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PATIENT INFORMATION

Name:	SS#:	NCDS#:
Address:	Email:	
City/State/Zip:	DOB:	Sex:
Home Phone:	Marital Status:	
Cell Phone:	Emergency Contact:	
Work Phone:	Emergency Phone:	
Primary Care Physician:	Emergency Relationship:	
Language:		
Race: (circle one) ☐ White ☐ American Indian ☐ Asian ☐ Black/African American ☐ Unknown ☐ Declined		
Ethnicity: (circle one) ☐ Non-Hispanic or Latino ☐ Hispanic or Latino ☐ Declined		

INSURANCE INFORMATION

Primary Ins:	Secondary Ins:
ID #:	ID #:
Group #:	Group #:
Co-Pay:	Co-Pay:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:

Consent for Treatment: I as the patient or legal guardian of, authorize the Insurance Carrier to make checks for medical expenses due me payable to the attending staff or associated practice. I also authorize the release of any information regarding treatment to the Insurance Carrier. I further understand that I am responsible for all medical expenses and agree to pay any expenses not covered by the above Insurance Carriers. I understand that after my primary carrier has paid or rejected payment, I am responsible for the remaining balance and that billing my insurance is done of contractual obligation for participating carriers and is done only as a courtesy for other non-participating carriers.

Health Information Privacy Act (HIPAA) - Check all that apply

Home ☐ OK to leave message w/ detailed information OR ☐ Leave return phone # only
Cell ☐ OK to leave message w/ detailed information OR ☐ Leave return phone # only
Text ☐ Appointment Reminder/General message to call our office
Email ☐ Appointment Reminder/General message to call our office
Home Address: ☐ Ok to mail to my home address

☐ I permit the Practice to discuss my personal health information (PHI) with, and to disclose to, the following individuals:

Name: _____ Phone: _____
Relationship to Patient: _____
Name: _____ Phone: _____
Relationship to Patient: _____

I verify that all of the above demographic, insurance, and HIPAA information is true and correct:

_____ _____
Patient Signature Date
(Typed name confirms electronic signature)

If signed by patient's authorized representative, describe the representative's authority: _____
(Typed name confirms electronic signature)

NWO CENTER FOR
PELVIC REHAB & WELLNESS

NWO CENTER FOR
UROGYNECOLOGY & WOMEN'S HEALTH

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

Who referred you to our office? _____Primary Care Provider _____

What is the reason for your visit today? _____

Menstrual History

Age at first menstrual period _____ First day of your last period _____ If applicable: How many days do your periods last? _____
How many pads/tampons do you typically use in a 24 hours? _____ pads _____ tampons

	Yes	No	N/A
Are your menstrual cycles regular (every 21-35 days)?	☐	☐	☐
Do you have bleeding or spotting between periods?	☐	☐	☐
Do you have pain with your periods?	☐	☐	☐
Do you have pain in your lower abdomen or pelvis other than painful periods?	☐	☐	☐
If you are menopausal, have you experienced any further vaginal bleeding?	☐	☐	☐

In order to have complete medical diagnoses and treatment, please answer the following:
Gender Identity: ☐ Male ☐ Female ☐ Transgender: ☐ MTF ☐ FTM
If applicable, preference of Gender Pronoun to be used: _____

Sexual History

	Yes	No	N/A
Are you sexually active? (If yes, please circle: with a man/woman/both)	☐	☐	☐
Do you have pain with intercourse?	☐	☐	☐
Do you have bleeding during or after intercourse?	☐	☐	☐
Are you satisfied with your current sexual health?	☐	☐	☐
Are you using birth control? If yes, what method? _____	☐	☐	☐
Have you ever had a sexually transmitted infection? If yes, please explain: _____ _____	☐	☐	☐

Pregnancy History

Total number of pregnancies: _____ Vaginal Deliveries: _____ C-Sections: _____ Miscarriages: _____
Ectopic pregnancies: _____ Abortions: _____

Have you recently had any of the following symptoms (within the last month)?

