Doctor: _____ *Patient ID #:*

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____ Sex: [ ]M [ ]F

Address: _____ Social Security #: _____

_____ _____ Phone: _____ [ ]Home [ ]Work [X]Other

City,State, Zip: _____ Phone: _____ [ ]Home [ ]Work [X]Other

Pharmacy Name & Address: _____ Phone: _____ [ ]Home [ ]Work [X]Other

_____ Marital Status: [ ]Married [ ]Single [ ]Divorced

Email Address: _____

Ethnicity: [ ]Hispanic or Latino [ ]Non Hispanic or Latino [ ]Other

Preferred Language: _____

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American

☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Unspecified ☐ Patient Declined

PATIENT EMPLOYMENT INFORMATION

[ ]Employed [ ]Retired [ ]Unemployed [X]Other

Employer's Name: _____ Referring Physician: _____

Employer's Phone: _____ Primary Physician: _____

Occupation: _____

EMERGENCY CONTACTS

Name	*Relationship*	*Phone*

RESPONSIBLE PARTY (If patient is under 18 years of age)

Name: _____ Employer: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

City,State, Zip: _____ SSN: _____

Date of Birth: _____

PRIMARY INSURANCE

Insurance Company Name: _____

ID #: _____

Group/Policy #: _____

Subscriber's Name: _____

Subscriber's Phone #: _____

Relationship to Patient: _____

Subscriber's Employer: _____

Subscriber's SS #: _____

Subscriber's Date of Birth: _____

SECONDARY INSURANCE

Insurance Company Name: _____

ID #: _____

Group/Policy #: _____

Subscriber's Name: _____

Subscriber's Phone #: _____

Relationship to Patient: _____

Subscriber's Employer: _____

Subscriber's SS #: _____

Subscriber's Date of Birth: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my illness to my insurance carrier. ***I understand that I am responsible for any amount not paid for by my insurance.***

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

I authorize the clinic to obtain medication history electronically from my pharmacy benefit administrator.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

Women's Healthcare Clinic of Oregon, P.C.
COLLECTION POLICY

TO OUR PATIENTS - Thank you for allowing us be of service to you. Non payment of medical bills has a direct effect on you, your community and the medical provider. Therefore, we have implemented the following policies:

INSURANCE BILLING – We agree to bill primary and secondary insurance carrier(s) for you, *provided* you bring all necessary information needed at the time of service. Requests for re-filing claims, due to incorrect information provided, will result in a $10.00 re-filing fee.

BILLING POLICY – We will provide you with an itemization of services rendered within thirty days of service or after insurance payment received.

PAYMENT POLICY – We ask that you pay your co-payments upon check-in and all co-insurance amounts (due by patient) within thirty days of insurance reimbursement. Uninsured patients will be expected to pay 100% of charges (less 20% for cash discount) at the time of service.
We accept payments of cash, check, VISA, MasterCard or Bank Debit cards. *There is a $5.00 per month rebilling fee for patient balances not paid within 60 days from the date of service, until balance is paid in full or the account is referred to an outside agency.*

COLLECTION POLICY – All patient balances not paid in accordance with the payment policy noted above, may be referred to an outside collection agency. *Whether or not litigation is instituted to collect the amounts owed, you and/or your responsible party will be liable for all reasonable collection agency fees charged and any related expenses incurred in connection with any related legal action to collect amounts owed.*

RETURNED CHECK CHARGES - Should a check be returned for any reason, a fee of $20.00 will be charged. If necessary to collect the amount of the check, it may be assigned to a collection agency or referred to an attorney. In that event, the writer of the check shall be liable for the face value of the check plus collection charges as stated above, plus any other damages or charges permitted under applicable law.

There will be a $25.00 charge for missed appointments that are not cancelled 24 hours prior to the appointment time. Timely cancellations allow us to offer that time to someone on our wait list.

Signed_____ Date_____

RELEASE AUTHORIZATION

I HEREBY AUTHORIZE WOMEN'S HEALTHCARE CLINIC OF OREGON to furnish the insured's insurance company all the information which said insurance company may request concerning my present medical condition. I hereby assign to the said doctor and/or surgical expense relative to the services performed from time to time, but not to exceed my indebtedness to said physician and surgeon. I understand I am financially responsible to said doctor for charges not covered by this agreement.

