

Form Instructions

1. Please complete the forms below
2. Please save and email to: WomensCare@suddenlinkmail.com or print and fax to: (318) 352-9818
3. If you have any questions or problems filling out the forms you may reach us at: (318) 352-9595

Scroll down to view the forms below

Natchitoches Women's Care

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

Today's 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 and pay for your services received, 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

Promoting women's health and wellness through all stages of life.

627 Bienville Circle, Natchitoches, LA 71457 – www.NatchitochesWomensCare.com

Phone: 318.352.9595 – Fax: 318.352.9818 – WomensCare@suddenlinkmail.com [Default->Login Title]

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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

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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 _____

EMERGENCY/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.

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NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: April 1, 2003

If you have any questions about this notice, please contact Privacy Officer, Lisa Pope, Mgr.

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

Described as follows are the ways we may use and disclose health information that identifies your ("Health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to **NWC Health Information Group.**

TREATMENT. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

PAYMENT. We may use and disclose Health Information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

HEALTH CARE OPERATIONS. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

APPOINTMENT REMINDERS, TREATMENT ALTERNATIVES, AND HEALTH RELATED BENEFITS AND SERVICES. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

RESEARCH. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS

AS REQUIRED BY LAW. We will disclose Health Information when required to do so by international, federal, state, or local law.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

BUSINESS ASSOCIATES. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing or lab services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

ORGAN AND TISSUE DONATION. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation; and transplantation.

MILITARY AND VETERANS. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

WORKERS' COMPENSATION. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

PUBLIC HEALTH RISKS. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury, or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people or recalls of products they may be using; inform a person who may have been exposed to a disease or condition; and report to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

HEALTH OVERSIGHT ACTIVITIES. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government programs, and compliance with civil rights laws.

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LAWSUITS AND DISPUTES. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

LAW ENFORCEMENT. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the persons' agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises; and 6) in an emergency to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

PROTECTIVE SERVICES FOR THE PRESIDENT AND OTHERS. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized person or foreign heads of state, or to conduct special investigations.

INMATES OR INDIVIDUALS IN CUSTODY. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary; 1) for the institution to provide you with health care, 2) to protect your health and safety or the health and safety of others, or 3) for the safety and security of the correctional institution.

YOUR RIGHTS

You have the following rights regarding Health Information we have about you:

RIGHT TO INSPECT AND COPY. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request in writing to [NWC Health Information Group](#).

RIGHT TO AMEND. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request in writing to [NWC Health Information Group](#).

RIGHT TO AN ACCOUNTING OF DISCLOSURES. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosure, you must make your request in writing to [NWC Health Information Group](#).

RIGHT TO REQUEST RESTRICTIONS. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request in writing to [NWC Health Information Group](#). **WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For Example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request in writing to [NWC Health Information Group](#). Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

RIGHT TO A PAPER COPY OF THIS NOTICE. You have the right to a paper copy of this notice. You may ask us to give you another copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You must make your request in writing to [NWC Health Information](#).

CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, please make your request in writing to [Natchitoches Women's Care – Complaint Department](#). All Complaints must be made in writing. **You will not be penalized for filing a complaint.**

I, _____ have received a copy of the Natchitoches Women's Care Notice of Privacy Practice Policy on ____/____/____.

PLEASE COMPLETE AND SIGN ALL ENTRIES IN BLACK INK ONLY

Natchitoches Women's Care

Martin Aviles, MD FACOG – Kelli Porter, WHNP-BC

Obstetrics and Gynecology

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 your 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 your 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 received a copy of the Natchitoches Women's Care Notice of Privacy Policy on ____/____/____.

