Platte Valley Women's Healthcare

First Name _____M.I. _____ Last Name _____

Date of Birth _____ Social Security # _____

Gender _____F _____M Marital Status (circle one) Single Married Divorced Widowed Separated

Race _____ Ethnicity _____ Preferred Language _____

Address _____City _____ State _____ ZIP _____

Home Phone _____ Patient Cell Phone _____

E-mail _____ Primary Care Provider _____

Employer/Occupation _____ Work Phone _____

Emergency Contact _____ Relationship _____ Phone _____

Spouse's Name _____ Date of Birth _____ Phone _____

If you are a new patient, who can we thank for referring you? _____

Guarantor (Person financially responsible for account, for anyone under the age of 19 or legally otherwise):

Name_____ DOB: _____ Phone: _____

Address _____ City _____State_____ Zip _____

One Chart

Patient Portal Our office utilizes an internet based patient portal called One Chart. You can use the portal to update your patient information and insurance, send messages to providers and staff, access test results, and confirm your scheduled appointments.

Insurance Information

Name of Insurance _____ Policy Holder _____

Policy Holder's Date of Birth _____ Phone _____

Address (if different from above) _____

Relationship to Patient _____

Assignment of insurance benefits: I hereby authorize payment of medical benefits to Platte Valley Women's Healthcare for services rendered by them in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance company. **Co-Pays are due the date of service**.

MEDICARE-MEDICAID: I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

Self Pay Patients: It is our policy to collect a minimum of 50% of the total charges at the time of service. If you pay in full at time of service, a 25% discount will be offered. Durable medical supplies such as devices and medications are excluded from this policy and must be paid in full at time of service.

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Consent to Release Information to Others

Platte Valley Women's Healthcare understands that there may be times when you are unavailable and would like for us to leave messages, leave prescriptions/samples/records for pickup or speak to others on your behalf regarding appointments, referrals, insurance/billing or test results and treatment. Carefully consider who, if anyone, you would want to have access to your medical and/or account information. Please list below:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Special Instructions, if any:

_____

By signing below you are giving Platte Valley Women's Healthcare permission to speak, leave messages, or allow pickup of prescriptions/samples/records with persons other than yourself. This consent will remain valid until revoked in writing by the patient or guardian.

Patient/Guardian's Signature _____ Date _____

Print Name (if not patient) _____ Relationship _____

Platte Valley Women's Healthcare

Patient Name_____ Date of Birth _____

Name of Pharmacy_____

Do you take any medications on a regular basis? Please include any prescription, herbal, supplement, or over-the-counter medications (if you have a list we can make a copy):

_____

_____

_____

Do you have any medical allergies (medication, latex, iodine, or shellfish)? Please list and explain your reaction:

_____

_____

Social History:

Who do you live with? _____ Do you feel safe at home? Yes No

What is your occupation? _____

Are you feeling stressed or depressed? Yes No What do you do for exercise? _____

Do you have a living will, or power of attorney directive: Yes No

Are you on a special diet? Yes No If yes, please describe: _____ Do you use Tobacco? Yes No If yes, would you like to quit? Yes No

How many Alcoholic drinks per week? _____ Do you use recreational drugs? Yes No

If yes, what? _____Do you feel like you should cut down on your alcohol/drug use? Yes No

Medical Conditions/Diseases- Please check all that apply to you:

____Migraines
____Blood Clot or Clotting Disorder
____Bleeding Disorder
____Anemia
____Blood Transfusion
____Varicose Veins
____Stroke or Vascular Disease
____Lung Condition (Asthma, COPD)
____Heart Disease (Cong heart failure)
____Heart Attack
____High Blood Pressure
____High Cholesterol
____Pre-eclampsia in pregnancy
____Irregular Heart Rhythm
____Depression, Anxiety
____Learning Disability
____Breast Cancer, cyst, tumor, biopsy
____Liver Disease, hepatitis, cancer or tumor
____Diabetes or Gestational Diabetes
____Sickle Cell Disease or trait
____Seizure disorder or epilepsy
____Concussion or Brain Injury
____Allergy Disorder
____Bowel Disorder (IBS, Crohn's, Colitis)
____Cervical Cancer or Abnormal Pap
____Other Cancer (List) _____
____Sexually Transmitted Infection
____Infertility
____Endometriosis
____Kidney Issue (Stones, renal failure)
____Anorexia, Bulimia
____Chronic Pain
____Thyroid Problems
____Arthritis or Joint Problems
____Multiple Sclerosis (MS)
____Glaucoma or Eye Problems
____Hearing Impairment
____Other (List)_____

Patient Name_____ Date of Birth _____

Surgeries- Please check all that apply to you:

____Hysterectomy
____Ovaries Removed
____Tubal Ligation
____Uterine Ablation
____Mastectomy
____Cholecystectomy (gallbladder)
____Joint Replacement
____Laparoscopy
____Bariatric Surgery
____Tonsillectomy
____Other (List)
_____
_____

Have you ever had problems with anesthesia? Yes No Please Describe: _____

Family History- Please check all that apply to your family:

____Heart Attack
____Stroke
____Diabetes
____Blood Clot or Clotting Disorder
____Osteoporosis
____Alzheimers/Dementia
____Breast Cancer
____Colon Cancer
____Uterine Cancer
____Ovarian Cancer
____Other Cancer
_____
____Birth Defects
____Inherited Disorder
____Endometriosis
____Hemachromatosis
____Kidney Problems
____Thyroid Problems
____Mental Health Issue
(List)_____
_____Alcoholism/Drug Abuse
____Other
_____
_____
_____
_____

Female History:

Age of first period _____ Date of last period _____

Do you have any menstrual concerns?

_____

_____

Are you sexually active? Yes No Is your partner male or female? _____

Please List your Current Birth Control Method: _____

Have you had a new sexual partner in the last 90 days? Yes No

Would you like to become pregnant in the next 12 months? Yes No

Pregnancies:

Number of times_____ Number Premature _____ Miscarriages _____

Abortions_____ Living Children _____ Ectopic _____

Types of Deliveries: Vaginal_____ Cesarean_____ VBAC_____

Menopausal History: Year of last period_____ Problems or Concerns? _____

_____

Screening Tests (please list date of last exam):

Pap smear _____ Mammogram_____ Colonoscopy _____

Bone Density _____ Cholesterol Level_____ Dental Exam/Cleaning_____

Eye Exam_____ Cardiac Stress Test or EKG _____

Patient Name_____ Date of Birth _____

CURRENT symptoms or concerns: Please check all that apply to you

____Weight Gain
____Weight Loss
____Menstrual Problems_____
____Bladder Issues
____Incontinence
____Bowel Problems
____Eating Disorder
____Headaches
____Low Energy
____Hot Flashes
____Depression
____Anxiety or Worry
____Suicidal Thoughts
____Premenstrual Syndrome (PMS)
____Muscle or Joint Pain
____Ankle or Foot Swelling
____Indigestion
____Blood in Urine
____Bloody Stools
____Constipation
____Diarrhea
____Hemorrhoids
____Breast Concerns
____Vaginal problems or discharge
____Pain with Intercourse
____Low interest in Sex
____Pelvic Pain
____Cough
____Shortness of Breath
____Indigestion
____Problems swallowing
____Skin Changes
____Varicose Veins
____Acne
____Memory Problems
____Chest Pain
____Palpitations
____Trouble Sleeping
____Exercise intolerance
____Other_____

I have answered the questions regarding my medical history to the best of my knowledge:

Patient Signature _____ Date: _____

If completed by guardian/other: _____Date: _____