Signed_____ Date_____

WOMEN'S HEALTHCARE CLINIC OF OREGON, PC.
Physicians & Surgeon ♦ Obstetrics & Gynecology
10000 SE Main, Suite 10, Portland OR 97216
(503)256-1470 Fax (503)256-1283

GYNECOLOGY UPDATE

Date_____

Last Name_____ First Name _____ Middle Initial _____

Age_____ Marital Status _____ Primary Care Provider_____

1. Have you been hospitalized or had surgery since your last annual exam? ❑ Yes ❑ No
If yes, please specify _____
_____

2. Date of last Pap test _____ Normal ❑ Yes ❑ No
Date of last Mammogram _____ Normal ❑ Yes ❑ No
Date of Colonoscopy _____ Normal ❑ Yes ❑ No
Date of Bone-Density Scan _____ Normal ❑ Yes ❑ No
Date of Cholesterol Panel _____ Normal ❑ Yes ❑ No
If answered no above, please specify abnormal findings and treatment _____

3. Have you had any other imaging tests or lab work since your last annual exam? ❑ Yes ❑ No
If yes, please specify _____
_____

4. Please list your current medications (include herbs, vitamins, supplements, aspirin and over the counter medications)

Name	Dose	Frequency	Why you take it

5. Please list allergies: ❑ No known allergies
Medication Reaction
_____
_____
_____

6. Have there been any family illnesses or deaths since your last visit? ❑ Yes ❑ No
If yes, please specify _____
_____

7. Any history of breast or ovarian cancer in the family?
❑ Yes ❑ No If yes, please specify _____
_____

8. Do you exercise regularly? ❑ Yes ❑ No
Please specify activity and number of hours/week
_____

9. What is your typical use of
Cigarettes _____ ❑ Packs/day ❑ Cigarettes
Alcohol (glasses/week)____ ❑ Wine ❑ Beer ❑ Liquor
Caffeine (cups/day) _____ ❑ Coffee ❑ Soda ❑ Tea

10. Current medical illnesses, check all that apply:
❑ Diabetes ❑ High blood pressure
❑ High cholesterol ❑ Thyroid disorder
❑ Weight gain or loss ❑ Uncontrolled loss of urine
❑ Other: _____

11. # of pregnancies _____ # of children_____

12. # of miscarriages, abortions or ectopic pregnancies
_____

13. Are you having abnormal discharge? ❑ Yes ❑ No

14. Have you received the Gardasil vaccine? ❑ Yes ❑ No

15. Any new sexual partners the past year? ❑ Yes ❑ No

16. STD testing desired? ❑ Yes ❑ No
(for example: HIV, gonorrhea, Chlamydia, etc.)

17. **Are you postmenopausal?** ❑ Yes ❑ No
If yes, do you have postmenopausal vaginal bleeding?
❑ Yes ❑ No

If you are still having menstrual periods, please continue:

18. First day of last menstrual period _____

19. How many days does your period last_____

20. # days between 1st day of each menstrual cycle _____

21. Do you spot or bleed between periods? ❑ Yes ❑ No

22. Do you suffer from cramps? ❑ Yes ❑ No

23. Are you using any birth control? ❑ Yes ❑ No
If yes, what? ❑ Pills/Patch/Ring ❑ Tubal ❑ Vasectomy
❑ Essure ❑ IUD ❑ Diaphragm
❑ Condoms ❑ Rhythm method
Other: _____

24. Are you planning or currently trying to conceive a baby?
❑ Yes ❑ No
If yes, how long have you been trying? _____

25. Any specific concerns you'd like to discuss today?
_____
_____

PROVIDER NOTES:

Please return the completed form to the receptionist. Thank you.