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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: | |

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Obstetrics and Gynecology

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| PATIENT INTAKE HISTORY (1/5) | | | |
|------------------------------|-------------|---------|-------|
| PATIENT NAME: | BIRTH DATE: | ID NO.: | DATE: |

OBSTETRIC HISTORY

| | | NUMBER | | | NUMBER | | | NUMBER |
|----------------------------|------------|-----------------|-------------|----------------|--|-----------------|----------------|--------|
| PREGNANCIES | | | ABORTIONS | | | MISCARRIAGES | | |
| PREMATURE BIRTHS (<37 WKS) | | | LIVE BIRTHS | | | LIVING CHILDREN | | |
| NO. | BIRTH DATE | WEIGHT AT BIRTH | BABY'S SEX | WEEKS PREGNANT | TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.) | | COMPLICATIONS? | |
| 1. | | | | | | | | |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |

PHYSICIAN'S NOTES ON OBSTETRIC HISTORY:

CURRENT MEDICATIONS

(Including hormones, vitamins, herbs, nonprescription medications)

| DRUG NAME | DOSAGE | WHO PRESCRIBED | DRUG NAME | DOSAGE | WHO PRESCRIBED |
|-----------|--------|----------------|-----------|--------|----------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

FAMILY HISTORY

| MOTHER: <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED CAUSE: | | AGE: | FATHER: <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED CAUSE: | | AGE: |
|--|--------------------------|------------------------------------|--|--------------------|-------------|
| SIBLINGS: | | NUMBER LIVING: | NUMBER DECEASED: | CAUSE(S)/AGE(S): | |
| CHILDREN: | | NUMBER LIVING: | NUMBER DECEASED: | CAUSE(S)/AGE(S): | |
| ILLNESS | YES | WHICH RELATIVE(S) AND AGE OF ONSET | | PHYSICIAN'S NOTES: | |
| DIABETES | <input type="checkbox"/> | | | | |
| STROKE | <input type="checkbox"/> | | | | |
| HEART DISEASE | <input type="checkbox"/> | | | | |
| BLOOD CLOTS IN LUNGS OR LEGS | <input type="checkbox"/> | | | | |
| HIGH BLOOD PRESSURE | <input type="checkbox"/> | | | | |
| HIGH CHOLESTEROL | <input type="checkbox"/> | | | | |
| OSTEOPOROSIS (WEAK BONES) | <input type="checkbox"/> | | | | |
| HEPATITIS | <input type="checkbox"/> | | | | |
| HIV/AIDS | <input type="checkbox"/> | | | | |
| TUBERCULOSIS | <input type="checkbox"/> | | | | |
| BIRTH DEFECTS | <input type="checkbox"/> | | | | |
| DRINKING OR DRUG PROBLEMS | <input type="checkbox"/> | | | | |
| BREAST CANCER | <input type="checkbox"/> | | | | |
| COLON CANCER | <input type="checkbox"/> | | | | |
| OVARIAN CANCER | <input type="checkbox"/> | | | | |
| UTERINE CANCER | <input type="checkbox"/> | | | | |
| MENTAL ILLNESS/DEPRESSION | <input type="checkbox"/> | | | | |
| ALZHEIMER'S DISEASE | <input type="checkbox"/> | | | | |
| OTHER | <input type="checkbox"/> | | | | |

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| PATIENT INTAKE HISTORY (2/5) |
|------------------------------|
|------------------------------|

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| | | | |
|---------------|-------------|---------|-------|
| PATIENT NAME: | BIRTH DATE: | ID NO.: | DATE: |
|---------------|-------------|---------|-------|

SOCIAL HISTORY

| | YES | NO | PHYSICIAN'S NOTES: |
|--|--------------------------|--------------------------|--------------------|
| EVER SMOKED? CURRENT SMOKING: PACKS PER DAY: YEARS: | <input type="checkbox"/> | <input type="checkbox"/> | |
| ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK: | <input type="checkbox"/> | <input type="checkbox"/> | |
| RECREATIONAL DRUG USE | <input type="checkbox"/> | <input type="checkbox"/> | |
| SEAT BELT USE | <input type="checkbox"/> | <input type="checkbox"/> | |
| REGULAR EXERCISE: HOW LONG AND HOW OFTEN? | <input type="checkbox"/> | <input type="checkbox"/> | |
| DAIRY PRODUCT INTAKE/CALCIUM SUPPLEMENTS: QUANTITY: | <input type="checkbox"/> | <input type="checkbox"/> | |
| HEALTH HAZARDS AT HOME OR WORK? | <input type="checkbox"/> | <input type="checkbox"/> | |
| HAVE YOU BEEN SEXUALLY ABUSED, THREATENED OR HURT BY ANYONE? | <input type="checkbox"/> | <input type="checkbox"/> | |

