Martin Aviles, MD FACOG – Kelli Porter, WHNP-BC *Obstetrics and Gynecology*

Patient Demographic Form

New government standards require all information below be completed entirely.

Please PRINT **Date ____/____/______**

PATIENT INFORMATION

Last Name **First Name** **Middle Initial** **Maiden Name** **Nickname/AKA**

___/___/___ ___-___-___

Date of Birth **Social Security Number** **Gender** ☐ Female ☐ Male

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Other

Language(s) Preferred other than English ____

Race

☐ African American/Black ☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Hispanic ☐ Non Hispanic ☐ White/Caucasian ☐ Other

Ethnic Group

☐ Andalusian ☐ Argentinean ☐ Asturian ☐ Belearic Islander ☐ Bolivian ☐ Canal Zone ☐ Canarian ☐ Castillian ☐ Catalonian ☐ Central American
☐ Central American Indian ☐ Chicano ☐ Chilean ☐ Colombian ☐ Costa Rican ☐ Criollo ☐ Cuban ☐ Dominican ☐ Ecuadorian ☐ Gallego ☐ Guatemalan
☐ Hispanic or Latino ☐ Honduran ☐ La Raza ☐ Latin American ☐ Mexican ☐ Mexican American ☐ Mexican American Indian ☐ Mexicano ☐ Nicaraguan
☐ Not Hispanic or Latino ☐ Panamanian ☐ Paraguayan ☐ Peruvian ☐ Puerto Rican ☐ Salvadoran South American ☐ South American Indian ☐ Spaniard
☐ Spanish Basque ☐ Uruguayan ☐ Valencian ☐ Venezuelan ☐ Other

Home Address **Apt #** **City** **State** **Zip Code + 4 digits**

( ) ( ) ( ) ( )

Home Phone **Cell Phone** **Work Phone** **Other Phone**

@

Email Address **Place of Employment/Employer &** **Employer Phone**

Employment Status

☐ Active Duty Military ☐ Child ☐ Disabled ☐ Employed Full-Time ☐ Employed Part-Time ☐ Homemaker ☐ Not Employed ☐ Retired

☐ Self Employed ☐ Student Full-Time ☐ Student Part-Time ☐ Other______________________

Driver's License # ______________________ State _______________ Expiration Date ____/____/______

APPOINTMENT REMINDERS

NWC provides automated scheduled appointment reminders from Televox. You will be prompted to confirm, cancel, or reschedule your appointment. Please select your response accurately. All automated "appointment cancellation responses" are irreversible and will be made available to patients on our waiting list.

What is your preferred contact method? ☐ **Phone** ☐ **Text** ☐ **Email**
What is your preferred reminder method? ☐ **Cell Phone** ☐ **Home Phone** ☐ **Work Phone**

PHYSICIAN REFERRAL INFORMATION

☐ **Primary Care Physician** ☐ **Referring Physician**

Physician's Name Physician's Phone#

If your insurance requires you to obtain a referral from your primary doctor for our providers to treat you, it is your responsibility to get any necessary referral(s) and present it to the receptionist today.

Does your insurance require a referral to be treated here today? ☐ Yes ☐ No **Did you bring a referral today?** ☐ Yes ☐ No

627 Bienville Circle, Natchitoches, LA 71457 – www.NatchitochesWomensCare.com
Phone: 318.352.9595 – Fax: 318.352.9818 – WomensCare@suddenlinkmail.com [Default->Login Title]

Natchitoches Women's Care

Martin Aviles, MD FACOG – Kelli Porter, WHNP-BC *Obstetrics and Gynecology*

How did you hear about us?

