

Date \_\_\_\_\_ Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Race/Ethnicity \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Is there someone we can thank for referring you? \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

**Circle your RWG Physician:** Meritt Collins Neyman Smith Gilbert Mills Jahangiri Garza Loar

*Although some of the information requested below may not seem pertinent, it helps us provide you with the best care. We ask that you fill out ALL of the following questions completely.*

**REASON FOR YOUR VISIT (give details as needed)** \_\_\_\_\_

**PAST MEDICAL HX**

Date of last **Annual Exam** \_\_\_\_\_ Date/Type of last **Labwork:** \_\_\_\_\_ Date of Last **Pap Smear** \_\_\_\_\_

Have you had an **Abnormal pap smear?** \_\_\_\_\_ List dates & treatment \_\_\_\_\_

Date/ Results of last **Mammogram** \_\_\_\_\_

Date/ Results of last **Colonoscopy / flexsigmoidoscopy** \_\_\_\_\_

Date/ Results of last **Bone Density scan?** \_\_\_\_\_

Have you ever had a **Blood Transfusion?** (List date/reason) \_\_\_\_\_

Would you **accept blood or blood products** in case of an emergency? \_\_\_\_\_ If not, please explain \_\_\_\_\_

Did your mother receive a drug called **DES** when she was pregnant with you? \_\_\_\_\_

Do you have an **advanced directive?** \_\_\_\_\_

**REPRODUCTIVE HISTORY**

Age at 1<sup>st</sup> period \_\_\_\_\_ How far apart are your cycles (ex.28days) \_\_\_\_\_ How many days do you bleed (i.e. 5days) \_\_\_\_\_

**\*Flow:**  light  medium  heavy  clots **Symptoms:**  cramps  pelvic pain  headaches  mood changes

Date your **last period** started \_\_\_\_\_ How certain are you:  Very  Somewhat  Not at all

Current Birth Control Method (i.e. condoms, birth control pills/ring/patch, IUD, menopause, Hysterectomy) \_\_\_\_\_

Do you desire a change? \_\_\_\_\_

Are you Menopausal:  N/A  Yes  No Age at Menopause: \_\_\_\_\_ Are you on hormones? Type? \_\_\_\_\_

Total # of pregnancies: \_\_\_\_\_ # of Term Deliveries (**after** 36weeks) \_\_\_\_\_ # of Preterm Deliveries (**before** 36weeks) \_\_\_\_\_

How many Cesarean Sections \_\_\_\_\_ How many Living Children \_\_\_\_\_

# Abortions (please list approximate year) \_\_\_\_\_

# Miscarriages (please list approximate dates & weeks of pregnancy) \_\_\_\_\_

# Ectopics (list dates, weeks of pregnancy, treatment): \_\_\_\_\_

Pregnancy or Delivery Complications: \_\_\_\_\_

**SURGICAL HX**

Please list any surgeries or hospitalizations you have undergone (D&C, Hysterectomy, Cesarean Section)

Year of Surgery Type / Reason for MD Hospital

**Meds & Allergies**

List **Drug Allergies** (and the Reaction you had):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List **Medications** (include over-the-counter & supplements), **Doses**, the **Reason** you are taking, and **Who prescribed** it:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PERSONAL & FAMILY HISTORY (PLACE AN "X" IN THE WHITE BOXES THAT APPLY)**

PATIENT PAST MEDICAL HX & FAMILY HX

	You	Mother	Father	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	Brothers or Sisters	Children	OTHER family members
Anemia										
Ashkenazi Jewish descent (Eastern European or Russian)										
Arthritis										
Asthma										
Birth defects (i.e. cleft palate, spina bifida...)										
Clotting disorder, or deep vein thrombosis										
Blood disorders (i.e. ITP, sickle cell)										
Breast disorders										
Cancer, Breast										
Cancer, Colon										
Cancer, Ovarian										
Cancer, Uterine/Endometrial										
Colon polyps										
Diabetes										
Endometriosis										
Epilepsy										
Gallbladder disease										
Genetic disorders (i.e. mental retardation, cystic fibrosis...)										
Glaucoma										
Heart disease or Mitral valve prolapse										
High blood pressure										
High cholesterol										
Kidney disorder/disease										
Mental Illness, type?										
Menstrual irregularities										
Osteoporosis										
Pelvic Inflammatory dis.										
Stroke										
Thyroid disorder										
Uterine anomalies										
...Still Living?	X									
...Deceased at Age?	----									

**OTHER DISEASES/ILLNESSES:**

SOCIAL HISTORY

**Marital Status (please check one):**

Single/Not Dating                       Married  
 Single/ Dating                             Divorced  
 In a committed relationship        Widowed  
 Engaged

