each visit. Failure to do so is fraudulent. Our office is required and will report all such misrepresentations.

INSURANCE AUTHORIZATION (Please Read & Sign)
I HEREBY AUTHORIZE WOMEN'S HEALTH SPECIALISTS TO FURNISH TO INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONCERNING MY (MY DEPENDENT'S) ILLNESS AND TREATMENT AND I HEREBY ASSIGN TO WOMEN'S HEALTH SPECIALISTS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

_____ _____
Signature of Patient or Parent Date

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HEALTH PROFILE

Patient Name _____ **Today's Date** _____
(Last, First, Middle Initial)

Date of Birth _____ Age _____ Social Security # _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Why are you seeing the Doctor? _____

When was the first day of your last menstrual period? _____

How often do you get your period? _____ How long does the bleeding last? _____

How severe is the cramping with your period (none / mild / severe)? _____

Are you doing anything for Birth Control right now? Yes No If yes, what? _____

When was your last PAP smear? _____ Ever had an abnormal PAP? Yes No When?_____

When was your last Mammogram? _____ Ever had an abnormal mammogram? Yes No When? _____

What medications are you currently taking (name & dose)? _____

_____

Primary Pharmacy _____ Location (City, State) _____

Do you smoke? Yes No If yes, how many packs of cigarettes per day? _____

Do you use alcohol (beer, wine, etc.)? Yes No If yes, what kind? _____

How many times have you been pregnant? _____ How many babies have you delivered? _____

How many miscarriages have you had? _____How many abortions have you had? _____

Have you ever had a Cesarean Section? Yes No

What surgeries have you had? (Please list all & year) _____

_____

Do you have any medical problems (i.e. diabetes, thyroid disease, high blood pressure, heart disease, asthma, joint problems, etc.)? Please list any _____

_____

Do you have a history of seizures? _____

Has anyone in your family had any of the following problems?

Cancer _____ Who_____ What kind/location (i.e. breast, colon, etc.) _____

Diabetes _____ Who _____ High Blood Pressure _____ Who _____

Heart Disease _____ Who _____ Asthma _____Who _____

Any other major medical problems to note? Please list _____

Latex Allergy Screening Tool

1. Do you have a confirmed latex sensitivity, or do you have spina bifida? Yes No
2. Have you ever had a reaction after handling/using poinsettia plants, balloons, rubber products or spandex? Yes No
3. Have you ever had one of the following after a medical/dental appointment: itching, tearing, fatigue, sneezing or running nose? Yes No
4. Have you ever reacted after eating bananas, avocados, kiwi, or chestnuts? Yes No

For patients who have responded in the affirmative to most of these questions, latex precautions will be utilized, unless otherwise stipulated by the physician. The suspected allergy will be documented in the patient's chart and the referring physician will be contacted.

_____ _____ _____
Date Employee Signature Patient Signature

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HEALTH HISTORY

Patient Name _____ **Today's Date** _____
(Last, First, Middle Initial)

Date of Birth _____ Social Security # _____

Have you had any of the following problems: (check all that apply)

Problem	Yes	No	Approximate Date
More than 10 lb change in weight (+ / -)			
Loss of appetite			
Unusual fatigue			
Difficulty sleeping			
Fevers, chills, night sweats			
Dizziness, blurred vision			
Nausea and/or vomiting			
Diarrhea			
Blood in stool or black, tarry stools			
Blood in urine, cloudy urine, painful urination			
Leakage of urine			
Shortness of breath, cough, wheezing			
Chest pain, pounding in chest			
Joint pain, unusual muscle stiffness			
New or changing growths or moles			
Unusual nervousness			
Feelings of depression			

Anything else you would like to discuss today? _____

_____

_____

_____

Any known allergies? Please list _____

_____

_____

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