PERSONAL PROFILE

| |
|---|
| SEXUAL ORIENTATION: <input type="checkbox"/> HETEROSEXUAL <input type="checkbox"/> HOMOSEXUAL <input type="checkbox"/> BISEXUAL |
| MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> LIVING WITH PARTNER <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED |
| NUMBER OF LIVING CHILDREN: |
| NUMBER OF PEOPLE IN HOUSEHOLD: |
| SCHOOL COMPLETED: <input type="checkbox"/> HIGH SCHOOL <input type="checkbox"/> SOME COLLEGE/AA DEGREE <input type="checkbox"/> COLLEGE <input type="checkbox"/> GRADUATE DEGREE <input type="checkbox"/> OTHER |
| CURRENT OR MOST RECENT JOB: |
| TRAVEL OUTSIDE THE U.S.? LOCATION: |

PERSONAL PAST HISTORY OF ILLNESSES

| MAJOR ILLNESSES | IF YES - LIST DATE | NO | NOT SURE | PHYSICIAN'S NOTES |
|---|--------------------|--------------------------|--------------------------|-------------------|
| ASTHMA | | <input type="checkbox"/> | <input type="checkbox"/> | |
| PNEUMONIA/LUNG DISEASE | | <input type="checkbox"/> | <input type="checkbox"/> | |
| KIDNEY INFECTIONS/STONES | | <input type="checkbox"/> | <input type="checkbox"/> | |
| TUBERCULOSIS | | <input type="checkbox"/> | <input type="checkbox"/> | |
| SEXUALLY TRANSMITTED DISEASE | | <input type="checkbox"/> | <input type="checkbox"/> | |
| HIV/AIDS | | <input type="checkbox"/> | <input type="checkbox"/> | |
| HEART ATTACH/PROBLEMS | | <input type="checkbox"/> | <input type="checkbox"/> | |
| DIABETES | | <input type="checkbox"/> | <input type="checkbox"/> | |
| HIGH BLOOD PRESSURE | | <input type="checkbox"/> | <input type="checkbox"/> | |
| STROKE | | <input type="checkbox"/> | <input type="checkbox"/> | |
| RHEUMATIC FEVER | | <input type="checkbox"/> | <input type="checkbox"/> | |
| BLOOD CLOTS IN LUNGS OR LEGS | | <input type="checkbox"/> | <input type="checkbox"/> | |
| EATING DISORDERS | | <input type="checkbox"/> | <input type="checkbox"/> | |
| COLLAGEN VASCULAR DISEASE (LUPUS) | | <input type="checkbox"/> | <input type="checkbox"/> | |
| CHICKENPOX | | <input type="checkbox"/> | <input type="checkbox"/> | |
| CANCER | | <input type="checkbox"/> | <input type="checkbox"/> | |
| REFLUX/HIATAL HERNIA/ULCERS | | <input type="checkbox"/> | <input type="checkbox"/> | |
| DEPRESSION/ANXIETY | | <input type="checkbox"/> | <input type="checkbox"/> | |
| ANEMIA | | <input type="checkbox"/> | <input type="checkbox"/> | |
| BLOOD TRANSFUSIONS | | <input type="checkbox"/> | <input type="checkbox"/> | |
| SEIZURES/CONVULSIONS/EPILEPSY | | <input type="checkbox"/> | <input type="checkbox"/> | |
| BOWEL PROBLEMS | | <input type="checkbox"/> | <input type="checkbox"/> | |
| GLAUCOMA | | <input type="checkbox"/> | <input type="checkbox"/> | |
| CATARACTS | | <input type="checkbox"/> | <input type="checkbox"/> | |
| ARTHRITIS/JOINT PAIN/ BACK PROBLEMS | | <input type="checkbox"/> | <input type="checkbox"/> | |
| BROKEN BONES | | <input type="checkbox"/> | <input type="checkbox"/> | |
| HEPATITIS/YELLOW JAUNDICE/LIVER DISEASE | | <input type="checkbox"/> | <input type="checkbox"/> | |

