WOMEN'S SPECIALTY ASSOCIATES, P.C.

Obstetrics and Gynecology
Dr. Carol Powers D.O.
Dr. Alisa Wolner D.O.
Dr. Julianna Friesen D.O.

Thank you for choosing Women's Specialty Associates!

Name: _____

You have been scheduled to see Dr. _____ on _____ at _____.

In an attempt to expedite your upcoming appointment, please take a few minutes to complete these forms. Be sure to **bring them filled out on your scheduled appointment date**. If you are unable to keep your appointment, please call 24 hours in advance as we do charge a $25.00 fee for missed or late canceled appointments.

The patient must pay all co-pays and deductibles on the date of service. If you are not prepared to pay your portion on the date of service, you may want to reschedule, **as an additional $3.00 statement fee will be added to your account for each statement sent to you without payment.**

You MUST bring your INSURANCE CARD AND PHOTO IDENTIFICATION. If you do not possess an insurance card, contact your insurance carrier immediately as we require an actual card to be presented at the time of your visit. If you arrive for your appointment without the insurance card, your appointment may be rescheduled. **All patients with managed care insurance (HMO) must secure a referral for your appointment.** If our office does not receive a valid referral for your visit, your appointment may be rescheduled. Patents/guardians of minor children who do not possess photo identification will need to supply their identification as the responsible party. **Minor children are required to bring the financially responsible party to their office visits.**

Please arrive approximately 15 minutes prior to your appointment time, to allow time to process your completed paperwork.
For directions and more information about our facility please visit our web site at,
www.womensspecialtyassociatespc.com

***Please note a 3.99% processing fee is applied to all credit and debit transactions.**

Thank you

3434 Regency Park Drive, Suite A ▪ Grand Blanc, Michigan 48439 ▪ Phone (810)694-9400 ▪ Fax (810)694-9445

WOMENS SPECIALTY ASSOCIATES
ANNUAL PATIENT INFORMATION FORM

PATIENT NAME_____DATE OF BIRTH_____AGE_____

SOCIAL SECURITY NUMBER_____MARITAL STATUS_____

ADDRESS_____ APT_____ CITY_____STATE_____ZIP_____

HOME PHONE (____) _____CELL PHONE (____) _____ Text appointment reminders? Yes___ No___

EMPLOYER_____FAMILY DOCTOR_____PHONE (____) _____

SPOUSES NAME_____ DATE OF BIRTH_____PHONE NUMBER (____) _____

HEALTH INSURANCE_____ SUBSCRIBERS NAME_____D.O.B_____

SUBSCRIBERS SOCIAL SECURITY NUMBER_____ SUBSCRIBERS EMPLOYER _____

EMERGENCY CONTACT NAME_____ PHONE (____) _____RELATIONSHIP_____

PHARMACY NAME_____PHONE NUMBER (____) _____

RACE: African American Asian Caucasian Hispanic Other_____ Refused

PRIVACY STATEMENT:

We protect our patient's information and the record that we have about their health and the services received in our office. We must have your written, signed consent in order to disclose your health information to your family doctor, insurance company (including disability claims) for the purposes of your treatment, the payment of your bills, appointment reminders, etc. I have received a copy of the Privacy Notice.

(HIPAA- 164.520 © Effective 04/14/2003) *To be filed and retained for a minimum of six (6) years.

Signature_____ Date_____

Please list the family member or persons, if any, whom we may inform about your general medical condition and diagnosis.

