

THE CENTER FOR WOMEN, INC.
4139 BOARDMAN-CANFIELD ROAD • CANFIELD, OH 44406
(330) 702-1281

PATIENT INFORMATION

TODAY'S DATE _____ PREFERRED PHARMACY _____ LOCATION _____

PATIENT'S NAME _____ DATE OF BIRTH _____ SS# _____

RACE AFRICAN-AMERICAN ASIAN CAUCASION NATIVE HAWAIIAN
 AMERICAN INDIAN HISPANIC OTHER _____

ETHNICITY _____ PREFERRED LANGUAGE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMAIL ADDRESS _____

MARITAL STATUS SINGLE MARRIED DIVORCED WIDOWED

SPOUSE'S NAME _____ DATE OF BIRTH _____ SS# _____
(OR RESPONSIBLE PARTY)

FAMILY DOCTOR _____ PREVIOUS OB/GYN SEEN _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

DO YOU HAVE A LIVING WILL? _____ DO YOU HAVE A DURABLE POWER OF ATTORNEY? _____

EMPLOYER INFORMATION

PATIENT'S EMPLOYER _____
 FULL TIME PART TIME UNEMPLOYED RETIRED

SPOUSE'S EMPLOYER _____
(OR RESPONSIBLE PARTY) FULL TIME PART TIME UNEMPLOYED RETIRED

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT _____ RELATIONSHIP TO PATIENT _____

PHONE NUMBER _____

I hereby authorize Jennifer Baird, MD; Laura Musser, DO; Gaye Simpson, CNM; Cecelia Gallagan, WHNP; Julie Brennan, WHNP; and/or Stefanie Reed, WHNP to apply for benefits on my behalf for services rendered by them or by their order. I request payment from my insurance company to be made directly to The Center for Women, Inc.

I certify that the information reported with regard to my insurance coverage is correct. If my insurance company does not cover the cost of any services, I agree to be fully responsible for them. If I default on any payment, I will be responsible for collection costs including , but not limited to, collection agency fees, court costs, and reasonable attorney fees incurred to collect this debt. I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of the original.

I have read, fully understand and agree to the above.

SIGNATURE _____
(PATIENT, PARENT, OR GUARDIAN)

DATE _____

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PATIENT QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

REASON FOR VISIT: _____ Age: _____

Last menstrual period: _____ Not Applicable due to: Menopause Mirena IUD
 Hysterectomy Breastfeeding
 Ablation Other

Flow: Light Medium Heavy
Clots: Yes No
Severe Cramps: Yes No
of days you bleed: _____
of days between periods: _____ (i.e. 28,30)

Number of **NEW** sexual partners since last visit: _____ Current Sexual Partner: Male Female

Are you currently sexually active? Yes No

Type of contraception currently used: Pills NuvaRing DepoProvera
 Condoms Tubal Ligation Vasectomy
 IUD Diaphragm Foam
 Other _____

Date of last Colonoscopy: _____ Date of last Mammogram: _____ Date of last Bone Density: _____

Alcohol Use: Never Current Former Amount _____
Recreational Drug Use: Never Current Former Amount _____
Tobacco Use: Never Current Former Amount _____

Domestic Violence: Emotional: Current Past Physical: Current Past Sexual: Current Past

Do you perform breast self exam? Yes No

REVIEW OF SYSTEMS Please check if you are **CURRENTLY** experiencing any of these symptoms.

CONSTITUTIONAL	GASTROINTESTINAL	INTEGUMENTARY
<input type="checkbox"/> Unexplained Weight Loss	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Rash
<input type="checkbox"/> Unexplained Weight Gain	<input type="checkbox"/> Nausea	<input type="checkbox"/> Skin Lesions
<input type="checkbox"/> Fever	<input type="checkbox"/> Vomiting	NEUROLOGIC
<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Seizures
<input type="checkbox"/> Excessive Urination	<input type="checkbox"/> Bloating	<input type="checkbox"/> Dizziness
HEENT	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Syncope (Fainting / Passing out)
<input type="checkbox"/> Headaches	<input type="checkbox"/> Constipation	ENDOCRINE
<input type="checkbox"/> Problems with teeth/gums	<input type="checkbox"/> Bloody Stool	<input type="checkbox"/> Cold Intolerance
BREAST	GENITOURINARY	<input type="checkbox"/> Heat Intolerance
<input type="checkbox"/> Breast Lumps	<input type="checkbox"/> Pain with Intercourse	<input type="checkbox"/> Excessive Hair Growth
<input type="checkbox"/> Breast Pain	<input type="checkbox"/> Spotting with or after Intercourse	
<input type="checkbox"/> Breast Discharge	<input type="checkbox"/> Abnormal Vaginal Discharge	
<input type="checkbox"/> Changes in Skin	<input type="checkbox"/> Vaginal Dryness	
CARDIOVASCULAR	<input type="checkbox"/> Urinary Frequency	
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Urinary Urgency	
<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Urinary Retention	
RESPIRATORY	<input type="checkbox"/> Painful Urination	
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Blood in Urine	
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Incontinence	
<input type="checkbox"/> Cough		

Patient's Signature _____ Doctor's Signature _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. I acknowledge that I have received The Center for Women's Rights and Responsibilities policy and have been offered a copy of the entire HIPAA privacy notice. This notice is also available at all times in The Center for Women's waiting room and I may request an additional copy of it at any time by contacting the Office Manager at 330-702-1281.

I wish to be contacted in the following manner (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Home Telephone | <input type="checkbox"/> Written Communication |
| <input type="checkbox"/> OK to leave message with detailed information | <input type="checkbox"/> OK to mail to my home address |
| <input type="checkbox"/> Leave message with call back number only | <input type="checkbox"/> OK to mail to my work address |
| <input type="checkbox"/> Work Telephone | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> OK to leave message with detailed information | |
| <input type="checkbox"/> Leave message with call back number only | |

YOU MAY DISCUSS MY HEALTH INFORMATION WITH:

NAME	RELATIONSHIP	PHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature

Date

Printed Name

Date of Birth