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| |
|-------------------------------------|
| PATIENT INTAKE HISTORY (3/5) |
|-------------------------------------|

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Obstetrics and Gynecology

| | | | |
|---------------|-------------|---------|-------|
| PATIENT NAME: | BIRTH DATE: | ID NO.: | DATE: |
|---------------|-------------|---------|-------|

PERSONAL PAST HISTORY OF ILLNESSES

| MAJOR ILLNESSES | YES(DATE) | NO | NOT SURE | PHYSICIAN'S NOTES |
|---------------------|-----------|----|----------|-------------------|
| GALLBLADDER DISEASE | | | | |
| HEADACHES | | | | |
| OTHER | | | | |
| | | | | |

OPERATIONS/HOSPITALIZATIONS

| REASON | DATE | HOSPITAL |
|--------|------|----------|
| | | |
| | | |
| | | |
| | | |
| | | |

INJURIES/ILLNESSES

| TYPE | DATE | TYPE | DATE |
|------|------|------|------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

IMMUNIZATIONS/TESTS

| DATE | DATE |
|-------------------------------------|---|
| TETANUS-DIPHTHERIA BOOSTER | INFLUENZA VACCINE (FLUE SHOT) |
| HEPATITIS A VACCINE | HEPATITIS B VACCINE |
| VARICELLA VACCINE | PNEUMOCOCCAL VACCINE |
| MEASLES-MUMPS-RUBELLA (MMR) VACCINE | TUBERCULOSIS (TB) SKIN TEST: <input type="checkbox"/> Reactive <input type="checkbox"/> Non |

PHYSICIAN'S NOTES: _____

REVIEW OF SYSTEMS

Please check X if any of the following symptoms apply to you now or since adulthood.

| | NOW | PAST | NEVER | NOT SURE | PHYSICIAN'S NOTES: |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------|
| 1. CONSTITUTIONAL | | | | | |
| WEIGHT LOSS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| WEIGHT GAIN | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| FEVER | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| FATIGUE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| CHANGE IN HEIGHT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. EYES | | | | | |
| DOUBLE VISION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| SPOTS BEFORE EYES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| VISION CHANGES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| GLASSES/CONTACTS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

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Natchitoches Women's Care

Martin Aviles, MD FACOG – Kelli Porter, WHNP-BC

Obstetrics and Gynecology

| PATIENT INTAKE HISTORY (4/5) | | | |
|------------------------------|-------------|---------|-------|
| PATIENT NAME: | BIRTH DATE: | ID NO.: | DATE: |

REVIEW OF SYSTEMS (Continued)

| | NOW | PAST | NEVER | NOT SURE | PHYSICIAN'S NOTES |
|-------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------------------|
| 3. EARS NOSE & THROAT | | | | | |
| EARACHES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| RINGING IN EARS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| HEARING PROBLEMS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| SINUS PROBLEMS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| SORE THROAT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| MOUTH SORES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| DENTAL PROBLEMS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. CARDIOVASCULAR | | | | | |
| PAINFUL BREATHING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| CHEST PAIN OR PRESSURE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| DIFFICULTY BREATHING ON EXERTION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| SWELLING OF LEGS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| RAPID OR IRREGULAR HEARTBEAT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. RESPIRATORY | | | | | |
| WHEEZING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| SPITTING UP BLOOD | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| SHORTNESS OF BREATH | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| CHRONIC COUGH | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. GASTROINTESTINAL | | | | | |
| FREQUENT DIARRHEA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| BLOODY STOOL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| NAUSEA/VOMITING/INDIGESTION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| CONSTIPATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| INVOLUNTARY LOSS OF GAS OR STOOL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. GENITOURNARY | | | | | |
| BLOOD IN URINE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| PAIN WITH URINATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| STRONG URGENCY TO URINATE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| FREQUENT URINATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| INCOMPLETE EMPTYING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| INVOLUNTARY/UNINTENDED URINE LOSS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| URINE LOSS WHEN COUGHING OR LIFTING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| ABNORMAL BLEEDING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| PAINFUL PERIODS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| PREMENSTRUAL SYNDROME (PMS) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| PAINFUL INTERCOURSE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| FIBROIDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| INFERTILITY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| DES EXPOSURE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| ABNORMAL VAGINAL DISCHARGE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. MUSKULOSKELETAL | | | | | |
| MUSCLE OR JOINT PAIN | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| MUSCLE WEAKNESS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

