NAPLES WOMEN'S CENTER: ESTABLISHED PATIENT MEDICAL HISTORY FORM

Name:_____ Date of Birth:_____ Today's Date:_____

Reason for visit: Well Woman Exam **OR** Problem Visit: _____

(**PLEASE NOTE**: Extra charges may/will occur if both a Well Woman exam and Problem visit are discussed on the same day)

Medications (with dosages):

Medication Allergies: _____

New Surgeries Since Last Visit:_____

Date of last period _____ Cycle Length: every _____ day(s) Lasting _____ day(s)

Periods are: ☐ Regular ☐ Irregular ☐ Painful

Flow is: ☐ Light ☐ Moderate ☐ Heavy ☐ Very Heavy

Are you sexually active? ☐ Yes ☐ No ☐ Never **New Partners?** ☐ Yes ☐ No

Current Method of Birth Control:

☐ Condoms ☐ Natural Family Planning ☐ Pills: _____ ☐ Vasectomy (Partner) ☐ Depo Provera
☐ IUD: Brand _____ Year inserted ____ ☐ Tubal/ Essure ☐ Vaginal Ring ☐ Cervical Cap
☐ Sponge ☐ Spermicide ☐ Withdrawal ☐ Other ☐ None

Please list the Month/Year for the following tests performed:

Pap smear _____ Mammogram_____ Bone Density Scan _____ Colonoscopy _____

Social History:

Tobacco use ☐ Yes ☐ No If yes, _____ pack(s) per day for _____ year(s)
Alcohol use ☐ Yes ☐ No If yes, _____ drink(s) per day/week/month
Caffeine ☐ Yes ☐ No If yes, _____ caffeinated drinks (coffee, tea, soda) per day/week/month
Exercise ☐ Yes ☐ No Type(s) and frequency_____
Recreational Drug use ☐ Yes ☐ No Type(s) and frequency_____

Do you have any of the following symptoms today?

☐ Yes ☐ No Generally healthy
☐ Yes ☐ No Recent weight gain/loss of 25 lbs.
☐ Yes ☐ No Fever
☐ Yes ☐ No Vision problems (excluding glasses)
☐ Yes ☐ No Sinus problems
☐ Yes ☐ No Hearing loss
☐ Yes ☐ No Chest Pain
☐ Yes ☐ No Varicose Veins
☐ Yes ☐ No Shortness of breath
☐ Yes ☐ No Chronic Cough
☐ Yes ☐ No Diarrhea
☐ Yes ☐ No Constipation
☐ Yes ☐ No Blood in stools
☐ Yes ☐ No Heartburn/reflux

☐ Yes ☐ No Abnormal Frequent urination
☐ Yes ☐ No Burning w/ urination
☐ Yes ☐ No Incontinence
☐ Yes ☐ No Abnormal Urinary Urgency
☐ Yes ☐ No Bladder infection
☐ Yes ☐ No Abdominal pains
☐ Yes ☐ No Abnormal vaginal discharge
☐ Yes ☐ No Irregular vaginal bleeding
☐ Yes ☐ No Pelvic pain
☐ Yes ☐ No Painful intercourse
☐ Yes ☐ No Breast lumps
☐ Yes ☐ No Back pain
☐ Yes ☐ No Joint/muscle pain
☐ Yes ☐ No Depression/anxiety

Current Pharmacy: Name:_____ Location:_____ Phone:_____

Preferred Lab: Name:_____ Location:_____ Phone:_____

_____ _____
Patient Signature Date

NAPLES WOMEN'S CENTER

A Health

Patient Payment Policy

Naples Women's Center does not participate with all insurance companies, and each patient is responsible to know their insurance benefits as policies vary from person to person even with in the same insurer.

Co pays and deductibles may be due and are required to be collected at the time of your visit.

If we do not participate with your insurance, you will be asked to pay for your services at the time of visit. We will provide a receipt for your visit that you can submit to your insurance for reimbursement or if possible, we may submit to your insurance for reimbursement on your behalf.

Patient or Responsible Party Signature Date

Last updated: 06/15/2022

NAPLES WOMEN'S CENTER

A HealthSpring Company

CONSENT FOR MEDICAL TREATMENT AND SERVICES

I, voluntarily, consent to the physical exam, treatment and/or procedures under specific instructions of the healthcare provider at NAPLES WOMEN'S CENTER. Our number one priority is our patients' health. Our physician's assign codes that we will submit to your insurance based on the service they provided at the time of your visit.

Print Name: _____ **Signature:** _____

Date: _____

NAPLES WOMEN'S CENTER

A Health

CONSENT FOR SERVICES

1. If you are here for a scheduled **Gynecology** appointment with one of our providers, please note that most insurance companies have an allowable number of annuals every 12-24 months and it is your responsibility to know if you are having your exam within your insurance company's guidelines. If you are not within the allowable time frame for your exam, your insurance will deny the claim we send, and it will be **your responsibility to pay your bill in full.**

2. If you are here for a Schedule visit with a **Gynecology** provider and you discuss **ANYTHING** that addresses a problem issue (i.e.: burning, itching, discharge, foreign body, etc.) along with your annual exam, that warrants being billed for BOTH your annual and your problem visit.

3. Effective December 5th, 2022, ALL patients will be required to pay an **Annual Patient Administration Fee** of $100. This fee is not billable to insurance and non-reimbursable. The fee includes consulting patients over the phone, faxing documents to employers and other healthcare providers for continuity of care, calling in prescription refills, and completing any necessary forms you, the patient, may need.

Please note: Problem visits and Annual visits are NOT to be done at the same time and the services cannot be combined. If you are experiencing a problem, that should be addressed in one visit. Your annual will then be a separate visit. The reason we do not combine the visit types is because you, the patient, will be responsible for the bill in full when your insurance only covers one of the visit types. In the event a provider finds a problem during your annual exam that cannot wait to be addressed at a later date, your insurance may require you to pay a co-pay and/or deductible/coinsurance for the visit because of the annual and problem visit charge on the same day.

I have read and understand all the information above and agree that regardless of my insurance status, I am responsible for the balance on my account. In the event my insurance company is billed, I authorize all payments of medical benefits to be paid directly to Naples Women's Center.

Print Name: _____ **Signature:** _____

Date: _____