WOMEN'S WELLNESS CENTER

Obstetrics • Gynecology • Infertility • Osteopathy

PATIENT INFORMATION

First Name: _____ Last Name: _____ M.I.:____ Marital Status: _____

Date of Birth: _____ Social Security #: _____

Address: _____ Apt: ____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Contact Preference (please circle) Home Phone Cell Phone Work Phone

Email: _____ Emergency Contact: _____ Phone: _____

Parents Names (if < 18 you.): _____ Religion: _____

Spouse/Significant Other's Name: _____

Maiden Name: _____ How did you hear about us? _____

Primary Language: _____ Race: _____ Ethnicity: _____

Primary Care Provider: _____ Co-Pay: _____

I give WWC permission to obtain my medication history. ☐ Yes ☐ No
I give WWC permission to contact me through automated reminders via ☐ Phone ☐ Text ☐ Email ☐ ALL
I give WWC permission to leave detailed voice messages. ☐ Yes ☐ No

INSURANCE HOLDER INFORMATION

(*IF NOT THE SAME AS ABOVE*)

Policyholder's First Name: _____ Last Name: _____

Home Address: _____ Apt: ___ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Social Security #: _____

Relationship to Patient: _____ Employer Name: _____

Insurance Information

Please bring your insurance card to every appointment.

(As a courtesy, we will file your claim to insurance. It is your responsibility to provide requested documentation and information to your insurance carrier, as the insurance contract is between you and your insurance company. Should there be a problem we will assist you as much as possible.)

SARA CASTELLANOS, D.O., FACOOG, OBGYN ELYSE BROCK, M.D., FACOG, OB/GYN

142 Third Street SE, Suite 2, Huron, SD 57350 | T 605.554.1020 F 605.554.1021

Assignment of Benefits

I authorize payment of medical benefits to Women's Wellness Center, Prof. L.L.C. for professional services rendered.

Acknowledgement of Financial Responsibility

The above information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, regardless of insurance coverage, and the cost of collections in the event that it is not. I further understand that if payment becomes over 60 days past due, Women's Wellness Center, Prof. L.L.C. will begin collection activity if alternative payment arrangements have not been made. This collection activity may include the involvement of a collection agency.

Release of Information

I authorize the release of any medical information necessary to process all present and future claims.

15 minute/No Show/Cancellation Policy

I acknowledge that I have reviewed and understand these policies and that cancellations made within 24 hours of my appointment will be considered a no show and I may be billed for the full charge of the appointment (NOT my insurance).

Co-Pay Policy

I acknowledge that I am responsible for paying my co-payment amount to Women's Wellness Center, Prof. L.L.C. Prior to any appointment. If I fail to comply, I acknowledge that I will be billed a $15.00 fee (NOT my insurance).

Notice of Privacy Practices

I acknowledge that I have been offered access to Women's Wellness Center's Notice of Privacy Practices via the posted form and/or a hard copy provided by the person checking in. I also acknowledge that I have reviewed the form by signing below.

Patient Signature: _____ Date: _____
(Or parent, if a minor)

Interpreter Signature: _____ Date: _____

Please fill out this form in its entirety to ensure proper handling of your account.
****Please provide your insurance card & driver's license at the reception desk for scanning. ****

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142 3rd St SE Suite 2 Huron, SD 57350
P: 605.554.1020 F: 605.554.1021

Medical Records Release

Name: _____ DOB: _____

Maiden (Previous) Name: _____

Authorization
I hereby authorize my physician and/or the administrative and clinical staff at: (from)
to use and/or disclose my protected health information to: (to)

Protected Health Information to be Used or Disclosed: (please initial)	
_____ All Medical Records	_____ Lab Results
_____ X-ray Reports	_____ Progress Notes
_____ Other: _____	

Do Not Disclose:	
_____ HIV/STD Results	_____ Other: _____

Reason For Use or Disclosure:	
_____ Second Opinion	_____ Relocating
_____ Continuing Medical Care	_____ Other: _____

This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance to this authorization.
I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Authorizing Signature:

I certify that the information listed above is correct to the best of my knowledge, and that I am giving this authorization voluntarily. By signing as personal representative to the patient, I certify that I have legal authority to do so.