_____ _____

_____ _____

Can we leave a confidential message about your care on your answering machine/voice mail? _____

Do you have an authorized power of attorney? Yes___ No___ Do you have an advanced directive? Yes___ No___

Would you be interested in information about advanced directives? Yes___ No __

→ **FINANCIAL RESPONSIBILITY**: I authorize the release of medical information to insurance carriers concerning my illness and treatment and I hereby assign to the doctor all payment for medical services rendered to me or my dependent. I understand that I am responsible for any amount not covered by insurance and that I will pay any co-pays on the date of service unless other arrangements are made. I understand that each statement sent without payment will accrue a $3 fee. *Please note a 3.99% processing fee is applied to all credit and debit transactions

RESPONSIBLE PARTY SIGNATURE_____ DATE _____

→ **MEDICARE AUTHORIZATION:** I request that payment of authorized Medicare benefits be made to Women's Specialty Associates on my behalf. I authorize the holder of my medical information to release to the HCFA and their agents any information needed to determine these benefits for related services. I understand that HCFA is the government Medicare agency.

_____ _____ _____

Medicare Beneficiary Signature Date Medicare Number

PATIENT QUESTIONNAIRE

NAME_____

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

HAVE YOU HAD ANY PROBLEMS WITH YOUR MENSTRUAL CYCLES?	YES___	NO___
IRREGULAR BLEEDING?	YES ___	NO___
CRAMPS WITH YOUR PERIOD?	YES___	NO___
ABNORMAL VAGINAL DISCHARGE?	YES___	NO___
PELVIC/ ABDOMINAL PAIN?	YES___	NO___
BREASTS?	YES___	NO___
CHANGE IN BOWEL HABITS?	YES___	NO___
ANY URINARY PROBLEMS, BURNING OR FREQUENCY?	YES___	NO___
PHYSICAL/ MENTAL/ SEXUAL ABUSE?	YES___	NO___
IN THE LAST YEAR, HAVE YOU HAD ANY MEDICAL PROBLEMS?	YES___	NO___
SEXUAL PROBLEMS?	YES___	NO___
DENTAL PROBLEMS?	YES___	NO___
SURGERIES?	YES___	NO___
CHANGE IN FAMILY HISTORY?	YES___	NO___
PLANS TO ATTEMPT PREGNANCY **THIS** YEAR?	YES___	NO___

PLEASE LIST **ALL ALLERGIES:**

_____

_____

PLEASE LIST ALL MEDICATIONS (PRESCRIPTION OR OVER-THE-COUNTER) THAT YOU TAKE ON A REGULAR BASIS:

_____

_____

DO YOU SMOKE?	YES___	NO___ (HOW MUCH?_____)
DO YOU DRINK ALCOHOL?	YES___	NO___ (HOW MUCH?_____)
DO YOU DRINK CAFFEINE?	YES___	NO___ (HOW MUCH?_____)
DO YOU USE MARIJUANA,	YES___	NO ___
COCAINE, ANY OTHER STREET DRUGS?	YES___	NO___
DO YOU DO SELF BREAST EXAMS?	YES___	NO___
DO YOU EXERCISE ON A REGULAR BASIS?	YES___	NO___ (WHAT TYPE?_____)

ANY OTHER PROBLEMS YOU WOULD LIKE TO DISCUSS? _____

_____

Family history questionnaire

MyRisk™
Hereditary Cancer Test

Personal information

Patient name | Date of birth | Healthcare provider | Today's date

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based on your personal and family history of cancer. The following blood relatives should be considered: **parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces** and **nephews** on both sides of the family. For cancer sites with a '1st-degree relative' notation, only parents, siblings, and children should be considered.

Do you have personal history of breast, ovarian, or pancreatic cancer at any age? ☐ Y ☐ N

Do you have personal history of colorectal or uterine cancer at 64 or younger? ☐ Y ☐ N

