MERIDIAN
WOMEN'S HEALTH & WELLNESS

New Patient OB - History and Physical

Name: _____

Reason for Visit: _____

Who is your Primary Care Physician (PCP)? _____

Any international travel in the last year? If yes, where? _____

Medications - Please list all current medications with dosage (including over-the-counter):

_____ _____ _____

_____ _____ _____

_____ _____ _____

Prenatal Vitamin? ☐ Yes ☐ No

Past Medical History:

Please list all medical conditions with year of diagnosis: _____

_____

Any known allergies? _____

Any previous surgeries? If so, provide date(s): _____

_____

Any previous hospitalizations, not including child birth? If so, provide date(s): _____

_____

Family History:

Do you have any children? Are they healthy? If not, what condition or disease do they have?

_____

_____

Do you have any siblings? Are they healthy? If not, what condition or disease do they have? _____

_____

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WOMEN'S HEALTH & WELLNESS

Patient Name: _____

Your Father: Current age, living or deceased? Please list all health conditions. _____

_____

Your Mother: Current age, living or deceased? Please list all health conditions. _____

_____

Any other family members with health conditions? List member, current age, conditions, and alive or deceased:

_____

_____

Drugs/Alcohol:

Do you drink alcohol? ☐ Yes ☐ No Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Once in a while

Have you used any illegal drugs in the past 10 years? ☐ Yes ☐ No If so, what? _____

Do you smoke marijuana? ☐ Yes ☐ No

Tobacco Use/Smoking:

Do you currently use tobacco? ☐ Yes ☐ No How often? ☐ Every day ☐ Some days ☐ Socially

How many cigarettes per day? _____ Other tobacco products _____

Are you a past smoker? ☐ Yes ☐ No What year did you quit? _____

Are you interested in quitting? ☐ Yes ☐ No

Sexual History:

Have you had sex in the past 12 months: ☐ Yes ☐ No ☐ Vaginal ☐ Oral ☐ Anal

Do you have sex with ☐ Men, ☐ Women, or ☐ Both?

Have you ever had any sexually transmitted disease or infections (STD's or STI's)? ☐ Yes ☐ No
If yes, what was your diagnosis: _____

Have you ever been sexually assaulted or abused? ☐ Yes ☐ No

Do you feel safe at home? ☐ Yes ☐ No

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WOMEN'S HEALTH & WELLNESS

Patient Name: _____

GYN History:

At what age did you have your first period? _____

What was the first day of your last period? _____

How often are your periods? ☐ 28-30 days ☐ More than monthly ☐ Infrequently ☐ Totally irregular

Do you have heavy periods? ☐ Yes ☐ No Do you have severe pain with your periods? ☐ Yes ☐ No

When was your last pap smear? _____ Have you ever had an abnormal pap? ☐ Yes ☐ No

What age were you when you started menopause? _____

Are you currently using birth control? ☐ Yes ☐ No. If so, what kind? ☐ Condoms ☐ Pills ☐ IUD ☐ Tubes tied ☐ Other _____

OB History: **check all that apply**

Do you have any personal history of: ☐ Heart Disease ☐ High Blood Pressure ☐ Auto Immune Disease ☐ Kidney Disease/Infection
☐ Diabetes ☐ Neurologic problems/seizures ☐ Depression/Postpartum Depression ☐ Hepatitis/Liver Disease ☐ Varicosities
☐ Thyroid Disorders ☐ Trauma/domestic violence ☐ Blood Transfusion ☐ Lung Disease (TB or Asthma) ☐ Seasonal Allergies
☐ Drug Allergies/Latex Allergy ☐ Breast Diseases ☐ Anesthesia Complications ☐ Infertility

Baby's Father's name: _____

Any family history or Father's family history of:

☐ Thalassemia ☐ Spina Bifida or neural tube defect ☐ Heart Defect ☐ Down Syndrome ☐ Ashkenazi Jewish Ancestry ☐ Tay-Sachs
☐ Canavan Disease ☐ Sickle Cell Disease or Trait ☐ Hemophilia or Blood Disorders ☐ Cystic Fibrosis ☐ Mental Disability or Autism
☐ Fragile X ☐ Other inherited or chromosomal Disorder ☐ Metabolic Disorder ☐ Birth Defects ☐ Recurrent miscarriages ☐ Still Births
☐ Other: _____

