Natchitoches Women's Care

Martin Aviles, MD FACOG – *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, <u>it is your responsibility to get any necessary referral(s) and present it to the receptionist today</u>.

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

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TERTIARY INSURANCE POLICY HOLDER INFORMATION

Name of Insurance__________ Insurance ID #__________ Group #__________

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.

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 abut 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 coy 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-had 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

627 Bienville Circle, Natchitoches, LA 71457 – www.NatchitochesWomensCare.com
Phone: 318.352.9595 – Fax: 318.352.9818 – WomensCare@suddenlinkmail.com

Natchitoches Women's Care

Martin Aviles, MD FACOG – *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 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, ____________________ 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.**

****If needed, can we fax work or school excuses to your employer or school office? ☐ Yes ☐ No**

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 ____/____/____.

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

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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: ______________________________ Chart # ____________

E-mail Address: ______________________________ 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**

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

627 Bienville Circle, Natchitoches, LA 71457 – www.NatchitochesWomensCare.com
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Martin Aviles, MD FACOG –

Obstetrics and Gynecology

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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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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: ☐ LIVING ☐ DECEASED CAUSE: AGE: FATHER: ☐ LIVING ☐ 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	☐		
STROKE	☐		
HEART DISEASE	☐		
BLOOD CLOTS IN LUNGS OR LEGS	☐		
HIGH BLOOD PRESSURE	☐		
HIGH CHOLESTEROL	☐		
OSTEOPOROSIS (WEAK BONES)	☐		
HEPATITIS	☐		
HIV/AIDS	☐		
TUBERCULOSIS	☐		
BIRTH DEFECTS	☐		
DRINKING OR DRUG PROBLEMS	☐		
BREAST CANCER	☐		
COLON CANCER	☐		
OVARIAN CANCER	☐		
UTERINE CANCER	☐		
MENTAL ILLNESS/DEPRESSION	☐		
ALZHEIMER'S DISEASE	☐		
OTHER	☐		

PLEASE COMPLETE AND PRINT ALL ENTRIES IN BLACK INK ONLY

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PATIENT INTAKE HISTORY (2/5)

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

SOCIAL HISTORY

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

PERSONAL PROFILE

SEXUAL ORIENTATION: ☐ HETEROSEXUAL ☐ HOMOSEXUAL ☐ BISEXUAL

MARITAL STATUS: ☐ MARRIED ☐ LIVING WITH PARTNER ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

NUMBER OF LIVING CHILDREN:

NUMBER OF PEOPLE IN HOUSEHOLD:

SCHOOL COMPLETED: ☐ HIGH SCHOOL ☐ SOME COLLEGE/AA DEGREE ☐ COLLEGE ☐ GRADUATE DEGREE ☐ 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		☐	☐	
PNEUMONIA/LUNG DISEASE		☐	☐	
KIDNEY INFECTIONS/STONES		☐	☐	
TUBERCULOSIS		☐	☐	
SEXUALLY TRANSMITTED DISEASE		☐	☐	
HIV/AIDS		☐	☐	
HEART ATTACH/PROBLEMS		☐	☐	
DIABETES		☐	☐	
HIGH BLOOD PRESSURE		☐	☐	
STROKE		☐	☐	
RHEUMATIC FEVER		☐	☐	
BLOOD CLOTS IN LUNGS OR LEGS		☐	☐	
EATING DISORDERS		☐	☐	
COLLAGEN VASCULAR DISEASE (LUPUS)		☐	☐	
CHICKENPOX		☐	☐	
CANCER		☐	☐	
REFLUX/HIATAL HERNIA/ULCERS		☐	☐	
DEPRESSION/ANXIETY		☐	☐	
ANEMIA		☐	☐	
BLOOD TRANSFUSIONS		☐	☐	
SEIZURES/CONVULSIONS/EPILEPSY		☐	☐	
BOWEL PROBLEMS		☐	☐	
GLAUCOMA		☐	☐	
CATARACTS		☐	☐	
ARTHRITIS/JOINT PAIN/ BACK PROBLEMS		☐	☐	
BROKEN BONES		☐	☐	
HEPATITIS/YELLOW JAUNDICE/LIVER DISEASE		☐	☐	

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PATIENT INTAKE HISTORY (3/5)

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-DIPTHERIA BOOSTER		INFLUENZA VACCINE (FLUE SHOT)	
HEPATITIS A VACCINE		HEPATITIS B VACCINE	
VARICELLA VACCINE		PNEUMOCOCCAL VACCINE	
MEASLES-MUMPS-RUBELLA (MMR) VACCINE		TUBERCULOSIS (TB) SKIN TEST: ☐ Reactive ☐ 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	PHYSICAN'S NOTES:
1. CONSTITUTIONAL					
WEIGHT LOSS	☐	☐	☐	☐	
WEIGHT GAIN	☐	☐	☐	☐	
FEVER	☐	☐	☐	☐	
FATIGUE	☐	☐	☐	☐	
CHANGE IN HEIGHT	☐	☐	☐	☐	
2. EYES					
DOUBLE VISION	☐	☐	☐	☐	
SPOTS BEFORE EYES	☐	☐	☐	☐	
VISION CHANGES	☐	☐	☐	☐	
GLASSES/CONTACTS	☐	☐	☐	☐	