☐ Billboard ☐ Employer ☐ Family Member ☐ Friend ☐ Health Fair Event ☐ Insurance ☐ Magazine ☐ Mail ☐ News ☐ Physician
☐ Radio ☐ Television ☐ Website ☐ Yellow Pages ☐ Other_______________________

RESPONSIBLE PARTY (GUARENTOR) INFORMATION

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other_______________________________

Last Name **First Name** **Middle Initial**

/ / - -
Date of Birth **Social Security Number** **Gender** ☐ Female ☐ Male

Home Address **Apt #** **City** **State** **Zip Code + 4 digits**

Home Phone **Cell Phone** **Work Phone** **Other Phone**

PRIMARY INSURANCE POLICY HOLDER INFORMATION

Name of Insurance____ **Insurance ID #**____

Full Claims Mailing Address____

Relationship to Patient ☐ Spouse ☐ Parent ☐ Other _______________________________

Last Name **First Name** **Middle Initial**

/ / - -
Date of Birth **Social Security Number** **Gender** ☐ Female ☐ Male

Home Address **Apt #** **City** **State** **Zip Code + 4 digits**

Home Phone **Cell Phone** **Work Phone** **Other Phone**

SECONDARY INSURANCE POLICY HOLDER INFORMATION

Name of Insurance____ **Insurance ID #**____

Full Claims Mailing Address____

Relationship to Patient ☐ Spouse ☐ Parent ☐ Other _______________________________

Last Name **First Name** **Middle Initial**

/ / - -
Date of Birth **Social Security Number** **Gender** ☐ Female ☐ Male

Home Address **Apt #** **City** **State** **Zip Code + 4 digits**

Home Phone **Cell Phone** **Work Phone** **Other Phone**

Natchitoches Women's Care

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TERTIARY INSURANCE POLICY HOLDER INFORMATION

Name of Insurance________________________________ **Insurance ID #**________________________________

Full Claims Mailing Address____

Relationship to Patient ☐ Spouse ☐ Parent ☐ Other ____________________

Last Name **First Name** **Middle Initial**

/ / - -

Date of Birth **Social Security Number** **Gender** ☐ Female ☐ Male

Home Address **Apt #** **City** **State** **Zip Code + 4 digits**

Home Phone **Cell Phone** **Work Phone** **Other Phone**

EMERGENY/NEXT OF KIN CONTACT INFORMATION

Relationship to Patient ☐ Spouse ☐ Parent ☐ Other ____________________

Last Name **First Name** **Middle Initial**

/ / - -

Date of Birth **Social Security Number** **Gender** ☐ Female ☐ Male

Home Address **Apt #** **City** **State** **Zip Code + 4 digits**

Home Phone **Cell Phone** **Work Phone** **Other Phone**

OTHER CONTACT INFORMATION

Relationship to Patient ☐ Spouse ☐ Parent ☐ Other ____________________

Last Name **First Name** **Middle Initial**

/ / - -

Date of Birth **Social Security Number** **Gender** ☐ Female ☐ Male

Home Address **Apt #** **City** **State** **Zip Code + 4 digits**

Home Phone **Cell Phone** **Work Phone** **Other Phone**

- **You may fax completed form and insurance cards (front & back) to NWC Patient Demographics (318)352-9818 prior to your appointment only.**

All co-pays, co-insurance and any charges meeting the unmet portion of your deductible are due today. We do not offer installment plans.

Martin Aviles, MD FACOG – Kelli Porter, WHNP-BC *Obstetrics and Gynecology*

PLEASE COMPLETE AND PRINT ALL ENTRIES IN <u>BLACK INK ONLY</u>

PHI AUTHORIZATION

All the personnel of Natchitoches women's Care take your medical confidentiality very seriously. We will not and cannot release any of your information without yoru written authorization.

This authorization form, when completed and signed, allows our staff to speak only with an individual or individuals you designate in the event that you are not available to receive our phone calls or you have an adult family member that helps coordinate yoru medical care or bills. You should not designate a physician.

If you feel, for example, comfortable allowing us to talk with another person regarding an appointment, you should check that box. Please check all the boxes that apply to the designated person you choose. If there are two persons you wish to authorize, please complete the next section on both.