	Yes	No		Yes	No		Yes	No
Vaginal discharge	☐	☐	Burning or pain with urination	☐	☐	Pressure or bulge at the opening of the vagina	☐	☐
Vulvar itching or irritation	☐	☐	Leakage of urine	☐	☐			
Breast pain	☐	☐	Frequent urination	☐	☐	Incontinence of stool	☐	☐
Breast lump/mass	☐	☐	Difficulty emptying your bladder	☐	☐	Blood in your stool	☐	☐
Hot flashes and/or night sweats	☐	☐	Urinary tract infections	☐	☐	Significant/chronic diarrhea	☐	☐
Weight gain/loss of 10 lbs	☐	☐	Chronic coughing	☐	☐	Significant/chronic constipation	☐	☐

Patient Name _____

Personal Medical History (check all that apply)

☐ Breast cancer	☐ Tension headaches	☐ Thyroid disease	☐ Jaundice/Hepatitis
☐ Ovarian cancer	☐ Migraine headaches	☐ Parkinson's disease	☐ HIV/AIDS
☐ Uterine cancer	☐ Seizures/Epilepsy	☐ Osteoporosis/osteopenia	☐ Birth defects
☐ Colon cancer	☐ Multiple sclerosis	☐ Bone fracture	☐ Exposure to DES
☐ Other cancer: _____	☐ Anxiety	☐ Vitamin D deficiency	☐ Digestive problems
☐ Abnormal pap test	☐ Depression	☐ Arthritis	☐ Breast problems
☐ Diabetes	☐ Heart attack	☐ Joint replacement	☐ Colon problems
☐ High blood pressure	☐ Stroke	☐ Lung disease	☐ Bladder/kidney disease
☐ High cholesterol	☐ Blood clots	☐ Skin problems	☐ Urinary infections
☐ Heart disease	☐ Heart valve problem	☐ Anemia	☐ Glaucoma

Please provide details for any conditions selected above or list other diagnoses not above: _____

_____

_____

_____

Do you have to take antibiotics before dental work or other procedures? ☐ Yes ☐ No If yes,_____(Reason)

Drug/Food/Other Allergies (Please give reaction, i.e. hives)

☐ **N/A** (please check box if this does not apply)

_____

_____

Surgical History

Date	Procedure	Reason for Surgery
☐ **N/A** (please check box if this does not apply)		

Medications

Please list all prescription and over-the-counter medications, vitamins, and herbal supplements:

☐ **N/A** (please check box if this does not apply)

	Dose	How often taken	Name of medication	Dose	How often taken

Patient Name _____

Pharmacy Information

	Name	Street Address	City, State Zip	Phone
LOCAL				
MAIL ORDER				

Family History

	Father	Mother	Brothers	Sisters	Sons	Daughters
How Many?	1	1				
Deceased? Yes/no	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Diagnosis:						
Diabetes	☐	☐	☐	☐	☐	☐
Cardiac	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐
Cervical Cancer	☐	☐	☐	☐	☐	☐
Uterine Cancer	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐
Bleeding Disorders	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Occupation: _____ ☐ Retired

How many servings of caffeine do you consume per day? _____ Type? _____

Do you currently smoke? ☐ Yes ☐ No # Cigarettes/Day: _____ How many years? _____

If no, did you ever smoke? ☐ Yes ☐ No How ong ago did you quit? _____

Do you consume alcohol? ☐ Yes ☐ No How many alcoholic beverages/week? _____

Do you use illicit drugs? ☐ Yes ☐ No List: _____

In an average week, how many minutes of vigorous physical activity do you get? _____

Do you consume foods/drinks containing calcium on a daily basis? (i.e., milk, yogurt, cheese, etc.) ☐ Yes ☐ No

Please list any religious or cultural needs regarding your care: _____

Preventative History

Last Pap Smear/Pelvic Exam: _____ Facility: _____

Have you ever had an abnormal pap smear? ☐ Yes ☐ No Treatment if applicable: _____

Last Mammogram: _____ Facility: _____

Have you ever had an abnormal mammogram? ☐ Yes ☐ No Treatment if applicable: _____