Do you have family history of:	Yes(Y)/No(N)	Maternal(M)/ Paternal (P)	Which relative?	Age at diagnosis?
Breast cancer at 49 or younger	☐ Y ☐ N	☐ M ☐ P		
Two different breast cancers in one relative at any age	☐ Y ☐ N	☐ M ☐ P		
Three breast cancers in relatives on the same side of the family at any age	☐ Y ☐ N	☐ M ☐ P		
Ovarian cancer at any age	☐ Y ☐ N	☐ M ☐ P		
Male breast cancer at any age	☐ Y ☐ N	☐ M ☐ P		
Triple negative breast cancer at any age	☐ Y ☐ N	☐ M ☐ P		
Ashkenazi Jewish ancestry with breast cancer at any age	☐ Y ☐ N	☐ M ☐ P		
Pancreatic cancer at any age (1st-degree relative)	☐ Y ☐ N	☐ M ☐ P		
Metastatic or high-risk prostate cancer at any age (1st-degree relative)	☐ Y ☐ N	☐ M ☐ P		
Do you have family history of other cancers?	List them here:			
Have you or anyone in your family had genetic testing for hereditary cancer?	Who?	What gene?		Result?

Medical history questions

Height (ft. and in.) | Weight (lbs.) | Age at first menstrual period:

Are you: ☐ Pre-menopausal ☐ Peri-menopausal ☐ Post-menopausal Age at menopause:

Have you ever had a live birth? ☐ No ☐ Yes Your age at first child's birth:

Have you ever used hormone replacement therapy? ☐ No ☐ Yes If yes, treatment type? ☐ Combined ☐ Estrogen only ☐ Progesterone only

If yes, are you a: ☐ Current user: started years ago, intended use for more years ☐ Past user: stopped years ago

Please indicate if you have had a breast biopsy showing one or more of the following results:

☐ N/A (no biopsy or none of the listed results) ☐ Hyperplasia ☐ Atypical hyperplasia

☐ Lobular carcinoma in situ (LCIS) ☐ Biopsy with unknown or pending results

Information about your female relatives:

Number of daughters: Number of sisters: Number of maternal aunts (mother's sisters): Number of paternal aunts (father's sisters):

Cancer risk assessment review (to be completed after discussion with your healthcare provider)

Patient signature | Date

Healthcare provider signature | Date

Office use only Patient offered hereditary cancer genetic testing? ☐ Yes ☐ No ☐ Accepted ☐ Declined

If yes, which test? ☐ BRACAnalysis® with MyRisk™ ☐ Multisite 3 BRACAnalysis® REFLEX to BRACAnalysis® with MyRisk™

☐ COLARIS®PLUS with MyRisk™ ☐ COLARIS AP®PLUS with MyRisk™ ☐ Single Site Testing ☐ MyRisk™ Update Test

☐ Other:

Follow-up appointment scheduled? ☐ Yes ☐ No Date of next appointment:

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Our goal as your physician is to provide you with professional, high quality and effective care. In order for us to achieve timely consultations and enhanced quality of care, we need to work closely with your primary care physician and any other specialist.

Do you have a primary care physician? ☐ Yes ☐No

If yes, who is your primary care physician?

Doctor's Name: _____
FIRST *LAST*

Address: _____

_____

Do you authorize us to access your previous prescription history?

☐ Yes ☐No

Do you authorize us to provide your primary care physician with our medical recommendations and care you have been receiving in our office? ☐ Yes ☐No

If no, please explain why: _____

_____

I have read and understand the information provided in regards to My Medical Neighborhood (see back). I have been counseled on the importance of continuity of care between myself (the patient), my primary care physician and the specialist(s).