Do any of the following apply:

Do you live with someone who has TB or have you been exposed to TB? ☐ Yes ☐ No

Do you or your partner have herpes? ☐ Yes ☐ No

Have you had a rash or fever or viral illness since your last period? ☐ Yes ☐ No

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Patient Name: _____

Past Pregnancy Outcomes:

Total number of pregnancies (including miscarriages and abortions? _____

Number of total living children? _____ Number of still births? _____

Number of miscarriages? _____ Number of abortions? _____

Number of Cesarean Sections? _____

Pregnancy #1:

Date: _____

Weeks at delivery/miscarriage/abortion? _____

Length of Labor in hours? _____

Birth weight: _____

Name of child: _____ ☐ Male ☐ Female

Type of delivery: ☐ Vaginal ☐ C-Section ☐ Forceps or vacuum ☐ Miscarriage ☐ Abortion

Anesthesia: _____

Place of birth: _____

Any complications: _____

Pregnancy #2:

Date: _____

Weeks at delivery/miscarriage/abortion? _____

Length of Labor in hours? _____

Birth weight: _____

Name of child: _____ ☐ Male ☐ Female

Type of delivery: ☐ Vaginal ☐ C-Section ☐ Forceps or vacuum ☐ Miscarriage ☐ Abortion

Anesthesia: _____

Place of birth: _____

Any complications: _____

_____

Pregnancy #3:

Date: _____

Weeks at delivery/miscarriage/abortion? _____

Length of Labor in hours? _____

Birth weight: _____

Name of child: _____ ☐ Male ☐ Female

Type of delivery: ☐ Vaginal ☐ C-Section ☐ Forceps or vacuum ☐ Miscarriage ☐ Abortion

Anesthesia: _____

Place of birth: _____

Any complications: _____

_____

Pregnancy #4:

Date: _____

Weeks at delivery/miscarriage/abortion? _____

Length of Labor in hours? _____

Birth weight: _____

Name of child: _____ ☐ Male ☐ Female

Type of delivery: ☐ Vaginal ☐ C-Section ☐ Forceps or vacuum ☐ Miscarriage ☐ Abortion

Anesthesia: _____

Place of birth: _____

Any complications: _____

_____

Pregnancy #5:

Date: _____

Weeks at delivery/miscarriage/abortion? _____

Length of Labor in hours? _____

Birth weight: _____

Name of child: _____ ☐ Male ☐ Female

Type of delivery: ☐ Vaginal ☐ C-Section ☐ Forceps or vacuum ☐ Miscarriage ☐ Abortion

Anesthesia: _____

Place of birth: _____

Any complications: _____

_____

Review of Systems:

General/Constitutional: check all that apply

☐ Change in appetite ☐ Chills ☐ Fatigue ☐ Fever ☐ Headache ☐ Light Headedness ☐ Night sweats

☐ Weight gain ☐ Weight loss

Eyes: check all that apply

☐ Blurred vision ☐ Decreased visual acuity ☐ Itching and redness ☐ Wears contact lenses/glasses

ENT: check all that apply

☐ Capped teeth, veneers, dentures ☐ Decreased hearing ☐ Difficulty swallowing ☐ Dry mouth ☐ Ear pain ☐ Masses

☐ Mouth breathing at night ☐ Nose bleeds ☐ Ringing in ears ☐ Sinus pain ☐ Snoring ☐ Sore throat ☐ Swollen Glands

Cardiovascular: check all that apply

☐ Chest pain ☐ Bluish/purple skin coloring ☐ Shortness of breath on exertion ☐ Heart problems ☐ High blood pressure
☐ Irregular heartbeat ☐ Shortness of Breath while lying flat ☐ Palpitations ☐ Swelling in Hands/Feet ☐ Weakness

Respiratory: check all that apply

☐ Cough ☐ Breathing problems ☐ Coughing up blood ☐ Pain with inspiration ☐ Shortness of breath ☐ Sputum production ☐ Wheezing

Gastrointestinal: check all that apply

☐ Abdominal pain ☐ Blood in stool ☐ Change in bowel habits ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Vomiting blood ☐ Nausea
☐ Vomiting