Last Bone Density Test (DEXA scan): _____ Facility: _____

Last Colonoscopy/sigmoidoscopy: _____ Facility: _____

Are you up-to-date on your immunizations? Yes No

Dates of Last: Flu: _____ Tdap: _____ Pneumonia: _____ Shingles: _____ Gardasil (HPV): _____ Covid-19: _____

Have you had any prior physical/occupational/speech or chiropractic treatments this year? ☐ Yes ☐ No How many _____

OFFICE POLICIES SIGNATURE PAGE

Date Packet Issued: _____ **Issued by: _____ (initials)**

Thank you for choosing the Northwest Ohio Center for Urogynecology and Women's Health as your health care provider. We are committed to your treatment being successful. Listed below are pertinent points taken from our Office Policies Packet. ***Please read the ENTIRE Office Policy Packet for complete clarification***. This form is a highlighted version that requires signature. A copy will be returned to you.

HIPPA PRIVACY STANDARDS: The United States Department of Health and Human Services has adopted privacy standards -- the "HIPAA Privacy Standards"-- which protect your health information. The HIPAA Privacy Standards establish rules for when healthcare providers and billing agents, such as NCDS Medical Billing, may use or disclose your health information. Importantly, the HIPAA Privacy Standards also tell us what we cannot do with your health information. Activities that are not permitted under HIPAA will require your written authorization. This requires updating and signature yearly. Please refer to the complete packet for clarification.

BILLING & INSURANCE:

• No Insurance: ***If you do not have insurance, payment in full is expected at the time of service.***

• Co-Pays: ***All insurance co-pays are due at the time of service as required by your insurance company***. If you carry a secondary insurance, a co-pay is still required based on insurance guidelines. ***If you do not have your copay but still wish to be seen, a $30 fee will be applied to your account.***

• Pre-surgical Payments: A deposit may be required to schedule elective surgery and is determined by your insurance deductible owed or by cash fee for service. Any deposit is due 2 weeks prior to the scheduled surgery date.

• Plan Participation: ***It is the patient's responsibility to know and understand their insurance plan.***

• Secondary Insurers: A patient is responsible for any balances after your primary insurance has cleared. Secondary insurance may be billed as a courtesy, with no guarantee of payment.

• Referrals: If you belong to an insurance plan that requires a referral for specialist care, it is your responsibility to obtain the referral from your Primary Care Physician (PCP) prior to your visit with us.

• Patient Statements: If there is a balance on account, you will receive a monthly statement showing amount due. An unpaid balance is considered past due after 45 days. If two consecutive statements have been sent to you but no payment has been received on your account to reduce your responsibility, you may receive a collection letter and be considered for further collection activity.

PENDING OR THREATENING LITIGATION: Dr. Croak takes care of many patients who have had suboptimal surgical outcomes elsewhere. Some situations may not be able to be helped to a patient's degree of satisfaction despite Dr. Croak's best efforts. Because of this fact, Dr. Croak makes it clear that if you are threatening or involved in pursuing litigation for a prior suboptimal outcome, it is your responsibility to inform him of your plan at the time of your first consultation. Dr. Croak reserves the right to decline care at any time pending investigation into your specific situation. The failure to disclose litigation will result in immediate termination from the practice.

MISSED/CANCELLED APPOINTMENTS: If you do not show for an appointment or do not cancel a scheduled appointment 48 hours in advance, a $50 fee may be charged to your account. Repeated missed or cancelled appointments may result in termination of services with this office. If you run late for your appointment (10 minutes or more), staff reserve the right to reschedule the appointment.

THESE POLICES REMAIN IN FORCE INDEFINITELY AND/OR IF ANY REVISIONS ARE MADE TO SAME.

I have received, read and understand the Office Policies of the NWO Center for Urogynecology & Women's Health & NWO Center for Pelvic Rehabilitation & Wellness.

_____ Date: _____

Patient Signature
(Typed name confirms electronic signature)

Rev 05/01/2018

_____

Printed Name