**Safety:** Do you feel safe in your current relationship: Yes No  
 If not please explain \_\_\_\_\_

Have you ever been physically abused in a relationship: Yes No  
 If so, please explain \_\_\_\_\_

Have you ever had an unwanted sexual encounter: Yes No  
 If so, please let us know when this occurred: \_\_\_\_\_

**Substance Use:**

Do you drink alcohol: Yes No  
     How many drinks per day or week: \_\_\_\_\_  
 Do you currently use any illicit drugs: Yes No  
     Type \_\_\_\_\_  
     How often \_\_\_\_\_  
 Do you smoke cigarettes: Yes No  
     How many per day \_\_\_\_\_  
     How long have you been a smoker: \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Do you Exercise:** Yes No  
 Type \_\_\_\_\_  
 How often \_\_\_\_\_

**Infection Risk:**

Have you ever been sexually active? Yes No  
 Are you currently sexually active? Yes No  
 Sexual preference (circle one): Heterosexual Lesbian Bisexual Other  
 How many sexual partners in the last 1 year? \_\_\_\_\_  
     In your lifetime: 1-5\_\_ 5-10\_\_ 10-20\_\_ 20+\_\_

Have you ever had a sexually transmitted disease (STD)? Yes No  
 Hepatitis (Type?) \_\_\_\_\_  
 Syphilis (when? treated?) \_\_\_\_\_  
 Chlamydia (when? treated?) \_\_\_\_\_  
 Gonorrhea (when? treated?) \_\_\_\_\_  
 Genital Herpes (taking meds?) \_\_\_\_\_  
 HPV (human papilloma virus) \_\_\_\_\_  
 Genital warts? \_\_\_\_\_

...see next page regarding STD testing

**PRINT NAME HERE:** \_\_\_\_\_

**The American College of Obstetrics and Gynecology (ACOG) recommends:**

- HIV screening for all women ages 19-64
- HIV screening for sexually active teenagers under the age of 19
- HIV screening for women older than 64 who have had multiple partners in recent years
- Annual Chlamydia screening of all sexually active women age 25 and younger
- HPV (human papilloma virus) screening, in addition to an annual pap smear, for women over the age of 30

**I would like to be screened for the following sexually transmitted diseases today: (please circle below)**

**\*\*Please be advised, we cannot guarantee insurance coverage for any tests\*\***

**HPV    Chlamydia    Gonorrhea    Genital herpes    HIV    Hepatitis B    Syphilis    *No testing today***

**REVIEW OF SYMPTOMS**

<p><b>Constitutional:</b> Frequent Fatigue Excess weight gain Excess weight loss</p> <p><b>Eyes, Ears, Nose, Mouth:</b> Frequent or severe headaches Frequent lightheadedness</p> <p><b>Breasts:</b> Lumps Pain Swelling Nipple discharge</p> <p><b>Cardiovascular:</b> Chest pain Fainting Swollen/Painful varicose veins Calf pain</p> <p><b>Respiratory:</b> Frequent shortness of breath Frequent Hoarseness</p> <p><b>Gastrointestinal:</b> Nausea/ Vomiting Frequent Diarrhea Frequent Constipation Frequent Heartburn/ reflux Abdominal Pain Blood in stool Hemorrhoids</p> <p><b>Genitourinary:</b> Urgency Frequency Pain with urination Blood in urine Frequent Urine leakage Pain with intercourse Genital sores</p>	<p><b>Circle One:</b> Current    Past    N/A Current    Past    N/A Current    Past    N/A</p> <p><b>Circle One:</b> Current    Past    N/A Current    Past    N/A</p> <p><b>Circle One:</b> Current    Past    N/A Current    Past    N/A Current    Past    N/A</p> <p><b>Circle One:</b> Current    Past    N/A Current    Past    N/A Current    Past    N/A Current    Past    N/A</p> <p><b>Circle One:</b> Current    Past    N/A Current    Past    N/A Current    Past    N/A</p> <p><b>Circle One:</b> Current    Past    N/A Current    Past    N/A Current    Past    N/A</p> <p><b>Circle One:</b> Current    Past    N/A Current    Past    N/A Current    Past    N/A Current    Past    N/A</p> <p><b>Circle One:</b> Current    Past    N/A Current    Past    N/A Current    Past    N/A Current    Past    N/A Current    Past    N/A</p> <p><b>Circle One:</b> Current    Past    N/A Current    Past    N/A Current    Past    N/A Current    Past    N/A Current    Past    N/A</p> <p><b>Circle One:</b> Current    Past    N/A Current    Past    N/A Current    Past    N/A Current    Past    N/A Current    Past    N/A</p>	<p><b>Genitourinary (continued)</b> Irregular periods Painful periods Heavy periods No periods Possible pregnancy? Abnormal vaginal discharge Significant PMS</p> <p><b>Integument (skin):</b> New skin lesions Changes to moles/skin lesions</p> <p><b>Musculoskeletal:</b> Joint pain Joint swelling Recent back pain</p> <p><b>Endocrine:</b> Excess bodily hair growth Excess hair loss Cold intolerance Heat intolerance Acne Thyroid abnormalities/ treatment?</p> <p><b>Psychiatric:</b> Frequent Anxiety Frequent Depression Suicidal thoughts Psychiatric treatment</p> <p><b>Hematologic/Lymphatic:</b> Easy bleeding Easy bruising</p>	<p><b>Circle One:</b> Current    Past    N/A Current    Past    N/A Current    Past    N/A Current    Past    N/A Current    Past    N/A Current    Past    N/A</p> <p><b>Circle One:</b> Current    Past    N/A Current    Past    N/A</p> <p><b>Circle One:</b> Current    Past    N/A Current    Past    N/A Current    Past    N/A Current    Past    N/A Current    Past    N/A</p> <p><b>Circle One:</b> Current    Past    N/A Current    Past    N/A Current    Past    N/A Current    Past    N/A Current    Past    N/A</p> <p><b>Circle One:</b> Current    Past    N/A Current    Past    N/A Current    Past    N/A Current    Past    N/A Current    Past    N/A</p> <p><b>Circle One:</b> Current    Past    N/A Current    Past    N/A Current    Past    N/A Current    Past    N/A</p>
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**List any other symptoms bothering you today:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**YOUR HEIGHT:** \_\_\_\_\_ **YOUR WEIGHT:** \_\_\_\_\_

