Eastwind Women's Health

★ **Patient Information:** ★

(Please print and complete fully)

Legal Name: ____
(Last) (First) (Middle Initial)

Address: ____
(Street Address) (Apt/Unit) (City) (State) (Zip)

SS # (required): ______________________ Birth Date: _________________ Age: ___________

Marital Status (circle one): Single Married Widowed Divorced Partner

Cell: _____________________ Home: _____________________ Work: ______________________

Do we have your permission to leave a message (circle one): Yes No

Primary Email: ____

Employer: ___________________________________ Occupation: _________________________

★ **Emergency Contact**: Name:___________________________ Relationship:__________________

Emergency Contact Phone: ____

★ **Primary Care Physician:** _______________________ Phone: ___________________________

★ **Primary Pharmacy:** _____________________________ Phone: ___________________________

Address: ________________________________ City/Zip: _________________________

★ **Medical Insurance Information: (Must present card at each visit)** ★

****(It is the patient's responsibility to determine coverage / benefits at the time of service)****

Do you Currently Have Insurance? (Circle One): Yes No

Primary Insurance: ____

Subscriber Name: ______________________________ Date of Birth: _________________________

Relationship to Patient: __________________________

Secondary Insurance: ____

Subscriber Name: ______________________________ Date of Birth: _________________________

Relationship to Patient: __________________________

Consent to Medical Care and Treatment: While at Eastwind Women's Health I Give consent for all medical care, any tests and examinations needed. I will not hold Eastwind Women's Health or any person responsible for the results if I refuse medical treatment or advice. This consent will be valid for one year unless otherwise indicated in writing by either party.

Patient or Guardian Signature: ___________________________________ Date: ____________________

Eastwind Women's Health

★**Release of Information:**

I understand that Eastwind Women's Health may use or release my medical/ health information for the following reasons as needed:

- Insurance information, billing and payment
- Release to other healthcare providers for billing, payment, referrals and discharge planning
- Quality improvement reviews
- Medicare, Medicaid and other government programs
- Employer, if injured
- Public health reporting
- Legal, regulatory and accreditation agencies
- Eastwind Women's Health may receive or release my health information, whether written, verbal, fax, or electronic using secured internet websites.

★**Acknowledgement of Privacy Practices:**

Option 1:

____ I do not want to receive a copy of the privacy policy..

Option 2:

____ I would like to receive a copy of Eastwind Women's Health Notice of Privacy Practices.

I understand I have a right to keep my medical information private.
If you would like someone (spouse, sister, brother, son, daughter, etc.) to have access to your medical information please fill in the blanks below:

I, ______________________, hereby allow Eastwind Women's Health, to discuss my medical information with
(Patient Name)

Name: ____________________________________ Relationship: ___________________________.

★**Payment and Financial Responsibility:**

I hereby authorize and/ or assign my Medicare and/or my insurance benefits to be paid directly to Eastwind Women's Health. I realize I am responsible to pay non- covered services as well as any deductibles, copays or coinsurance. I am aware that all unpaid balances and copays are due at the time of my visit. I certify that the information given to me by the practice, in applying for under Medicare and/ or insurance coverage or other protection is correct and complete. I authorize any holder of medical information about me to release to Medicare and/ or the insurance company or its agents, any information needed to determine the benefits payable to related services. I consent to any request for review or appeal by Eastwind Women's Health, to challenge a determination of benefits made by a third party payer or insurer. This assignment will remain in effect until revoked by me if writing. A photocopy of this assignment is considered to be as valid as the original. If you are a self pay patient any quotes provided are strictly estimates.

Print Name: ____________________________________ Date of Birth:_______________________

Patient or Guardian Signature: _______________________________ Date:______________________

Eastwind Women's Health

★ Eastwind Women's Health Financial Policy ★

Welcome to Eastwind Women's Health. In order for our medical staff to be able to deliver the quality of care that you are accustomed to, we have established our financial policies. The following is a list of guidelines that are necessary to continue to provide high- quality care and make your visit as pleasant as possible.