Genitourinary: check all that apply

☐ Blood in urine ☐ Difficulty urinating ☐ Frequent urination ☐ Painful urination

Musculoskeletal: check all that apply

☐ Joint stiffness ☐ Leg cramps ☐ Muscle aches ☐ Painful joints ☐ Sciatica ☐ Swollen Joints ☐ Weakness

Skin: check all that apply

☐ Acne ☐ Discoloration ☐ Dry skin ☐ Eczema ☐ Hair change ☐ Nail changes ☐ Rash

Neurologic: check all that apply

☐ Dizziness ☐ Fainting ☐ Memory loss ☐ Seizures ☐ Stroke ☐ Tingling/numbness ☐ Tremor

Psychiatric: check all that apply

☐ Anxiety ☐ Auditory/visual hallucinations ☐ Depressed mood ☐ Difficulty sleeping ☐ Eating disorder ☐ Substance abuse ☐ Suicidal thoughts

Endocrine: check all that apply

☐ Cold tolerance ☐ Excessive sweating ☐ Excessive thirst ☐ Hair loss ☐ Heat intolerance ☐ Hot flashes ☐ Thyroid problems

Hematology: check all that apply

☐ Anemia ☐ Bleeding problems ☐ Easy bruising ☐ Prolonged bleeding ☐ Family member with bleeding problem ☐ Swollen glands

Allergy/Immunology: check all that apply

☐ Congestion ☐ Cough ☐ HIV positive ☐ Hives ☐ Itching ☐ Rash ☐ Seasonal allergies ☐ Sneezing ☐ Wheezing
☐ Unusual reaction to medications, food, animals or insects ☐ You or family member have problem with anesthesia

Breast: check all that apply

☐ Bloody nipple discharge ☐ Breast lumps ☐ Breast pain ☐ Breast swelling ☐ Nipple discharge

OB/GYN: check all that apply

☐ Heavy bleeding ☐ Irregular periods ☐ Painful periods ☐ Missed periods ☐ Painful intercourse ☐ Vaginal bleeding between periods
☐ Vaginal discharge/itching

MERIDIAN
WOMEN'S HEALTH & WELLNESS

Patient Registration Form

Patient's Name: _____ _____ _____ Previous Name:_____
Last *First* *MI*

Address:_____ City, State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

Email: _____

Date of Birth (mm/dd/yyyy)_____ Sex: ☐ Female ☐ Male ☐ Transgender ☐ Undefined

Primary Care Physician (PCP): _____ Referring provider: _____

Pharmacy: _____ Phone:_____ Address:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Other: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Employment status: ☐ Full-time ☐ Part-Time ☐ Not employed ☐ Self-employed ☐ Retired ☐ Active Military

Occupation:_____ Employer:_____

Student Status: ☐ Full-time Student ☐ Part-time Student ☐ Not a student

Do you have a living will? ☐ Yes ☐ No

Emergency Contact Information:

Name: _____ Phone Number: _____

Relationship_____ Address:_____

Responsible Party Information

Responsible Party: ☐ Another patient ☐ Guarantor ☐ Self

Check here if information is same as patient ☐

Responsible Party Name: _____ _____ _____
Last *First* *MI*

Address:_____ City, State:_____ Zip:_____

Date of Birth (mm/dd/yyyy)_____ Gender: ☐ Female ☐ Male Employer:_____

Primary Insurance Information

Insurance Company:_____ Member ID _____ Group #:_____

Name of Insured:_____ Effective Date:_____ Subscriber DOB:_____

Secondary Insurance Information

Insurance Company:_____ Member ID _____ Group #:_____

Name of Insured:_____ Effective Date:_____ Subscriber DOB:_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or responsible party) signature:_____

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WOMEN'S HEALTH & WELLNESS

Patient HIPPA Acknowledgement and Consent Form

Patient Name:_____ Date of Birth_____

_____(Patient/Representative initials). **Notice of Privacy Practices**
I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaints. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____(Patient/Representative initials). **Release of Information**
I herby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carries for payment of Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMEBR OR INDIVIDUAL WITH WHOME THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?
I give permission for my protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1			
2			
3			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing. **Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided.**

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Prescription Order Pick-up: There may be times when you need a friend of family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for prescription.

