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New Patient Registration

Last Name_____ First Name_____ M_____

Date of Birth_____ Sex M F Marital Status_____ SSN_____

Address_____ City_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Race_____ Ethnicity Hispanic Non-Hispanic

Email_____

Occupation_____

Primary Care Provider_____ Referring Provider_____

Primary Pharmacy_____

Address_____

How did you hear about us? BILLBOARD FAMILY FRIEND PROVIDER INSURANCE
INTERNET SEARCH SOCIAL MEDIA WALK-IN OTHER_____

INSURANCE INFORMATION

IF NOT SELF, FILL OUT INFORMATION FOR RESPONSIBLE PARTY BELOW

Primary Insurance_____	Secondary Insurance_____
Individual ID # _____	Individual ID # _____
Group_____	Group_____
Policyholder_____	Policyholder_____
Relationship to Patient_____	Relationship to Patient_____
DOB____/____/ _____ SSN ____-____-_____	DOB____/____/ _____ SSN ____-____-_____

EMERGENCY CONTACT

Name_____ Relationship to Patient_____

Cell Phone_____ Work Phone _____

PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

Patient Signature _____Date_____

Time_____

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Reason for visit_____

Preventative Health

Immunization	Date Performed	
Influenza Vaccination		
Prevnar (1st Pneumonia Shot)		
Pneumovax (2nd Pneumonia Shot)		
Tetanus Vaccination		
TDAP		
Zostavax (Shingles Vaccine)		
Covid Vaccine		
Gardasil		

Screening Test	Date Performed	Results (Normal/Abnormal)
Colonoscopy		
Mammogram		
PAP		
PSA (prostate)		
Chest X-Ray		
Screening Chest CT (Lung Scan)		
Dexa Scan (Bone Scan)		
Annual Lab (in the past year)		

FEMALE QUESTIONS

Have you had a miscarriage?_____ *If yes, how many?* _____

Have you had an abortion?_____ *If yes, how many?* _____

Have you had a C-Section?_____ *If yes, how many?* _____

First day of last menstrual period: _____

How many days does your period last? ____

Have you ever had an abnormal pap smear? _____

If yes, when? _____

Treated with: _____

Age of first period: _____

Are you currently sexually active? _____

Have you ever had a sexually transmitted disease? _____

Number of lifetime sexual partners: _____

Method of Birth Control: _____

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ALLERGIES

Please list all food and drug allergies:

PAST MEDICAL HISTORY

PLEASE MARK ANY CURRENT OR PREVIOUS ILLNESSES OR HEATH PROBLEMS.

ANXIETY
ANEMIA
ARTHRITIS
ASBESTOS EXPOSURE
ASTHMA
BIPOLAR DISORDER
BLEEDING DISORDER
BLOOD CLOTS
COPD/EMPHYSEMA
DEMENTIA
DEPRESSION
DEGENERATIVE JOINT DISEASE
DIABETES MELLITUS
HEART ATTACK
HEART DISEASE
HEART RHYTHM PROBLEM
HEPATITIS
HIGH CHOLESTEROL
HIGH BLOOD PRESSURE
HIV
KIDNEY DISEASE
LUPUS
PARKINSON'S DISEASE
RHEUMATOID ARTHRITIS
SEIZURE DISORDER
SCHIZOPHRENIA
SLEEP APNEA
STROKE
THYROID DISEASE
TUBERCULOSIS (POSITIVE PPD)
ULCERS
CHRONIC PAIN related to _____
OTHER: _____

SURGICAL HISTORY/MAJOR DIAGNOSTIC PROCEDURES

APPENDECTOMY
BACK SURGERY
BARIATRIC (WEIGHT REDUCTION)
BREAST AUGMENTATION
BREAST CANCER REMOVAL
C-SECTION
GALLBLADDER
LUNG BIOPSY
LUNG RESECTION
HEART CATHETERIAZATION
HEART BYPASS SURGERY
PROSTATE SURGERY
HYSTERECTOMY
SKIN CANCER REMOVAL
TYPE_____
TONSILLECTOMY
TUBAL LIGATION
TUMOR REMOVAL
VASECTOMY
OTHER:
_____
_____
_____

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HOSPITALIZATIONS / ER VISITS

MEDICATIONS

Please attach a list or list all medications you are currently taking below, including over the counter and herbal remedies. Please include dosage and number of times a day the medicine is taken if known.