Signature: _____ Date: _____

Relationship to Patient: _____

This authorization will expire one year from the date of signature or on _____.

AUTHORIZATION FOR DIAGNOSTIC CARE/TREATMENT: I require diagnostics and/or care in the form of medical, surgical, obstetrical, outpatient or emergency services. I consent to services deemed necessary by my physician(s) and assisting providers, and students in medical training as deemed appropriate by my physician(s). This consent shall extend to diagnosis and treatment in the care of any newborn. Additional consents must be obtained by the treating physician for non-routine procedures. I authorize the Hospital to retain, preserve, or to dispose of specimens, tissues, parts or organs taken from my body. I authorize testing for HIV and/or hepatitis should a healthcare worker have accidental exposure to my blood or other body substances.

MEDICATION HISTORY CONSENT: HRMC uses a medical record that allows electronic prescribing of medications. To coordinate care between the Hospital and other providers, I authorize access to my prescription medication history.

Yes _____ (Initial) No _____ (Initial) NA _____

PATIENT BILLING & PAYMENT POLICY: I understand a portion of the total charges for services rendered are expected at the time of registration. I will then be responsible for any remaining balance not paid by insurance or another payer and a late payment fee may be added at a rate of 0.83% per month or 10% per year on outstanding balances. I also understand that if I have no insurance the hospital may apply for state or county assistance on my behalf. I understand physicians providing services at the Hospital may be independent contractors, not employees or agents of the Hospital, and I will receive a separate bill for their services.

ASSIGNMENT OF BENEFITS: I assign all payment of insurance benefits to the Hospital, to my physician(s), and associated providers of care.

MEDICARE NON-COVERED DRUGS: Any self-administered or oral medications given during outpatient services, including Observation Bed stays are not paid by Medicare. I understand it is my responsibility for payment of non-covered-charges. Medicare Part D beneficiaries can request an itemized description of oral or self-administered prescription drugs received to submit to their Medicare Part D Plan.

MEDICARE CONSENT: I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of my medical or related information to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim.

HRMC NOTICE OF PRIVACY PRACTICES: I acknowledge receipt of the Hospital's Notice of Privacy Practices.
I understand the Hospital, my physician and other providers of my care will release Protected Health Information (PHI) for treatment, payment and operations as defined in the Notice.

PERSONAL VALUABLES: I understand that the Hospital maintains a place for safekeeping of valuables and personal items. I agree to assume the risk for personal property that I chose not to deposit for safekeeping.

The following information and instructions were provided to me and I have an opportunity to ask questions:

- **Patient Bill of Rights or Home Care Bill of Rights**
- **Patient Visitation Rights**
- **Advance Directives**

INFORMATION STATUS: Please initial your choice for release of information. Status changes can be made at any time.

_____ (Initial) GENERAL: I authorize access by telephone, visitors, deliveries, and clergy.

_____ (Initial) SECURED: I do not authorize access by telephone, visitors, deliveries, and clergy.

I have read and understand the above information.

Patient Signature _____ Date _____

Or /by _____ Relationship to Patient _____

Patient unable to sign due to _____ Employee Initials _____

ADMISSION CONSENT FORM

Form A-45 Revised 3/11/14

Health History Form

Name: _____ DOB: _____

Women's Wellness Center requests this information for the purpose of providing patient care. No persons outside of Women's Wellness Center are provided with this information without a signed release of records.

Reason for today's visit: _____

Primary Care Provider: _____ Pharmacy: _____

Please list the dates of your most recent: Flu Shot: _____ Pap Smear:_____ Pneumonia: _____

Mammogram: _____ Colonoscopy: _____ Bone Density: _____ Tdap (tetanus): _____

Please list your medications, including over the counter:

Medication	Dose	Frequency

Please list all allergies, including food allergies:

Medication/Food	Reaction

Gynecological History

At what age did your periods start? _____ First day of your last period: _____

How many days do your periods last? _____

Cycle: _____ days (from 1st day of last period to 1st day of next period)

Are your periods regular? □ Yes □ No □ Varies

If postmenopausal, have you had any bleeding since menopause? □ Yes □ No

If postmenopausal, age at menopause: _____

During your periods, do(did) you bleed lightly, moderately, or heavily? _____

Describe the intensity of pain you experience with your periods: □ None □ Mild □ Moderate □ Severe

Do you experience pain with intercourse? □ Yes □ No

Are you currently using birth control? □ Yes □ No

If yes please specify: _____

How old were you when you had your first child? _____

Were you on birth control at the time of conception?