I, [Patient->Full Name] authorize the employees of Natchitoches Women's Care to speak with:

Contact Name:_________________________
Relation to Patient: _____________________
Phone:_______________________________

CHECK ALL THAT APPLY

- ☐ APPOINTMENTS
- ☐ LAB RESULTS
- ☐ TEST RESULTS
- ☐ MEDICAL CARE
- ☐ BILLS

Contact Name: ____________________________
Relation to Patient: ________________________
Phone: ____________________________

CHECK ALL THAT APPLY

- ☐ APPOINTMENTS
- ☐ LAB RESULTS
- ☐ TEST RESULTS
- ☐ MEDICAL CARE
- ☐ BILLS

***If you are on your parent's or other's insurance policy, we have the right to discuss your insurance plan information (ONLY) with the policy holder if needed. Your treatment will not be discussed with them unless you have authorized for us to do so.**

Information regarding any of the above may also be left on my:

☐ Answering Machine ☐ Voicemail ☐ Email

My e-mail address is: ____

☐ **I do not authorize anyone to receive information regarding my medical care.**

____ _________________________

Patient Signature Date

This PHI consent expires ______/______/______ or never.

- -

PRIVACY POLICY ACKNOWLEDGEMENT

I, ____, have receive a copy of the Natchitoches Women's Care Notice

of Privacy Policy on ______/______/______.

Martin Aviles, MD FACOG – Kelli Porter, WHNP-BC *Obstetrics and Gynecology*

PLEASE COMPLETE AND PRINT ALL ENTRIES IN BLACK INK ONLY

GYNECOLOGIC HISTORY

Patient: **Date:**

If you feel uncomfortable answering any questions: Leave blank and discuss you're your doctor or nurse.	
First day of last normal menstrual period?	
Age periods began?	
Length of periods? (Number of days bleeding)	
Number of days between periods?	
Number of sexual partners?	
Sexual partners are men, women or both?	
Present method of birth control:	
Have you ever used Intrauterine Device (IUD) or birth control pills?	
If yes, for how long?	
When was your last Pap Test?	
What was the result?	
Have you ever had an Abnormal Pap Test?	
Do you do regular Breast Self-Examination?	
How did you know about us:	

Martin Aviles, MD FACOG – Kelli Porter, WHNP-BC *Obstetrics and Gynecology*

PLEASE COMPLETE AND PRINT ALL ENTRIES IN <u>BLACK INK ONLY</u>

Obstetrical Information Form

Please fill out to the best of your ability.
If you are uncomfortable with any of the questions leave them blank and discuss with your nurse.

Name: _______________________________ Age: _____________ Date of Birth: ____________

Race: ___________________ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Address __________________________________ Phone: ________________________________
____

Place of Employment _____________________________ Job Description _________________________

Are you a student? ☐ Yes ☐ No If yes, what school are you attending? _________________________

What is your highest level of education completed? ____

Are you allergic to any medication? ☐ Yes ☐ No If yes, what? __________________________________

What was the first day of your last normal period? _____/_____/_____

Are your periods regular? ☐ Yes ☐ No Do your periods come every month? ☐ Yes ☐ No

How many times have you been pregnant? ______________________
(please include abortions, miscarriages, stillbirths and tubal pregnancies)

How many living children do you have? __________________________

Were any of your children born prematurely? ☐ Yes ☐ No If yes, how early? __________________

Have you had a miscarriage? ☐ Yes ☐ No If yes, how many? _____________________

Have you had an abortion? ☐ Yes ☐ No If yes, how many? _____________________

Do you take any medications? ☐ Yes ☐ No

If yes, please list: ____

Do you smoke cigarettes? ☐ Yes ☐ No If yes, how much? ____
Do you drink alcohol? ☐ Yes ☐ No If yes, how often? ____
Have you ever used any recreational drugs? ☐ Yes ☐ No If yes, what drug? ____________________________

Have you ever had any surgeries? ☐ Yes ☐ No If yes, list below:

Year of Surgery **Type of Surgery** **Hospital where surgery was performed**

____
____
____

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PLEASE COMPLETE AND PRINT ALL ENTRIES IN <u>BLACK INK ONLY</u>

Obstetrical Information Continued

Have you or your family ever been diagnosed with any of the following?