_____(Patient/Representative initials) I ***wish*** to designate the following individual to pick up a prescription order on my behalf:

Name:_____ Relationship to patient:_____

Name:_____ Relationship to Patient:_____

_____ (Patient/Representative Initial) I ***do not want*** to designate anyone to pick-up my prescription order.

Patient Name (Printed):_____ **DOB:**_____

Signature of Patient/Legally Authorized Representative: _____ **Date:** _____

Patient Representative Name (Printed):_____

I voluntarily consent to provide Meridian Women's Health & Wellness access to and use of my prescription medication history from other health care providers or third-party pharmacy benefit payors for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other healthcare drug historical information) from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may *include* prescription dating back for several years.

I acknowledge that Meridian Women's Health & Wellness may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

I understand that this Prescription History Consent will be valid and remain in effect as long as I attend or receive services from Meridian Women's Health & Wellness , unless revoked by me in writing with such written notice provided to each practice site I attend or from which I receive services.

I certify that I have read this form, or it has been read to me.

Patient Name: _____ **DOB**:_____ **Date**:_____

Signature of Patient/Legally Authorized Representative:_____

Relationship to Patient (if Patient not signing):_____

For patients requiring translation or verbal reading of this document, the person reading or translating should document and sign below:

Reader/Translator Signature:_____**Date:**_____

MERIDIAN
WOMEN'S HEALTH & WELLNESS

ULTRASOUND PROCEDURE & WAVIER FORM

Obstetrical Ultrasounds:
When an ultrasound is performed, it may involve multiple procedures during one visit and more than one charge may be generated. Additional procedures may be performed according to each clinical situation. Please be aware that even when a procedure is medically appropriate and necessary, this does not guarantee insurance coverage. It may also be necessary to perform an internal ultrasound to properly assess a clinical concern; this cannot always be determined at the time the ultrasound is ordered.

Pelvic Ultrasounds (not pregnant):
A complete pelvic ultrasound involves both a "trans-abdominal" (over the belly) and a "trans-vaginal" (internal) scan. They are both charged separately. As with OB scans, it is possible that based upon the findings of the initial scans, other procedures may be clinically indicated.

Ultrasound Detection of Birth defects:
In recent years, obstetrical ultrasound imaging has improved dramatically, and it is commonly thought that all birth defects can be detected. Limitations of sonographic imaging must be taken into consideration; Ultrasound can detect many but not all defects. The most common types of problems that are not seen are gastrointestinal (stomach & intestines) and cardiac (heart). Factors contributing to lac of visualization include fetal age, amount of amniotic fluid, mother's size, and fetal position.

After reading this statement, I understand that the sonographic examination cannot ensure a healthy, normal infant. I understand I may be charged for multiple ultrasounds on one day due to the types of ultrasounds that are done to achieve the pictures that the Provider requires. Again, even if a procedure is medically appropriate this does not always guarantee insurance coverage.

I have read and understand the above policy. By signing this I agree with Meridian Women's Health & Wellness ultrasound procedures.

Printed Name: _____ DOB:_____

Signature:_____ Date: _____

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician(s) and/or another person to order/perform all exams, tests, procedures, injections, phlebotomy, screening for HIV, drug screening and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to, with Meridian Women's Health & Wellness, unless revoked by me in writing.

Patient/Legal Representative Signature_____ Date: _____

Patient/Legal Representative Signature_____ Date:_____

Relationship to Patient: _____

MERIDIAN
WOMEN'S HEALTH & WELLNESS

We want to stay connected with our patients

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications

Patients in our practice may be contracted via email and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. Anytime, you provide an email address or text number below, you understand that you may get these communications from the Practice. You may opt out of these communications at any time. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

- The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is:_____
- The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is:_____

OR

_____ (Patient/Representative Initials) I decline to receive communication via text.

_____ (Patient/Representative Initials) I decline to receive communication via email.

If you have previously consented to receive communications via text and/or email and wish to remove the consent:

Opt out/revocation of communications via email and/or text. In other words, I do not want my email address or cell number to be used any longer for the above-mentioned communications.