Please read ALL information and acknowledge by signing below:

1. If you have a change of address, name, telephone number or insurance, please notify the receptionist.
2. We ask that you present a copy of your insurance card at each visit. It is your responsibility
3. to provide us with the correct information to bill your insurance. 3. We will collect your
4. co-payment at the time of your visit. If you have a balance after an insurance payment from a
5. previous visit, we will also ask for that payment. We accept checks, cash and all major credit
6. cards.
7. If we do not participate within the network of your insurance company, you will be expected to make payment in full at the time the service is rendered.
8. If your insurance denies our charges, does not pay us in a timely manner, or if your account becomes delinquent, we reserve the right to refer your account to a collection agency and report your account to the credit bureau.
9. HMO-PPO: If we participate with your plan, we will bill your insurance for you. Your co-payment will be collected at the time of the visit. If insurance requires a referral from your PCP. It is your responsibility to obtain it the day of the visit.
10. SELF-PAY: Patients with no insurance will be expected to pay in full at the time of the visit.
11. Your insurance is a contract between you, your employer, and the insurance company. It's very important that you understand the provisions of your policy. We cannot guarantee payment of all claims. If your insurance company only pays a portion of the bill or rejects your claim, any contract or explanation should be made to you, their policy holder. Reduction of rejection of your claim by your insurance does not relieve you of your financial obligation.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for your payment of the charges. If you have any questions regarding our financial policy, please contact our billing department at 614-890-1914, opt 5.

I have read and have a full understanding of the financial policy of Eastwind Women's Health.

Print Name_______________________________________ Date of Birth: _________________

Patient or Guardian Signature: ______________________________ Date: ___________________

Eastwind Women's Health

★ Genetic Cancer Screen ★

Patient Name:_________________________________ DOB:_______________________

If you have already had Genetic Testing (I.E. BRCA or My Risk) please mark one: Yes / No

	Yes	No	Mothers Side (Including Age of Diagnosis)	Fathers Side (Including Age of Diagnosis)
Have you or any family members been diagnosed with Breast Cancer?				
Have you or any family members been diagnosed with Ovarian Cancer?				
Have you or any family members been diagnosed with Colon Cancer?				
Have you or any family members been diagnosed with Pancreatic Cancer?				
Any Male Breast Cancer in the family?				
Do you or anyone in the family have BRCA mutation or any other mutation that increases the risk of cancer?				

Are you of Jewish (Ashkenazi) descent? (Circle one) Yes No

Patient or Guardian Signature: ____________________________ Date: __________________

Eastwind Women's Health

★ Medical History ★

Name: ______________________________ **Date of Birth:** ____________________

Preferred Pronoun: ____________________ **Preferred Sexual Partner:** (Circle One) Male / Female / Both / Other

Reason you are being seen at our office today:

____

____

Kind & Date of Surgical Operations:

*________________________
*________________________
*________________________
*________________________
*________________________
*________________________

Medical Diagnosis:

*________________________
*________________________
*________________________
*________________________

Current Medications:

*________________________
*________________________
*________________________
*________________________
*________________________
*________________________
*________________________
*________________________
*________________________

Drug Allergies / Reactions:

*________________________
*________________________
*________________________
*________________________

Dates of Last 2 Menstrual Periods:

*________________________
*________________________

Currently Sexually Active? Y / N

Current Method of Birth Control:

*________________________

Pap Smear History:
History of Abnormal Pap: Y / N
Date of Last Pap Smear: ___________

Pregnancy:
Number of Pregnancies _____
Number of Living Children _____
Miscarriages _____
Abortions _____
Multiples (Twins, etc) _____
Still Births ______

Social History:
Drink Alcohol: Y / N
Tobacco Smoker: Y / N
E-Cig/Vapor: Y / N
Drink Caffeine: Y / N
Drug Use/Abuse: Y / N

Check Any Of The Following That Apply:

_____Pelvic Pain
_____Back Pain
_____Abdominal Pain
_____Vaginal Discharge
_____Genital Lesion
_____STD Exposure
_____Irregular Menses
_____Painful Menses
_____Heavy Menses
_____Painful Intercourse
_____Breast Issues (Pain / Lump / Discharge)
_____Urinary Frequency / Incontinence
_____Post Menopausal Bleeding
_____Night Sweats / Hot Flashes

_____Chills
_____Fatigue
_____Fever
_____Easy Bleeding / Bruising
_____Weight Gain / Loss
_____Insomnia
_____Shortness of Breath
_____Wheezing
_____Chest Pain
_____Skin Changes (Mole / Rash / Tag)
_____Edema
_____Palpitations
_____Anxiety
_____Depression

_____Blood in Stool
_____ Constipation
_____ Diarrhea
_____Heartburn
_____Loss of Appetite
_____Nausea
_____Vomiting
_____Sore throat
_____Visual Changes
_____Chronic Cough
_____Hearing Loss
_____Headache
_____Hair loss
_____Ear Drainage / Discharge / Pain

Preferred Pharmacy: ____
(Pharmacy Name) (Address) (City/ Zip Code)

Patient or Guardian Signature: ________________________________ Date: _______________