Patient signature: _____ Date: _____

Parent/guardian signature: _____ Date: _____

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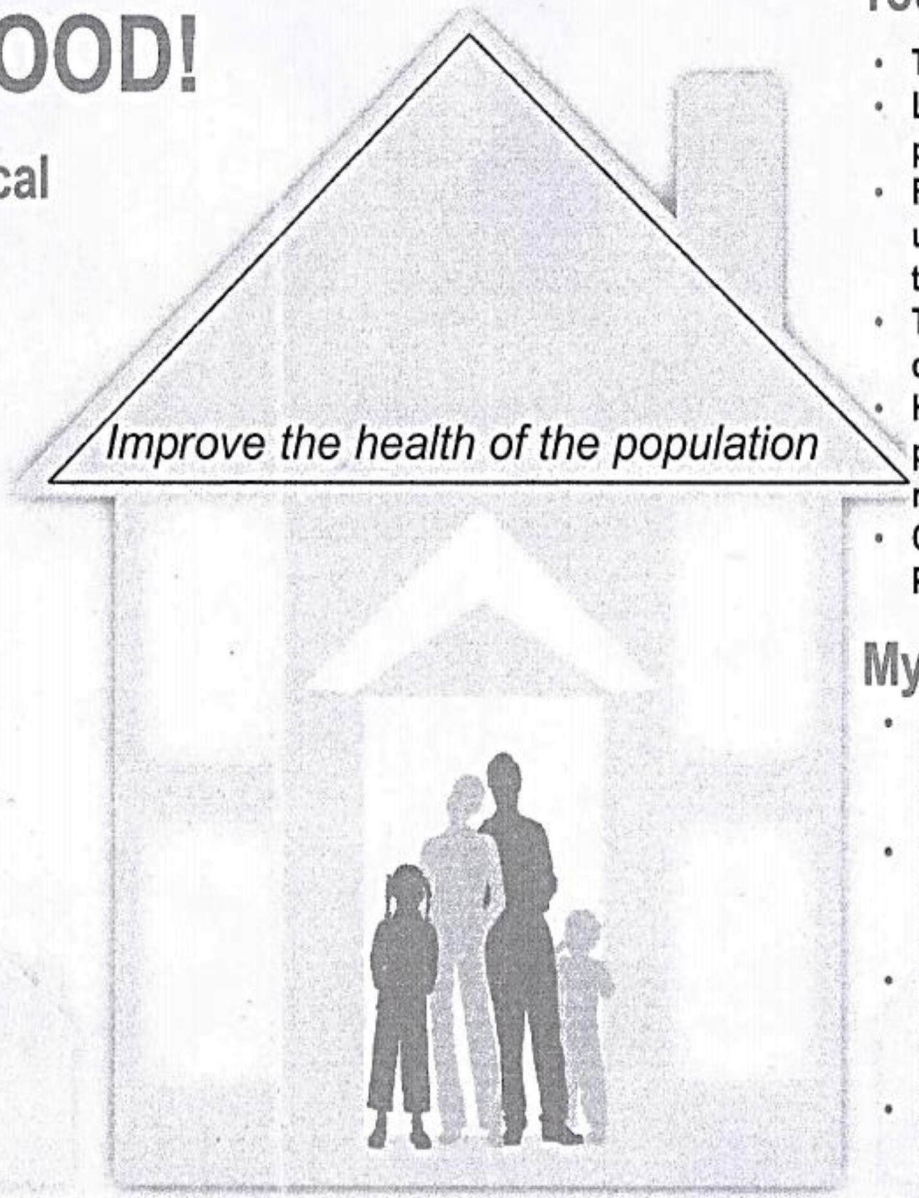
WE ARE PART OF YOUR MEDICAL NEIGHBORHOOD!

Patient Centered Medical Neighborhood

A Patient Centered Medical Home (PCMH) is a team approach to providing comprehensive healthcare to patients in a high quality and cost effective manner.

The Medical Neighborhood is an expansion of the PCMH model connecting primary care physicians, specialty practices, hospitals, and other community health services to work together more efficiently in meeting the specific needs of each patient.



Your Role As the Patient...

- Take part in planning your care
- Learn about wellness and how to prevent diseases
- Follow the care plan that is agreed upon and receive the recommended treatment
- Tell us any prescribed or over the counter medications you are taking
- Have all other physicians who take part in your care send us a report regarding your visit to them
- Continue to see your Primary Care Physician for preventive services

My Role As the Physician...

- Provide you with care that meets your needs and fits with your goals and values
- Work closely with your Primary Care Physician and other Specialists to provide coordinated care
- Ensure efficient flow of information, including timely consultations, referrals and test results
- Support enhanced access and patient-centered, high quality care

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