**PRINT NAME HERE:** \_\_\_\_\_

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE COMPLETED:** \_\_\_\_\_

**RENAISSANCE WOMEN'S GROUP**  
**PATIENT AUTHORIZATION FORM**

**Please.....read, initial, and sign below**

(Initial)\_\_\_\_\_ FINANCIAL RESPONSIBILITY: I understand that I am ultimately responsible for payment on my account. Payment is expected at the time of service. I understand that I am responsible for any referral or authorization that my insurance may require and for any charges not covered by my insurance plan, including co-payments, co-insurance and deductibles. Claims will be filed for PPO and HMO participants, Medicare and Medicaid. Payment of benefits will be made directly to Renaissance Women's Group.

(Initial)\_\_\_\_\_ INSURANCE COVERAGE: I understand that I am responsible for providing RWG with any and all insurance coverages at each and every visit. I will be responsible for any balances due as a result of not disclosing this information. ( \_\_\_\_\_ RWG Staff Initials)

(Initial) I DO \_\_\_\_\_ I DO NOT \_\_\_\_\_ CONSENT to necessary examinations and/or treatments performed and prescribed by my physician, nurse practitioner or physician's assistant as is necessary in his/her judgment, with patient approval. **Separate consent forms will be signed for procedures performed in the physician's office.**

(Initial)\_\_\_\_\_ RELEASE OF INFORMATION: I do hereby authorize Renaissance Women's Group to release information to North Austin Medical Center (NAMC) or St. David's Medical Center in the event of a scheduled surgery or procedure, emergency care or pregnancy. I authorize the release of any medical records or other information necessary to process my insurance claim.

(Initial)\_\_\_\_\_ HIPAA: I acknowledge that I have received a copy of RWG's Notice of Privacy Practices.

(Initial)\_\_\_\_\_ FEE FOR FORMS COMPLETION: I understand that I will be responsible for paying \$15 for forms completion by RWG physicians or staff. (Example: Disability forms, FMLA forms, etc.)

(Initial)\_\_\_\_\_ FEE FOR 'NO SHOW'. I understand that a \$25 'no show' fee will be assessed for appointments that I do not keep.