| PATIENT INTAKE HISTORY (5/5) | | | |
|------------------------------|-------------|---------|-------|
| PATIENT NAME: | BIRTH DATE: | ID NO.: | DATE: |

Natchitoches Women's Care

Martin Aviles, MD FACOG – Kelli Porter, WHNP-BC

Obstetrics and Gynecology

REVIEW OF SYMPTOMS (CONTINUED)

| | NOW | PAST | NEVER | NOT SURE | PHYSICIAN'S NOTES: |
|---|----------------------------------|---------------------------------------|------------------------------------|--------------------------------|--------------------|
| 9A. SKIN | | | | | |
| RASH | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| SORES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| DRY SKIN | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| MOLES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9B. BREASTS | | | | | |
| PAIN IN BREASTS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| NIPPLE DISCHARGE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| LUMPS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10. NEUROLOGIC | | | | | |
| DIZZINESS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| SEIZURES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| NUMBNESS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| TROUBLE WALKING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| SEVERE MEMORY PROBLEMS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| FREQUENT OR SEVERE HEADACHES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 11. PSYCHIATRIC | | | | | |
| DEPRESSION OR FREQUENT CRAVING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| SEVERE ANXIETY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12. ENDOCRINE | | | | | |
| HAIR LOSS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| HEAT COLD INTOLERANCE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| ABNORMAL THIRST | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| HOT FLASHES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 13. HEMATOLOGIC/LYMPHATIC | | | | | |
| FREQUENT BRUISES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| CUTS DO NOT STOP BLEEDING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| ENLARGED LYMPH NODES (GLANDS) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 14. ALLERGIC/IMMUNOLOGIC | | | | | |
| MEDICATION ALLERGIES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| PLEASE LIST ALLERGY AND TYPE OF REACTION: | | | | | |
| OTHER ALLERGIES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| PLEASE LIST ALLERGY AND TYPE OF REACTION: | | | | | |
| FORM COMPLETED BY: | <input type="checkbox"/> PATIENT | <input type="checkbox"/> OFFICE NURSE | <input type="checkbox"/> PHYSICIAN | <input type="checkbox"/> OTHER | |
| SIGNATURE OF PATIENT: | | | | | |
| DATE REVIEWED BY PHYSICIAN WITH PATIENT: | | PHYSICIAN SIGNATURE: | | | |
| ANNUAL REVIEW OF HISTORY | | | | | |
| DATE REVIEWED: | PHYSICIAN SIGNATURE: | | | | |
| DATE REVIEWED: | PHYSICIAN SIGNATURE: | | | | |
| DATE REVIEWED: | PHYSICIAN SIGNATURE: | | | | |
| DATE REVIEWED: | PHYSICIAN SIGNATURE: | | | | |

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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 (Print)

Date of Birth

Patient Signature

Natchitoches Women's Care

Martin Aviles, MD FACOG – Kelli Porter, WHNP-BC

Obstetrics and Gynecology

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

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Natchitoches Women's Care

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Obstetrics and Gynecology

COMPLETE AND/OR PRINT ALL ENTRIES IN **BLACK INK ONLY**

FINANCIAL POLICY

Patient: [Patient->Full Name]

DOB: [Patient->Date of Birth]

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]