Med Center Health®

Women's Health Specialists

Medical Arts Building ● 350 Park Street, Suite 203
Bowling Green, KY 42101
Phone: (270) 781-0075 ● Fax: (270) 781-0143
Toll Free: 1-866-997-5784
MedCenterHealth.org

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

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PARKING & ENTRANCE

Women's Health Specialists is located in the Medical Arts Building which is connected to The Medical Center. Although our address is Park Street, the Medical Arts Building entrance is on High Street. Designated parking for the Medical Arts Building is available on High Street.

The gated parking lot for the Medical Arts Building is designated specifically for doctor offices in the building. It is FREE to use for our patients! Upon entering the parking lot, push the button to get a ticket. Bring this ticket to our office for staff to validate. Then, when exiting the parking lot, put the validated ticket into the gate's slot.

Women's Health Specialists is located in Suite 203, on the second floor of the Medical Arts Building. If you have problems locating us, please feel free to call our office for directions.

Patients are also seen in Franklin, Scottsville & Caverna on select days.

The Medical Center at Franklin
Physician Specialty Clinics
Franklin Medical Plaza
1100 Brookhaven Road
Franklin, KY 42134

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

The Medical Center at Caverna
Physician Specialty Clinics
1501 South Dixie Street
Horse Cave, KY 42749

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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 HEARBY AUTHORIZE WOMEN'S HEALTH SPECIALISTS TO FURNISH TO INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONCERNING MY (MY DEPENDENT'S) ILLNESS AND TREATMENT AND I HEARBY 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 ____ 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 vomitting			
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 ____
____
____