Spouse's Name: \_\_\_\_\_ Spouse's Work Phone: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_  
**(other than spouse)**

**Patient Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Today's date:** \_\_\_\_\_

# Renaissance Women's Group

(GYN)

12201 Renfert Way Austin, Texas 78758

<b>Patient Name:</b>	<b>Appointment Date:</b>	<b>Today's Date:</b>
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**\*Please bring this completed form with you to your next appointment\***

We are pleased you have chosen Renaissance Women's Group and look forward to providing consistent high quality medical care and related services to you. To avoid confusion about your insurance coverage we ask that you contact your insurance company prior to your next appointment to understand your specific plan benefits and coverage. Please be aware that we will bill you privately for any charges not covered by your plan, so time taken now on your part will eliminate unexpected expenses to you later. **This form is to be used as a guide when calling your insurance company regarding your benefits.**

<b>Name of Insurance Company</b>	<b>Insurance Phone number for benefits</b>	<b>Insurance representative spoke with:</b>
<b>Insurance policy holder's name:</b>	<b>Policy holder's Social Security #:</b>	<b>Policy holder's employer's name:</b>
<b>Policy holder's date of birth:</b> -        - 19__ __	_____ - _____ - _____	<b>Policy Effective Date:</b> _____ - _____ - _____

**To find out if RWG is a participating provider on your plan, give the insurance representative our Tax ID # 74-2760437**

- 1). **What type of plan do I have?** \_\_\_ HMO \_\_\_ PPO \_\_\_ POS \_\_\_ Managed Care \_\_\_ Indemnity  
*Verify with your insurance that the doctor you are scheduled with is a contracted provider (IN NETWORK) for your type of policy. If you are seen by a physician at RWG and you are out of network you will be responsible for the payment of these services to RWG. Please be aware that RWG may be contracted with your insurance but not for your plan type. For example, we are contracted with Cigna PPO but we are not a contracted provider for Cigna HMO, POS and Managed Care plans.*
  
- 2). **Is Clinical Pathology Labs an IN-NETWORK Lab (Tax Id 74-2554159)?** \_\_\_ YES \_\_\_ NO...if not **what lab is in-network** \_\_\_\_\_
  
- 3). **Do I have Well Woman Exam coverage?** \_\_\_ YES \_\_\_ NO  
 If so, how is it covered? \_\_\_ 100% with a \$ \_\_\_\_\_ Copay, \_\_\_ 90% \_\_\_ 80% or \_\_\_\_\_  
 Do I have a deductible for Well Woman coverage? \_\_\_ YES \_\_\_ NO If YES, deductible amount? \_\_\_\_\_ Met? \_\_\_  
 Do I have coverage for Gardasil vaccine (HPV)? \_\_\_ YES \_\_\_ NO If YES, how will it be covered? \_\_\_\_\_ Is there an age limit?  
 Do I have a maximum benefit for preventative? \_\_\_\_\_  
 How often can I have an annual ( frequency ) ? \_\_\_\_\_
  
- 4). **Do I have coverage for a problem visit?** \_\_\_ YES \_\_\_ NO  
 If so, how is it covered? \_\_\_ 100% with a \$ \_\_\_\_\_ Copay, \_\_\_ 90%, \_\_\_ 80%, or \_\_\_\_\_  
 Do I have a deductible for problem visits? \_\_\_ YES \_\_\_ NO If YES, deductible amount? \_\_\_\_\_ Met? \_\_\_
  
- 5). **Do I have coverage for Gynecological Ultrasounds?** \_\_\_ YES \_\_\_ NO  
 If so, is a referral or authorization required? \_\_\_  
 How is it covered? \_\_\_ 100% with a \$ \_\_\_\_\_ Copay, \_\_\_ 90%, \_\_\_ 80%, or \_\_\_\_\_  
 Do you have to meet a deductible? \_\_\_ YES \_\_\_ NO If YES, deductible amount? \_\_\_\_\_ Met? \_\_\_
  
- 6). **Do I have coverage for Central bone densitometry testing?** \_\_\_ YES \_\_\_ NO  
 If so, how is it covered? \_\_\_ 100% with a \$ \_\_\_\_\_ Copay, \_\_\_ 90%, \_\_\_ 80%, or \_\_\_\_\_  
 Do I have a deductible for Bone density testing? \_\_\_ YES \_\_\_ NO If YES, deductible amount? \_\_\_\_\_ Met? \_\_\_
  
- 7). **If Contraception is relevant to you...**  
 Do I have coverage for Oral Contraception? \_\_\_ YES \_\_\_ NO  
**Depo?** \_\_\_ YES \_\_\_ NO      **Diaphragm?** \_\_\_ YES \_\_\_ NO      **Implanon?** \_\_\_ YES \_\_\_ NO  
**IUD?** \_\_\_ YES \_\_\_ NO      **IUD Insertion coverage?** \_\_\_ YES \_\_\_ NO      **IUD Device coverage?** \_\_\_ YES \_\_\_ NO  
 My responsibility is copay \_\_\_\_\_ coinsurance \_\_\_\_\_ deductible \_\_\_\_\_

If at any time, while you are a patient at **Renaissance Women's Group**, you change your PCP, insurance plan, or are informed of contract change, it is your responsibility to immediately inform our business office. **-THANK YOU -** **Revised 9/08**