Platte Valley Women's Healthcare, PC
810 W. Reid Ave, Suite 4, North Platte, NE 69101
Update Form -

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 ___________________________________
Preferred Pharmacy ________________________ 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? ____

If you are age 19 or under, Parent/Guardian name & phone number:
____

Updox Patient Portal
Our office utilizes an internet based patient portal called Updox. 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. Once you have provided an e-mail address, you should receive an e-mail within 24 hours, with a link and information to set up your account. If you do not receive an e-mail, please check your junk folder or you can call the office and request it. You can find a link to the patient portal on our website.

E-mail ____

Insurance Information
Name of Insurance __________________________ Policy Holder __________________________________
Policy Holder's Date of Birth ___________________ 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.

A PHOTOCOPY OF THESE ASSIGNMENTS SHALL BE VALID AS THE ORIGINAL

I have read and understand these financial policies, and agree to be financially responsible for the services I receive:

Patient's Signature ____ Date: _______________________

Parent/Guardian's Signature ____ Date: _______________________

HIPAA Patient Consent

Patient Name _______________________________________ Date of Birth ___________________________

I understand that as part of my health care, Platte Valley Women's Healthcare originates and maintains paper and/or electronic medical records describing my protected health information and any plans for future care of treatment.

I hereby authorize Platte Valley Women's Healthcare to release my medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

I understand that I have the following rights and privileges:

- **The right to review the notice prior to signing this consent.**
- **The right to object the use of my health information for directory purposes.**
- **The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.**

I understand that if I refuse to sign this consent, Platte Valley Women's Healthcare may refuse to treat me, as permitted by the Code of Federal Regulation.

A copy of Platte Valley Women's Healthcare's Notice of Privacy Practices is available upon request. If you would like a copy of the Notice, please check here: ______Yes ______No

I understand I consent to the use and disclosure of protected health information as described in the Notice of Privacy Practices.

Patient/Guardian's Signature ____ Date _____________________

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 __________________

Patient Name____ **Date of Birth** ________________________

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, power of attorney or advanced 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 ever feel like you should cut down on your alcohol or 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 (ex. Asthma, COPD)
____Heart Disease (ex. Congestive heart failure)
____Heart Attack
____High Blood Pressure
____High Cholesterol
____Pre-eclampsia in pregnancy
____Irregular Heart Rhythm
____Depression, Anxiety, Mood Disorder
____Learning Disability
____Breast cancer, cyst, tumor, biopsy
____Liver disease, hepatitis, cancer or tumor
____Diabetes or Gestational Diabetes
____Autoimmune Conditions (ex. Lupus)
____Sickle cell disease or trait
____Seizure disorder or epilepsy
____Concussion or Brain Injury
____Allergy Disorder
____Bowel Disorder (ex IBS, Crohn's, Colitis)
____Cervical Cancer or Abnormal Pap
____Other Cancer (list)_____________________
____Sexually Transmitted Infection
____Infertility
____Endometriosis
____Kidney Issue (ex. stones, renal failure)
____Anorexia/Bulemia
____Chronic Pain
____Thyroid Problems
____Arthritis or Joint Problems
____Multiple Sclerosis (MS)
____Glaucoma or Eye Problems
____Hearing Impairment
____Other (list)____________________________
____

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 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__________________________
____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 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 or Fecal Occult Test_________
Bone Density ____________
Cholesterol Level ___________
Dental Exam/Cleaning___________
Eye Exam ___________
Cardiac Stress Test or EKG ___________

This history form is strictly CONFIDENTIAL and, like your entire medical record,
will NOT be released without your specific request and written consent except as required by law.

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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: _________________________

Reviewed by ____ Date: ________________________

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