MEDICATION NAME	DOSAGE (mg, cc, etc)	FREQUENCY (how often)

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FAMILY HISTORY

Are you adopted? _____

	Father	Mother	Siblings	Paternal GF	Paternal GM	Maternal GF	Maternal GM
LIVING							
DECEASED							
DIABETES							
HYPERTENSION							
HEART DISEASE							
MENTAL ILLNESS							
CANCER (TYPE?)							
STROKE							
THYROID DISEASE							
HIGH CHOLESTEROL							
ASTHMA							
COPD/EMPHYSEMA							
BLOOD CLOTS							
TUBERCULOSIS							
HEADACHES							
SEIZURES							
OTHER (SPECIFY)							
UNKNOWN							

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SOCIAL HISTORY

Tobacco Use:

____ Never Smoked
____ Former Smoker
How long has it been since you quit?
___ Less than 1 year ___ 1-5 years ___ 5-10 years ___ 10-20 years ___ 20+ years
____ Current Smoker
If yes, how often do you smoke?
____ Daily ____ Frequently ____ Rarely
How many cigarettes do you smoke in 24 hours?
____ 5 or less ____ 6-10 ____ 11-20 ____ 21-30 ____ 31+
Do you use other forms of tobacco?
____ Cigar ____Pipe ____Chewing Tobacco ____Vapor

Medical Marijuana Use:
____ Yes ____ No

Recreational Drug Use:
____None ____Marijuana ____Cocaine ____Heroin ____Prescription Pain Pills
____Methamphetamines ____ Other

Alcohol Use:
How often do you drink? _____

Caffeine:
____ Coffee ____ Soda ____ Energy Drinks ____ Tea How many daily? _____

Children:
____ Yes ____ No
If yes, how many? _____
Have you completed your family?
____ Yes ____ No

Exercise:
____ Daily ____Occasionally ____ Rarely ___ Never
What kind of exercise? _____
General Stress Level:
____ Low _____ Moderate _____ High

Is a blood transfusion agreeable to in an emergency? History of a blood transfusion?
____ Yes ____ No
Advance Directive:
_____ Yes _____ No

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Important Information for our Patients Regarding Annual Well Woman Exams

The purpose of this handout is to inform our patients about the current coding practices for reporting medical services as dictated by Federal Law and your Insurance Carrier. The billing of Preventive and Screening Services can be complicated and confusing generating many questions from our patients.

An annual well-woman exam is a routine examination of a female who is, in general, not having any current health issues. These routine visits are scheduled separately from a visit to address specific problem health issues.

The Annual Well Woman Exam for our clinic will include:

- Measure height
- Record weight
- Take blood pressure
- Update personal and family medical history
- Update surgical history
- Update current medications and medication history
- Update allergies
- Update reproductive history
- Update social history
- Physical exam including but not limited to:
    - Appearance (face, eyes, neck. skin)
    - Breast
    - Abdomen
    - Vagina, urethra, cervix, uterus, ovaries and lymph nodes
- General discussion regarding findings during exam and general counseling about health and well-being
- Pap smear (if needed)
- HPV testing (if applicable)
- Ordering of routine blood work (if applicable)
- Ordering of other routine testing such as bone density study (if needed)
- Refill of maintenance medications pertinent to gynecological care and/or change in medications or dosages

In addition to the above, discussions about problems and conditions you are being treated for, that are under control, are considered an integral part of the Well Woman exam and cannot be billed as a "sick visit" under Federal Compliance rules.

If a separate problem is identified, addressed or treated during the course of the Annual Exam, we are required to submit our claims based on the documentation in the medical record of the service provided to you. This may result in a second office visit charge and/or second co-pay.

If at the time of scheduling your Well Woman Exam, you are aware of problems you would like to discuss, we recommend scheduling a separate "problem appointment". If you are scheduled for your Well Woman Exam today and are aware of problems you would like to discuss, please inform the nurse. In this event, your appointment may be converted to a "problem appointment" due to the time restraints and to avoid additional costs to you.

