WOMEN'S HEALTHCARE ASSOCIATES, P.C.

INTERIM HISTORY

NAME: ____

Do you still menstruate? If YES, first day of last cycle: ____________ Current contraception: ____________

If NO, please circle: Menopausal / Hysterectomy / Ablation / Mirena IUD / Hormone Tx

SINCE YOUR LAST EXAM, have you had any changes in the following? If so, please describe:

- Menstrual Cycle ______________________________
- Pelvic or abdominal pain ______________________________
- Vaginal discharge ______________________________
- Breast changes ______________________________
- Urinary frequency, pain or incontinence ______________________________
- Medical problems ______________________________
  ____
- Surgeries ______________________________
- Family History ______________________________
  ____
- Emotional Stress ______________________________

Current Medications ______________________________

____

Drug Allergies ______________________________

Do you smoke?	YES	NO	If yes, how much? ____________
Do you consume alcohol?	YES	NO	If yes, number per day / week / month ____________
Do you exercise?	YES	NO	How often? ____________ What kind? ____________
Have you had a mammogram?	YES	NO	If Yes, Date / Results ____________
Have you had a colonoscopy?	YES	NO	If Yes, Date / Results ____________
Have you had a Bone Density?	YES	NO	If Yes, Date / Results ____________

Do you take any of the following? Vitamins ________ Herbs ________ Calcium/Vitamin D ____________

Please check any of the following that apply ***AT PRESENT***

Weight Loss	___	Chronic diarrhea	___	Leak urine with urge	___
Weight Gain	___	Chronic constipation	___	Back pain	___
Fatigue/lethargy	___	Blood in stool	___	Acne	___
Incr/Decr appetite	___	Hemorrhoids	___	Excessive hair	___
Headache	___	Reflux	___	Hair loss	___
Snoring	___	Menstrual bleeding > 7 days	___	Change in mole color/size	___
Nasal congestion	___	Heavy menstrual bleeding	___	Warts	___
Mouth Ulcers	___	Cramps with menses	___	Breast mass	___
Palpitations	___	Pelvic pain not assoc with menses	___	Breast tenderness	___
Irregular heartbeat	___	Hot flushes	___	Nipple discharge	___
Chest pain	___	Night sweats	___	Change in mood	___
Edema	___	Loss of sex drive	___	Crying episodes	___
Fainting	___	Vaginal dryness	___	Irritability	___
Shortness of breath	___	Painful urination	___	Insomnia	___
Wheezing	___	Frequent urination	___	Excessive thirst	___
Chronic cough	___	Blood in urine	___	Lymph node enlargement	___
Abdominal pain	___	Leak urine with cough/sneeze	___	Heat/cold intolerance	___

Primary Care Physician ____________________ Pharmacy you use most often ____________________

Women's Healthcare Associates

We have added a text messaging system. This may be used to:

- Notify you to call our office to discuss labs.
- Notify you of necessary changes to your appointment.
- Remind you of specific recommendations prior to procedure.
- Notify you of changes in our clinic hours due to severe weather.
- Notify you of referrals to another office with instructions and directions.
- Notify you of medications being sent to your pharmacy.

Please note the following:

- Your phone number will not be shared with any other individuals or groups.
- We will never use this system to text you with any sensitive medical information.
- STANDARD DATA AND MESSAGE RATES MAY APPLY BASED ON YOUR MOBILE PLAN.

If you consent to receiving these text messages, please print your name and list your mobile number below, so that we may opt you in:

______________________ ____/____/____
Print Name Date of Birth

______________________ ____/____/____
Signature Date

____
Mobile Number

2. **If you DO NOT consent to receiving text messages from our office, please sign below so that we may opt you out:**

______________________ ____/____/____
Print Name Date of Birth

______________________ ____/____/____
Signature Date

Please complete forms and bring to your appointment, Thank you

PATIENT INFORMATION

NAME: ____________________

ADDRESS: ____________________

____

CELL: ____________________

HOME: ____________________

EMAIL: ____________________

SSN: ____________________

DATE OF BIRTH: ____________________

MARTIAL STATUS: [ ] MARRIED [ ] SINGLE

[ ] DIVORCED [ ] WIDOWED

EMERGENCY CONTACT: ____________________

____

PHONE: ____________________

RELATIONSHIP: ____________________

PATIENT EMPLOYMENT

[ ] EMPLOYED [ ] RETIRED [ ] OTHER

EMPLOYER: ____________________

PHONE: ____________________

GUARANTOR FOR INSURANCE

NAME: ____________________

DATE OF BIRTH: ____________________

RELATIONSHIP: ____________________

Would you like to be notified regarding future appointments or reminders via text message? [ ] YES [ ] NO

Authorization & Consent; I authorize the release of Medical information necessary to process my insurance claim. I authorize payment to Atlanta Women's Health Group, P.C. for any surgical and or medical benefits. I understand that payment in full is expected at the time of service. I authorize the physicians of Atlanta Women's Health Group to treat me. I consent to medical evaluation and treatment for office based procedures, necessary for my healthcare and understands that this consent shall not expire. IT IS MY RESPONSIBILITY TO INFORM Atlanta Women's Health Group IF I AM ON MEDICARE.

