



**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**

<b>Constitutional:</b>	<b>Circle One:</b>
Frequent Fatigue	Current Past N/A
Excess weight gain	Current Past N/A
Excess weight loss	Current Past N/A
<b>Eyes, Ears, Nose, Mouth:</b>	<b>Circle One:</b>
Frequent or severe headaches	Current Past N/A
Frequent lightheadedness	Current Past N/A
<b>Breasts:</b>	<b>Circle One:</b>
Lumps	Current Past N/A
Pain	Current Past N/A
Swelling	Current Past N/A
Nipple discharge	Current Past N/A
<b>Cardiovascular:</b>	<b>Circle One:</b>
Chest pain	Current Past N/A
Fainting	Current Past N/A
Swollen/Painful varicose veins	Current Past N/A
Calf pain	Current Past N/A
<b>Respiratory:</b>	<b>Circle One:</b>
Frequent shortness of breath	Current Past N/A
Frequent Hoarseness	Current Past N/A
<b>Gastrointestinal:</b>	<b>Circle One:</b>
Nausea/ Vomiting	Current Past N/A
Frequent Diarrhea	Current Past N/A
Frequent Constipation	Current Past N/A
Frequent Heartburn/ reflux	Current Past N/A
Abdominal Pain	Current Past N/A
Blood in stool	Current Past N/A
Hemorrhoids	Current Past N/A
<b>Genitourinary:</b>	<b>Circle One:</b>
Urgency	Current Past N/A
Frequency	Current Past N/A
Pain with urination	Current Past N/A
Blood in urine	Current Past N/A
Frequent Urine leakage	Current Past N/A
Pain with intercourse	Current Past N/A
Genital sores	Current Past N/A

<b>Genitourinary (continued)</b>	<b>Circle One:</b>
Irregular periods	Current Past N/A
Painful periods	Current Past N/A
Heavy periods	Current Past N/A
No periods	Current Past N/A
Possible pregnancy?	Current Past N/A
Abnormal vaginal discharge	Current Past N/A
Significant PMS	Current Past N/A
<b>Integument (skin):</b>	<b>Circle One:</b>
New skin lesions	Current Past N/A
Changes to moles/skin lesions	Current Past N/A
<b>Musculoskeletal:</b>	<b>Circle One:</b>
Joint pain	Current Past N/A
Joint swelling	Current Past N/A
Recent back pain	Current Past N/A
<b>Endocrine:</b>	<b>Circle One:</b>
Excess bodily hair growth	Current Past N/A
Excess hair loss	Current Past N/A
Cold intolerance	Current Past N/A
Heat intolerance	Current Past N/A
Acne	Current Past N/A
Thyroid abnormalities/ treatment?	Current Past N/A
<b>Psychiatric:</b>	<b>Circle One:</b>
Frequent Anxiety	Current Past N/A
Frequent Depression	Current Past N/A
Suicidal thoughts	Current Past N/A
Psychiatric treatment	Current Past N/A
<b>Hematologic/Lymphatic:</b>	<b>Circle One:</b>
Easy bleeding	Current Past N/A
Easy bruising	Current Past N/A

**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)\_\_\_\_\_ LABRATORY FEES: I understand that RWG uses Clinical Pathology Laboratory (CPL). RWG cannot guarantee your insurance will cover any lab/pathology performed at or ordered by RWG. If my insurance requires use of a different lab, I understand it is my responsibility to inform RWG for proper handling.

(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**