Have you ever had any of the following? (please check yes or no, if yes include date)

Abnormal Pap	□ Yes _____	□ No	HPV	□ Yes _____	□ No	Endometriosis	□ Yes _____	□ No
Gonorrhea	□ Yes _____	□ No	Gardasil	□ Yes _____	□ No	Infertility	□ Yes _____	□ No
Chlamydia	□ Yes _____	□ No	Fibroids	□ Yes _____	□ No	Ovarian Cysts	□ Yes _____	□ No

Other, please specify: _____

Obstetric History

How many times have you been pregnant? _____ □ Never

How many of your children were born full term? _____ □ None

Were any of your children premature? □ Yes □ No If so, how many? _____

Have you ever had a miscarriage, stillborn child, or abortion? □ Yes □ No If so, how many? _____

Have any of your children passed away? □ Yes □ No

Past Pregnancies

Date of Delivery	# of Fetuses	Gestational Age	Gender	Baby's Weight	Type of Delivery	Length of Labor	Labor Epidural	Place of Delivery	Problems/Complications

Personal and Family Medical History

Maternal = Mother's side Paternal = Father's side

MGM = maternal grandmother MGF = maternal grandfather PGM = paternal grandmother PGF = paternal grandfather

	Self	Mom	Dad	Sister	Brother	MGM	MGF	PGM	PGF	other	Specify if other
Diabetes Type I	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Diabetes Type II	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Blood Clot in Legs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Blood Clot in Lungs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Heart Attack	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Thyroid Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Rheumatoid Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Lupus	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Varicose Veins	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Endometriosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Birth Defects	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Multiple Gestation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Anesthesia Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Kidney Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Frequent UTIs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Liver Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Hepatitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
HIV/AIDS	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Neurologic Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Dementia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Seizures/Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Migraines	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Tuberculosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Lung Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Digestive problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Cancer:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Breast	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Ovarian	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Uterine	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Cervical	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Colon	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Liver Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Thyroid	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Lung	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Social History

Do you currently smoke cigarettes? □ Yes □ No If yes, number per day _____

Have you ever smoked? □ Yes □ No If yes, number of years_____

Current occupation and employer: _____

□ Part time □ Full time

Highest level of education: _____

Are you: □ Single □ Married □ Divorced □ Widowed

Do you drink alcohol? □ Yes □ No

If yes, number of drinks per week _____

How many days in the past year have you had heavy drinking consumption? (4+ drinks) _____

Do you use street drugs? □ Yes □ No

Are you currently sexually active? □ Yes □ No

Have you ever been sexually active? □ Yes □ No

If yes please circle: Men Women Both

Do you use protection with intercourse? □ Yes □ No

Number of sexual partners in the past year _____ Number of sexual partners in lifetime _____

Do you use your seatbelt? □ Yes □ No

Any personal history of abuse? (please circle) □ Yes □ No

physical mental sexual

Do you feel safe in your home? □ Yes □ No

Do you have guns present in your home? □ Yes □ No

Do you drink caffeine? □ Yes □ No If so, how much? _____

Is your exercise level: □ none □ occasional □ moderate □ heavy

Is your general stress level: □ low □ medium □ high

Do you follow a special diet? □ Yes □ No

If so, please explain _____

In the event of an emergency, do you accept a blood transfusion? □ Yes □ No

Are you adopted ? □ Yes □ No

Surgical History

Please list all surgeries and hospitalizations (other than c-sections previously listed):

Date	Surgery/Reason for Hospitalization	Doctor	Hospital	Problems/Complications

Do you have any implants, such as artificial heart valves or hip prosthesis? □ Yes □ No

Have you ever been told to use antibiotics prior to surgery because of a heart condition? □ Yes □ No

Symptoms/Conditions

Please check what symptoms you currently have or have had in the past year.