With the new health care laws regarding the coverage of preventive screening, we feel it is important to keep routine preventive screening separate from all other visits. This helps to ensure that accurate adjudication and payment from your insurance company for your routine well-woman visit is obtained and that you receive the full benefit of your plan allowances.

You as the insured will be responsible for payment as dictated by your insurance plan of all co-payments and deductibles at the time of service. Again, if an additional problem is treated or addressed during this exam, there may be an additional charge that you will be responsible for.

I understand the above information and agree to pay any charges incurred due to discussion/treatment of a problem during an Annual Well Woman Exam.

_____	_____	_____/_____/_____
PRINT NAME	SIGNATURE	TODAY'S DATE

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No Show and/or Cancellation Policy

Failure to CANCEL within a 24-hour time prior to your appointment time will result in a $35 fee.
Failure to NOT SHOW for an appointment will result in a $35 no show fee.

_____ _____
Patient Signature Date

Laboratory

We ask that each patient know his/her insurance benefits, including your lab benefits, prior to your scheduled appointment time.
You will need to know how much your individual lab policy covers and which lab your insurance prefers you go to (DLO or Lab Corp). You have the option to send your lab through your insurance or you can choose to do self-pay through us. If you choose to send through your insurance, you will be responsible for any co-insurance or deductible that applies. You will not receive a bill for lab work from Choctaw Women`s Clinic for your lab work, it will come from the lab itself.
If you choose self-pay, you pay us at date of service and you will not receive a bill from the labs.

Circle one: Insurance or Self-pay

_____ _____
Patient Signature Date

Medical Release Form

I, _____ hereby **DECLINE** the Provider and staff of Elite Wellness permission to release information concerning my health and well-being.
I, _____ hereby authorize the Provider and staff of Elite Wellness permission to release information concerning my health and well-being to the following:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

The following information may be given to the above individuals: (please check all you agree to):
( ) Any other information (No limitation) includes all communication.
( ) Appointment Time ( ) Test/Lab Results ( ) Procedures ( ) Medications

I understand I may revoke this consent at any time by giving written notice to the person or organization making the disclosure. I understand that this organization originates and maintains health records describing my health history, symptoms, diagnoses, examinations, past/current/future treatments and test results as well as financial information pertaining to my account. I acknowledge that I have been provided with Full Disclosure of their Notice of Privacy Practices and I consent to the use and disclosure of my own or persons from whom I am responsible (i.e. minors) Financial and Health Information for any reason that Choctaw Women's Clinic may require to carry out Health care operations to or for me and/or for persons whom I am responsible.

Patient Signature: _____ Date: _____
(Parent/Guardian Signature if patient is a minor.)

Witness Signature: _____ Date: _____

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Address and Contact Information

Name: _____ Date of Birth: _____

FEMALE HEALTH ASSESSMENT

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	Never (0)	Mild (1)	Moderate (2)	Severe (3)	Very Severe (4)
Hot flashes	☐	☐	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)	☐	☐	☐	☐	☐
Depressive mood (feeling down, sad, on the verge of tears, lack of drive)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension)	☐	☐	☐	☐	☐
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sexual problems (change in sexual desire, sexual activity, orgasm and/or satisfaction)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	☐	☐	☐	☐	☐
Vaginal symptoms (sensation of dryness or burning in vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory	☐	☐	☐	☐	☐
Problems with thinking, concentrating or reasoning	☐	☐	☐	☐	☐
Difficulty learning new things	☐	☐	☐	☐	☐
Trouble thinking of the right word to describe persons, places or things when speaking	☐	☐	☐	☐	☐
Increase in frequency or intensity of headaches or migraines	☐	☐	☐	☐	☐
Hair loss, thinning or change in texture of hair	☐	☐	☐	☐	☐
Feel cold all the time or have cold hands or feet	☐	☐	☐	☐	☐
Weight gain or difficulty losing weight despite diet and exercise	☐	☐	☐	☐	☐
Dry or wrinkled skin	☐	☐	☐	☐	☐
Total score	0				

Severity Score: Mild: 1-20 / Moderate: 21-40 / Severe: 41-60 / Very severe: 61-80