PATIENT SIGNATURE: ____________________ DATE: ____________________

Women's Healthcare Associates
355 Hawthorne Lane
Athens, GA 30606

Telephone: (706)369-0019 Facsimile: (706)369-1983

Website: womenshealthcareassociates.com

Stephanie Allen, M.D.
Leah Lowman, M.D.
Sandi Hayes, NP
Alexa Clay, CNM
Meredith Turner, CNM, PhD
Andrew H. Leach, M.D.
Lina Maria Millan, M.D.
Sarah M. Carey, PA-C
Amy Gutermuth, CNM

REQUEST FOR RECORDS FROM ANOTHER DOCTOR OR FACILITY

I, THE UNDERSIGNED PATIENT (OR PERSON AUTHORIZED TO CONSENT FOR THE PATIENT) HERBY AUTHORIZE THE RELEASE OF INFORMATION LISTED BELOW FROM THE RECORDS OF:

PATIENT NAME: ______________________ D.O.B. ______________________

ADDRESS: ____

FROM:

DOCTOR OR FACILITY: ____

ADDRESS: ____

TELEPHONE/FAX NO: ____

RECORDS REQUESTED: ____

TO:

Women's Healthcare Associates
355 Hawthorne Lane
Athens, GA 30606
TELEPHONE: 706-369-0019
FAX: 706-369-1983

I UNDERSTAND THE AUTHORIZATION INCLUDES RELEASE FROM ALL MEDICAL RECORDS INCLUDING HUMAN IMMUNODEFIENCY VIRUS RECORDS, PSYCHIATRIC, DRUG/ALCOHOL ABUSE RECORDS, VENERAL DISEASE, AND ANY OTHER STATUTURY PROTECTED DISEASE. THIS AUTHORIZATION AND CONSENT WILL EXPIRE (90) DAYS FOLLOWING THE DATE SIGNED. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AND CONSENT AT ANY TIME EXCEPT THAT ACTION THAT HAS BEEN PREVIOUSLY TAKEN IN RELIANCE HEREOF.

______________________ ______________________
PATIENT SIGNATURE DATE OF SIGNATURE

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I acknowledge that I have had the opportunity to review a copy of Women's Healthcare Associates, LLC ("WHA") Notice of Privacy Practice ("Notice"). I understand that I am responsible to read this Notice and notify WHA, in writing, of any request for the restrictions in the use or disclosure of my protected health information ("PHI"). I understand WHA has the right to revise this Notice at anytime and will post a copy of the current Notice in the office in a visible location at all times and on their website at www.womenshealthcareassociates.com. WHA will provide me with a copy of its most recent Notice upon my request.

If Women's Healthcare Associates, P.C. has signed contract with my insurance company, provisions of the contract will be followed. Otherwise charges for the office visits are due at the time of service. Other procedures covered by insurance will be filed as a courtesy.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize Women's Healthcare Associates, P.C. to disclose portions of my records or other privileged information (to include alcohol, drug dependence, or AIDS status) necessary to process insurance on my behalf or to assist in my care. This includes the release of information to the referring physician, primary care physician, or facility involved in my medical care. I also hereby assign all medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and other health plans, to Women's Healthcare Associates, P.C. for unpaid charges.

I understand I am responsible for seeing that all my charges are paid in a timely manner. Deductibles, co-insurances, co-pays, non-covered services, and all other balances not covered by insurance are my responsibility.

I hereby acknowledge that I have been provided with a copy of Women's Healthcare Associates Notice of Privacy Practices. The notice contains information regarding potential uses and disclosures of my protected health information (as that term is defined under the Health Insurance Portability and Accountability Act of 1996 "HIPPA") that may be made by the practice's legal duties with respect to my protected health information. I have had the opportunity to review the notice and take a copy with me if I choose.

____ I DO NOT authorize the release of my medical information to anyone.

____ I authorize the release of my medical information to the individual(s) listed below:

______________________________ (Individual) ______________________________ (Individual)

______________________________ (Individual) ______________________________ (Individual)

______________________________ (Individual) ______________________________ (Individual)

______________________________ ______________________________ ______________________

Patient Printed Name Patient/Guardian Signature Date