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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	☐	☐	☐	☐	
RINGING IN EARS	☐	☐	☐	☐	
HEARING PROBLEMS	☐	☐	☐	☐	
SINUS PROBLEMS	☐	☐	☐	☐	
SORE THROAT	☐	☐	☐	☐	
MOUTH SORES	☐	☐	☐	☐	
DENTAL PROBLEMS	☐	☐	☐	☐	
4. CARDIOVASCULAR					
PAINFUL BREATHING	☐	☐	☐	☐	
CHEST PAIN OR PRESSURE	☐	☐	☐	☐	
DIFFICULTY BREATHING ON EXERTION	☐	☐	☐	☐	
SWELLING OF LEGS	☐	☐	☐	☐	
RAPID OR IRREGULAR HEARTBEAT	☐	☐	☐	☐	
5. RESPIRATORY					
WHEEZING	☐	☐	☐	☐	
SPITTING UP BLOOD	☐	☐	☐	☐	
SHORTNESS OF BREATH	☐	☐	☐	☐	
CHRONIC COUGH	☐	☐	☐	☐	
6. GASTROINTESTINAL					
FREQUENT DIARRHEA	☐	☐	☐	☐	
BLOODY STOOL	☐	☐	☐	☐	
NAUSEA/VOMITING/INDIGESTION	☐	☐	☐	☐	
CONSTIPATION	☐	☐	☐	☐	
INVOLUNTARY LOSS OF GAS OR STOOL	☐	☐	☐	☐	
7. GENITOURNARY					
BLOOD IN URINE	☐	☐	☐	☐	
PAIN WITH URINATION	☐	☐	☐	☐	
STRONG URGENCY TO URINATE	☐	☐	☐	☐	
FREQUENT URINATION	☐	☐	☐	☐	
INCOMPLETE EMPTYING	☐	☐	☐	☐	
INVOLUNTARY/UNINTENDED URINE LOSS	☐	☐	☐	☐	
URINE LOSS WHEN COUGHING OR LIFTING	☐	☐	☐	☐	
ABNORMAL BLEEDING	☐	☐	☐	☐	
PAINFUL PERIODS	☐	☐	☐	☐	
PREMENSTRUAL SYNDROME (PMS)	☐	☐	☐	☐	
PAINFUL INTERCOURSE	☐	☐	☐	☐	
FIBROIDS	☐	☐	☐	☐	
INFERTILITY	☐	☐	☐	☐	
DES EXPOSURE	☐	☐	☐	☐	
ABNORMAL VAGINAL DISCHARGE	☐	☐	☐	☐	
8. MUSKULOSKELETAL					
MUSCLE OR JOINT PAIN	☐	☐	☐	☐	
MUSCLE WEAKNESS	☐	☐	☐	☐	

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PATIENT INTAKE HISTORY (5/5)

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

REVIEW OF SYMPTOMS (CONTINUED)

	NOW	PAST	NEVER	NOT SURE	PHYSICAN'S NOTES:
9A. SKIN					
RASH	☐	☐	☐	☐	
SORES					
DRY SKIN	☐	☐	☐	☐	
MOLES	☐	☐	☐	☐	
9B. BREASTS					
PAIN IN BREASTS	☐	☐	☐	☐	
NIPPLE DISCHARGE	☐	☐	☐	☐	
LUMPS	☐	☐	☐	☐	
10. NEUROLOGIC					
DIZZINESS	☐	☐	☐	☐	
SEIZURES	☐	☐	☐	☐	
NUMBNESS	☐	☐	☐	☐	
TROUBLE WALKING	☐	☐	☐	☐	
SEVERE MEMORY PROBLEMS	☐	☐	☐	☐	
FREQUENT OR SEVERE HEADACHES	☐	☐	☐	☐	
11. PSYCHIATRIC					
DEPRESSION OR FREQUENT CRAVING	☐	☐	☐	☐	
SEVERE ANXIETY	☐	☐	☐	☐	
12. ENDOCRINE					
HAIR LOSS	☐	☐	☐	☐	
HEAT COLD INTOLERANCE	☐	☐	☐	☐	
ABNORMAL THIRST	☐	☐	☐	☐	
HOT FLASHES	☐	☐	☐	☐	
13. HEMATOLOGIC/LYMPHATIC					
FREQUENT BRUISES	☐	☐	☐	☐	
CUTS DO NOT STOP BLEEDING	☐	☐	☐	☐	
ENLARGED LYMPH NODES (GLANDS)	☐	☐	☐	☐	
14. ALLERGIC/IMMUNOLOGIC					
MEDICATION ALLERGIES	☐	☐	☐	☐	
PLEASE LIST ALLERGY AND TYPE OF REACTION:					
OTHER ALLERGIES	☐	☐	☐	☐	
PLEASE LIST ALLERGY AND TYPE OF REACTION:					

FORM COMPLETED BY: ☐ PATIENT ☐ OFFICE NURSE ☐ PHYSICIAN ☐ 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:	

627 Bienville Circle, Natchitoches, LA 71457 – www.NatchitochesWomensCare.com
Phone: 318.352.9595 – Fax: 318.352.9818 – WomensCare@suddenlinkmail.com

Natchitoches Women's Care

Martin Aviles, MD FACOG – *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 (Print) Date of Birth

____

Patient Signature Patient's Preferred Pharmacy/City (Required*)

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

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COMPLETE AND/OR PRINT ALL ENTRIES IN BLACK INK ONLY

FINANCIAL POLICY

Patient: ______________________________ **DOB:** _____/_____/________

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, BCBS, 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

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