	YES	NO	FAMILY	RELATION TO PATIENT
Diabetes	☐	☐	☐	____________________
Heart Disease	☐	☐	☐	____________________
Kidney disease/UTI	☐	☐	☐	____________________
Epilepsy	☐	☐	☐	____________________
Hepatitis/Liver disease	☐	☐	☐	____________________
Phlebitis	☐	☐	☐	____________________
Asthma	☐	☐	☐	____________________
Lung Problems	☐	☐	☐	____________________
High blood pressure	☐	☐	☐	____________________
Autoimmune disorders	☐	☐	☐	____________________
Neurologic disorders	☐	☐	☐	____________________
Psychiatric disorders	☐	☐	☐	____________________
Vein problems	☐	☐	☐	____________________
Thyroid problems	☐	☐	☐	____________________
TB	☐	☐	☐	____________________
Breast problems	☐	☐	☐	____________________

Have you ever had any complications related to anesthesia? ☐ Yes ☐ No If yes, what type? ____________
Have you ever had an abnormal pap smear? ☐ Yes ☐ No
If yes, what treatment did you have? ☐ Pap repeated ☐ Colposcopy ☐ Cryotherapy ☐ Laser ☐ Leep

Do you have any uterine malformations? ☐ Yes ☐ No If yes, what type? ___________________________
Do you have a history of infertility? ☐ Yes ☐ No Did you ever have treatment for it? ☐ Yes ☐ No

If yes, what type? ____

Are there any genetic disorders on your side of the family or the father's side of the family, such as:

Bleeding disorders ☐ Yes ☐ No
Down syndrome ☐ Yes ☐ No
Sickle cell trait ☐ Yes ☐ No
Sickle cell disease ☐ Yes ☐ No
Fragile X ☐ Yes ☐ No
Muscular dystrophy ☐ Yes ☐ No
Cystic fibrosis ☐ Yes ☐ No
Huntington Chorea ☐ Yes ☐ No
Mental Retardation ☐ Yes ☐ No
Spina bifida/anacephaly/meningomyocele ☐ Yes ☐ No
Any other genetic disorders not listed above ☐ Yes ☐ No
If yes, please list: ____

Have you been tested for HIV? ☐ Yes ☐ No
Have you received the Hepatitis B Vaccine? ☐ Yes ☐ No
Have you lived with someone with TB or been exposed to someone with TB? ☐ Yes ☐ No
Do you or your sexual partner have genital herpes? ☐ Yes ☐ No
Have you ever been tested for genital herpes? ☐ Yes ☐ No
Have you ever been diagnosed with ☐ Chlamydia ☐ Gonorrhea ☐ Syphilis ☐ Trichomoniasis
If so, were you treated? ☐ Yes ☐ No