General	Fever		**Musc/Skel**	Muscle Weakness	
	Chills			Muscle or Joint Pain	
	Sweats			Back Pain	
	Weight Loss		**Skin**	Acne	
	Weight Gain			Rash	
	Fatigue			Non – Healing Sore	
Eyes	Vision Changes			Dry Skin	
ENT	Headache			Pigmented Lesions	
	Throat Pain		**Breast**	Breast Pain	
	Frequent Headaches			Nipple Discharge	
Heart	Chest Pain			Masses	
	Leg Swelling			Breast Tenderness	
	Palpitations		**Neuro**	Dizziness	
Respiration	Wheezing			Weakness	
	Coughing up Blood			Numbness	
	Shortness of Breath		**Psych**	Depressed Mood	
	Cough			Cries Easily	
Gastrointestinal	Diarrhea			Irritability	
	Bloody Stool			Severe Anxiety	
	Nausea/Vomiting/Indigestion			Trouble Concentrating	
	Constipation		**Endocrine**	Hot Flashes	
	Flatulence (Gas)			Hair Loss	
	Abdominal Pain			Heat/Cold Intolerance	
	Abdominal Bloating			Unusual Weight Changes	
	Heartburn			Excessive Thirst	
GYN	Vaginal Discharge			Excessive Hunger	
	Painful Periods		**Hem/Lymp**	Bruises	
	Painful Intercourse			Bleeding	
	Painful Bowel Movements			Enlarged Lymph Nodes	
	Abnormal Vaginal Bleeding		**Allergy**	Congestion	
	Heavy Menstrual Bleeding			Runny Nose	
	Missed Periods		**Other**		
Urinary	Blood in Urine				
	Painful Urination				
	Urgency				
	Frequency				
	Urinary Leaking				

PLEASE MARK ALL THAT **CURRENTLY** APPLY AND GIVE TO NURSE AT APPOINTMENT

NAME_____ DATE_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME:_____
(First) (Middle) (Last)

Date of Birth_____ **Social Security Number:**_____

Any Previous &/or Other Name(s):_____

PERMISSION IS HEREBY GRANTED FOR RELEASE OF INFORMATION

□ TO □ FROM

Women's Healthcare Clinic of Oregon, P.C.
10000 SE Main St. Suite 10
Portland, OR 97216
Office (503) 256-1470
Fax (503) 256-1283

□TO □ FROM _____

_____

_____

PURPOSE OF RELEASE: (Please check):
□ Changing Clinic □Continuing Care □ Legal □Other_____
(Please Specify)

PERMISSON TO FAX INFORMATION **Yes** □ **No** □
I specifically consent to the faxing of my records. All faxed material will contain a confidentiality statement, however, I understand confidentiality at the receiving end cannot always be guaranteed.

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

1) We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
2) You may inspect a copy of the protected health information to be used or disclosed;
3) You may refuse to sign this Authorization;
4) We must provide you with a copy of the signed Authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and with the exception that we have not already used and disclosed the information as instructed by this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire in 90 days from the date of signing or shall remain in effect for the period reasonably needed to complete request.

TYPE OF INFORMATION TO BE RELEASED

ALL ITEMS BELOW □

□ Medication Summary	□History & Physical	□Pathology Reports
□ Consultations	□Laboratory Reports	□Progress Notes
□ Discharge Summary	□ Operative Reports	□ X-ray Reports

For the following dates of service From:_____ To:_____

PROTECTIVE OR SENSITIVE INFORMATION: I understand that certain information can not be released without specific authorization as required by State/Federal Law(s). By initialing I authorize the release of the following protected or sensitive information:

___ Drug Abuse Diagnosis &/or Treatment ___Alcoholism Diagnosis &/or Treatment
___Mental Health &/or Treatment ___AIDS &/or HIV Test Results and Related Information
___Genetic Testing Including High Risk Behavior Documentation

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

_____ _____ _____ _____
Signature of Patient or Representative Relation to Patient Date Signed

_____ Witness Signature (optional)

Acknowledgement of Receipt of Notice

Sharon E. Wong, MD Julie T. Crawford, MD
Kelli L. Andersen, MD
10000 SE Main St., Ste 10, Portland OR 97216

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Signed:_____ Date:_____

Print Name:_____ Telephone:_____

If not signed by the patient, please indicate Relationship:

- ☐ Parent or guardian of minor patient.
- ☐ Guardian or conservator of an incompetent patient.
- ☐ Beneficiary or personal representative of deceased patient.

Name of Patient:_____

For Office Use Only:

☐ Signed form received by:_____ Date:_____

☐ Acknowledgment refused:

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____