General
□ Fatigue
□ Recurrent fever
□ Weight Gain _____ pounds
□ Weight Loss _____ pounds

Skin
□ Changes in moles
□ Rashes

Ear, Nose, Mouth, and Throat
□ Hearing loss
□ Earache
□ Sinus problems
□ Recurrent sore throat
□ Snoring
□ Dry mouth
□ Mouth ulcer

Respiratory
□ Shortness of breath
□ Persistent Cough
□ Sputum
□ Wheezing

Cardiovascular
□ Chest pain
□ Irregular heartbeat
□ High blood pressure

Gastrointestinal
□ Heartburn
□ Difficulty swallowing
□ Nausea
□ Vomiting
□ Abdominal pain
□ Bowel changes
□ Diarrhea
□ Constipation
□ Rectal bleeding

Genito-Urinary
□ Blood in the urine
□ Abnormal bleeding
□ Flank pain
□ Trouble urinating
□ Lack of bladder control
□ Rash
□ Lesion
□ Vaginal discharge
□ Vaginal odor
□ Vaginal itching/irritation

Endocrine
□ Irritability
□ Tension
□ Anxiety
□ Depression
□ Breast pain/tenderness
□ Bloating
□ Overwhelmed feeling
□ Hot flashes
□ Night sweats
□ Vaginal dryness
□ Impaired memory
□ Impaired concentration
□ Decreased libido
□ Orgasmic dysfunction
□ Pain with intercourse

Muscoskeletal
□ Muscle aches
□ Muscle weakness
□ Joint pain
□ Back pain

Neurological
□ Headaches
□ Dizzyness
□ Loss of consciousness
□ Weakness
□ Numbness
□ Seizures

Psychological
□ Depression
□ Alcoholism
□ Sleep disturbances

Lymphatic
□ Swollen glands
□ Bruise easily

Immunolgoic
□ Runny nose
□ Itching
□ Hives
□ Frequent sneezing

☐ NONE

Signature: _____ Date: _____

Interpreter Signature: _____ Date: _____

This page is for pregnant patients only

Genetics Screening

This includes the patient, baby's father, and anyone in either family.

Patient age 35 or older	□ Yes	□ No
Thalassemia (Italian, Greek, Mediterranean, or Asian background)	□ Yes	□ No
Neural tube defect (meningomyelocele, spina bifida, or anencephaly)	□ Yes	□ No
Congenital heart defect	□ Yes	□ No
Down Syndrome	□ Yes	□ No
Tay-Sachs (eg: Jewish, Cajun, French Canadian)	□ Yes	□ No
Canavan disease	□ Yes	□ No
Sickle Cell Disease or trait (African)	□ Yes	□ No
Hemophilia	□ Yes	□ No
Muscular Dystrophy	□ Yes	□ No
Cystic Fibrosis	□ Yes	□ No
Huntington's Chorea	□ Yes	□ No
Mental Retardation/Autism	□ Yes	□ No
if yes, was person tested for Fragile X?	□ Yes	□ No
Other inherited genetic or chromosomal disorder	□ Yes	□ No
Maternal Metabolic Disorder (eg, Type 1 Diabetes, PKU)	□ Yes	□ No
Patient or baby's father had a child with birth defects not listed above	□ Yes	□ No
Spontaneous miscarriage or stillbirth	□ Yes	□ No
Have you used medication/street drugs/alcohol since last period?	□ Yes	□ No
if yes, please list _____		
Any other genetic histories	□ Yes	□ No
if yes, please list _____		

Infection History:

This includes only the patient

Do you live with someone with TB or have you been exposed to TB?	□ Yes	□ No
Do you or your partner have a history of genital herpes?	□ Yes	□ No
Have you had a rash or viral illness since your last menstrual period?	□ Yes	□ No
Do you have a history of sexually transmitted diseases?	□ Yes	□ No
Do you have any reason to believe you are at high risk for HIV?	□ Yes	□ No
Do you have any reason to believe you are at high risk for Hepatitis B?	□ Yes	□ No
Have you been immunized against Hepatitis B?	□ Yes	□ No
Do you have a history of Pelvic Inflammatory Disease (PID)?	□ Yes	□ No
Do you have a history of infections of your tubes or ovaries?	□ Yes	□ No

Have you had any problems with this pregnancy (bleeding, cramping, headaches, visual problems, vaginal discharge, etc)?

_____

_____

_____

_____

_____