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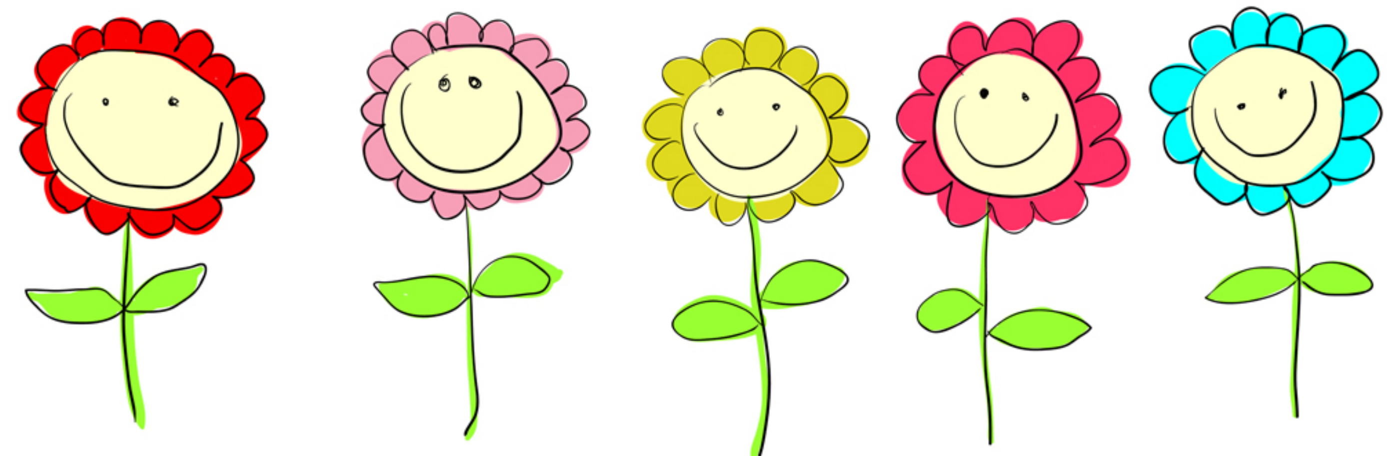

SNEAK PEEK

CATCH A GLIMPSE OF YOUR BABY LIKE NEVER SEEN BEFORE.

AVAILABLE AT THE INITIAL OB VISIT ONLY!!

(MUST BE LESS THAN 20 WEEKS PREGNANT)

FOR $50.00 YOU WILL RECEIVE TWO PICTURES OF YOUR BABY IN 3D/4D REAL TIME IMAGING.

Martin Aviles, MD FACOG – Kelli Porter, WHNP-BC *Obstetrics and Gynecology*

FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below I give permission for Natchitoches Women's Care to access my pharmacy benefits data electronically through RxHub. This consent will enable Natchitoches Women's Care to:

- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

☐ Patient Consent ☐ Restricted Patient Consent

☐ Parent/Guardian Consents ☐ Restricted Parent/Guardian Consent

☐ CONSENT DENIED

**** IF PATIENT IS NOT 18 YEARS OF AGE, THEN PARENT/GUARDIAN MUST GIVE CONSENT!!!**

_______________________________________ ________________

Patient Name (Printed) Date of Birth

____

Patient Signature

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PATIENT PORTAL

THIS ENABLES YOU TO SEE YOUR MEDICAL RECORDS ONLINE IF YOU HAVE AN EMAIL ADDRESS

Authorization to Use or Disclose Protected Health Information via Electronic Media

Please Print

Patient Name: [Patient->Full Name]______________________________ Chart # [Patient->AcctNo]

E-mail Address: ____ Date of Birth: [Patient->Date Of Birth]

Our patient portal lets established patients communicate more easily with us. The portal is not intended for 'Internet Doctor Visits' or new problems. Instead, it will make regular communication more flexible. NWC will provide notices via your personal e-mail that information can be found in your Patient Portal. No personal health information is transmitted via or into your personal e-mail. I understand that the following types of protected health information may be used, disclosed, and retained by health care providers of Natchitoches Women's Care as a result of the communications:

1. View documented health information
2. Get your Lab and Test Results quickly.
3. Email us securely back and forth.
4. Request referrals/refills for medications.
5. Print/Save electronic copies of medical records.
6. Update your demographics and insurance information.

Patients and/or personal representatives who want to communicate with their health care providers by clinic Portal should consider all of the following issues before signing this Authorization.