_____ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text.

_____I hereby revoke my request to receive any future appointment reminders, feedback, and general health vial email.

Patient Name:_____

Patient/Patient Representative Signature: _____ Date:_____ Time: _____

Answering Service and Patient Portal Messaging Expectations

Telephone calls made to our clinic outside of normal business hours are handled by an on-call answering service. This service is intended to provide patient support for urgent healthcare needs. If you are experience an after-hours emergency we ask that you proceed immediately to the emergency department or seek medical evaluation. Please do not use the on-call service to request refills, referrals, appointments or test results. A Meridian Women's provider will return your phone call as promptly as possible, however, there are times the provider may already be attending to a medical emergency causing a delay in receiving a return phone call.

To allow for better access and communication between patient and provider you can enable portal messaging. Portal messaging are for non-urgent concerns or questions. Response time to messages may vary. If you have an urgent medical issue, please call us or seek immediate medical attention.

Print Patient Name_____ Patient Signature_____

MERIDIAN
WOMEN'S HEALTH & WELLNESS

Financial Policy

Meridian Women's Health & Wellness is committed to providing you with the best possible care and can discuss our professional fees with you at any time. It is important to our patient physician relationship that you read and fully understand our financial policy. Please let us know if you have any questions about your financial responsibility.

New patients are required to complete patient registration documents and medical history form prior to seeing the physician. Established patients are required to update their information forms at least once a year. We will ask to see your insurance card and driver's license every visit and will scan your card into our system as needed to keep our information current. Patients are required to pay Copayments/Deductibles upon arrival to their visit. You can make your payment to the Front Office Receptionists with cash or check or by Credit Card.

Copayment and Deductibles:
Your insurance requires that we collect your designated co-pay and/or deductible at the time of service. Please be prepared to pay the above fees at each visit.

Insurance Policy:
Your insurance policy is a contract between you and your insurance company. If you did not follow your insurance plan's terms, they may not pay for all or part of your care, and you may not qualify for any managed care discounts. If your insurance company does not pay within 60 days of the date of service, you may be expected to pay the balance in full. We will bill participating insurance companies as a courtesy to you. We do require that payment of deductible, co-pays and co-insurance be paid at the time of service.

Out-of-Network Insurance Plans:
We do not bill third party insurance companies such as: Auto or Liability Insurance; therefore, payment is expected in full at the time of service. However, we will provide you with the necessary documentation to help you submit your claim to the appropriate insurance carrier.

Self-Pay Patients:
Payment is due at the time service is rendered unless other arrangements have been made in advance.

Referrals:
If your Insurance Plan (Primary or Secondary) requires a referral from your Primary Care Physician, it is YOUR responsibility to obtain it prior to your appointment and to have it with you at the time of the appointment. If you do not have your referral, you may be required to reschedule.

Returned Check Fees and Appointment Cancellations:
Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a $35 fee per check returned.
Appointment Cancellations within 24 hours of the scheduled time may result in a $45 charge.

Delinquent accounts:
Patients with outstanding balance 60 days or more must make payment arrangements prior to scheduling appointments.

Parental Consent:
Responsibilities for payments who are minor children, whose parents are divorced, rest with the parent who seeks the treatment (The parent is the guarantor). Any court ordered responsibility judgement must be determined between the individuals involved, without the inclusion of Meridian Obstetrics and Gynecology.

Forms Completion:
FMLA or disability form completion may result in a $25 charge.

Self Pay Patients or Prompt Pay Patients Who are Insured:
A prompt pay discount is applied to all full pay payments received at the time of service whether or not you carry insurance. This means anyone willing to/or needing to pay in full at the time of service will receive the discount off of the evaluation and management service codes only. Charges for supplies, tests, immunizations, medications, aesthetic services or hormone therapy are never discounted.

Elective Medical Treatment
For any medical cosmetic/aesthetics, infertility evaluation and treatment, hormone replacement or other services considered not medically necessary and therefore not covered by insurance plans, full payment is required at the time of service. If in addition, any medical decision making is provided for anything other than these services, your insurance carrier will be billed.

Payments: We accept cash, check (in state only), VISA, Master Card, Discover and Care Credit.

Patient (or responsible party) Signature:_____