MERCY ST. LUKE'S UROGYNECOLOGY & PELVIC REHABILITATION

Karen Liberi, MS, MPT, WCS ~ Amy Schnorberger, MS, PT, CNDT ~ Kelsey Dyer, PT ~ Peg Zientek, PTA
6005 MONCLOVA ROAD, SUITE 320 ~ MAUMEE, OH 43537
PHONE: 419 893 7134 ~ FAX: 419 893 6942

Dear _____,

You have an appointment scheduled with Mercy St. Luke's Pelvic Rehabilitation office on:

_____ at _____.

Welcome to our office. We are glad you chose us for all your personal care needs. Our office is located at ***6005 MONCLOVA ROAD, SUITE 320 ~ MAUMEE, OHIO 43537.*** *We can be reached at* ***419 893 7134, Option 5*** *if you have questions*. See maps below for office location and parking lot access.

Please fax, e-mail or mail all completed paperwork PRIOR to your visit.

FAX: 419 873 6812 E-MAIL: pftstaff@nwourogyn.com

It is mandatory that you bring your insurance card, driver's license, and any co-pay at the time of your visit.

We look forward to meeting you, and being able to assist with all of your needs and concerns.

Directions to the Office:

From I-475: Exit expressway at SR-24 Maumee Exit. Go East on SR-24 and follow first stop light. Turn left onto Monclova Road. Follow to Entrance #5 of Mercy St. Luke's campus and turn in to parking lot.

From Downtown Toledo: Use on-ramp for I-75 South to Anthony Wayne Trail. Follow AW Trail to Maumee (Monclova Road). Turn Right on Monclova Road. Follow to Entrance #5 of Mercy St. Luke's campus and turn into parking lot.

From Reynolds Road, West Toledo: Take Reynolds Road (US-20) that passes under the Ohio Turnpike Exit 4A, into Maumee (Conant Street) all the way to SR-24. Turn right on SR-24 and follow to Monclova Road. Turn Right on Monclova Road. Follow to Entrance #5 of Mercy St. Luke's campus and turn into parking lot.

From Ohio Turnpike: Exit at Toledo Reynolds Road Exit. Follow Reynolds Road into Maumee (Conant Street) all the way to SR-24. Turn right on SR-24 and follow to Monclova Road. Turn Right on Monclova Road. Follow to Entrance #5 of Mercy St. Luke's campus and turn into parking lot.

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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

If signed by patient's authorized representative, describe the representative's authority: _____

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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? _____

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: _____

Personal Medical History (check all that apply)

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

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

_____

_____

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?			
Have you ever had a sexually transmitted infection? If yes, please explain: _____ _____			

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)

_____

_____

_____

Patient Name _____

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)					
Name of medication	**Dose**	**How often taken**	**Name of medication**	**Dose**	**How often taken**

Pharmacy Information

	Name	Street Address	City, State Zip	Phone
LOCAL				
MAIL ORDER				

Family History

Diagnosis	Relationship	Age @ Diag	Diagnosis	Relationship	Age @ Diag
Testicular cancer		1	Heart Disease		
Prostate cancer			Stroke		
Colon cancer			Heart attack		
Other cancer: _____			High cholesterol		
Osteoporosis			Genetic disease		
Diabetes			Anesthesia complication		
Hypertension			Clotting disorder		
Other: _____			Other: _____		

Patient Name _____

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 long 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

When was your last prostate check? _____ Facility: _____

Last Colonoscopy/sigmoidoscopy: _____ Facility: _____

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

Dates of Last: Flu: _____ Tdap: _____ Pneumonia: _____ Shingles: _____ Covid-19: _____

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