1. Portal communication is a convenience and not appropriate for emergencies or time-sensitive issues.
2. Portal messages received at Natchitoches Women's Care can be forwarded, printed and/or read, stored by NWC staff members.
3. We advise caution when communicating highly sensitive or personal information via Portal messages (ex: HIV status, mental illness, chemical dependency, and workers compensation issues.)
4. Clinically relevant messages and responses will be documented in the medical record.
5. NWC will not be liable for information lost or misdirected due to technical errors or failures.
6. NWC does not own or have any internet in Portal website. EMDs' Portal is a secure conduit in which communication with our database and patient's medical records access is managed.

We want your records to be complete and correct. Let us know if there's any problem with your records. Sometimes we may use medical jargon in your records and it can lead to confusion. If something doesn't make sense, let us know. Privacy matters. We will never sell/trade/abuse your e-mail address. The patient portal is protected just like phone calls are. Use our Privacy Form to tell us who it's OK to share with. We also think it's important for you to protect privacy on your end. We take security seriously, too. Computer networks do have real risks. We use appropriate technologies to protect your health information. We track security laws like HIPPA and HITECH. We protect and maintain all of the data at our clinic.

Bedside manner is complicated via email. It's easy to misread information or emotion. We'll try to keep things brief and clear on the Portal. We really appreciate your help on that, too. If a message takes a long time to write, it's probably better done in person.

If we have troubles, abuse or 'Spam', we may need to change policies, suspend accounts, or even terminate the portal.
You can access the portal day or night, but we don't have a 24 hour presence on our end. As a safeguard, the portal should not be used for pressing issues. If there's an emergency, you should go to Urgent Care, the Emergency Room or call 911.

I understand that I have the right to refuse to sign or revoke this Authorization at any time. If I want to revoke this Authorization, I must do so in writing, and address it to Natchitoches Women's Care. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization. I will not disclose my patient access information to anyone.

I understand there are pros and cons to using the patient portal for communications with the clinic. The portal is a voluntary option and does not have a charge for its use.

I have read and understand the information in this authorization form and I ☐ accept or ☐ decline.

______________________		______________
Signature	**This consent expires in 1 year**	**Signature Date**

COMPLETE AND/OR PRINT ALL ENTRIES IN <u>BLACK INK ONLY</u>

FINANCIAL POLICY

Patient: <u>[Patient->Full Name]</u> **DOB: <u>[Patient->Date of Birth]</u>**

I understand that I am responsible for payment in full for any and all services rendered to the patient by the medical office of Martin Aviles, M.D. regardless of any insurance benefits payable or pending. I further understand that it is the policy of this medical practice that payment in full is due at time of service with the following exceptions:

1. **Medicare** patients do not have to pay at the time of service but are fully responsible for co-insurance and deductibles after Medicare pays.

2. **Medicaid** patients are responsible for any charge not covered by Medicaid including non-covered office and hospital visits/procedures of any kind. The Medicaid patient is also solely responsible for getting any necessary referrals from their Community Care Providers when this applies to them

3. **Private insurance** groups (State of LA, Group Benefits, EPO, PPO, Ochsner's, MultiPlan, and any other group, PPO or HMO) we participate in are only responsible for their co-pay or co-insurance at the time of service (deductibles, co-insurance, or co-payments). If you have any other insurance you are responsible for payment in full at time of service.

☐ I authorize any and all of my insurance policy carriers to send all payments and payment information for services provided by the staff of Martin Aviles, MD, APMC to Martin Aviles, MD, evident of my signature on file below.

NWC does not carry accounts. Any uncollected accounts are turned over to the Alexandria Credit Bureau. Also, any NSF check will be turned over to the *Natchitoches District Attorney's* office and the patient will be responsible for an additional NSF fee of $25.00.

I HAVE READ THE ABOVE STATEMENT AND ACCEPT SERVICES ON THE TERMS AS STATE ABOVE.

______________________________ _________________________

Patient or Guardian's Signature Date

Acct ID: [Patient->AcctNo]

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