NOTICE TO OUR PATIENTS

Thank you for choosing us as your healthcare provider. We look forward to providing an office environment and provider relationship that meets you and/or your family’s medical needs.

Items to bring to your first appointment:

1. Driver’s license or other photo identification.
2. All insurance cards.
3. Co-pays or payment in full at the time of your visit if you are not covered by insurance.
4. Actual bottles of all medications (prescribed and over the counter) that you are currently taking.

No-Show Policy

Our policy is to call patients the business day prior to their scheduled appointment to remind them of the appointment date and time. We perform these calls as a courtesy to our patients and to allow us the opportunity to reschedule the time slot should the appointment not be necessary. A phone call from you to cancel your appointment will allow us to schedule another patient that needs to be seen. Recognizing that everyone’s time is valuable and that appointment time is limited, we ask that you provide 24 hours notice if you are unable to keep your appointment. This will allow us to call one of our patients on a waiting list to fill the available slot on the schedule.

To improve care for our patients, we will track all “No-Show” visits. Each patient will be allowed to miss two scheduled appointments within a one year period without penalty. Once a third appointment is missed, the patient will be at risk of being discharged from the practice or the Southwest Medical Group. To prevent this from happening, patients shall receive a letter each time they no-show for an appointment reminding them of our no-show policy.

For the purposes of this policy, a no-show appointment is defined as follows:

1. An appointment which is missed by the patient without any advanced notice.
2. An appointment that is cancelled less than 24 hours prior to the scheduled appointment time.
3. An appointment in which the patient arrives 10 minutes or more beyond the scheduled appointment time.

Due to the check-in process, we request patients arrive 20 minutes prior to their scheduled appointment time to spend their allotted time with their provider.

Failure to show for the initial “new patient” appointment may eliminate your opportunity to establish care as a new patient.

Rx Refill Policy

Our policy is to refill patient prescriptions within 72 (business) hours of receiving the request. Please do not wait until you are completely out of medication or you will likely do without until the refill can be processed.

Patient Name: __________________________ Date of Birth: ________________

Signed (signature required): __________________________ Date/Time: ________________

Patient, Parent or Legal Guardian: __________________________ Date/Time: ________________
NEW PATIENT / HISTORY INFORMATION - ADULT

Date: __________________________

Patient Name: __________________________

First Name  Middle Name  Last Name

Date of Birth: ____________  Age: ____________  Gender:  Male  Female

Street Address: __________________________  City/State/Zip: __________________________

Mailing Address (if different): __________________________  City/State/Zip: __________________________

Best Contact Number: __________________________

Home Phone: ____________  Cell Phone: ____________  Work Phone: __________________________

Email Address: __________________________

Would you like to sign up for our Southwest Medical Group patient portal?  □ No  □ Yes

Social Security # ____________ - ____________ - ____________ Primary Care Physician: __________________________

Language: ____________  Race: [American Indian or Alaska Native/ Native American / African American / Asian / Chinese / Filipino / Japanese / White / Hispanic / Native Hawaiian / Other]

Marital Status: [Single  Married  Separated  Divorced  Widowed]  Number of Children ____________

Occupation: __________________________  Retired? Y / N

Patient's Employer: __________________________

Business Address: __________________________  Phone: __________________________

Name of Primary Insurance: __________________________  Name of Primary Insurance Holder: __________________________

Member ID#: __________________________  Group #: __________________________

Name of Secondary Insurance: __________________________

Member ID#: __________________________  Group#: __________________________

Patient's Relationship to Insurance Holder: __________________________

In case of Emergency, who should be notified?  Name: __________________________

Relationship to Patient: __________________________  Contact Phone Number: __________________________
Patient Name: ____________________________        ____DOB:___________             Today's Date: ________________

Reason for Visit: ☐ GYN Annual Exam ☐ OB ☐ Emergency ☐ Consultation ☐ Other:______________________________

Please give more information if needed: ________________________________________________________________

GYNECOLOGIC HISTORY

First day of last menstrual period: ____________________________  Age (or grade) when periods began:______________________
Are your periods usually: ☐ Regular ☐ Irregular ☐ No longer menstruating Date of Menopause: __________________
Periods last ________days  Periods occur every ________days  Bleeding is: ☐ Heavy ☐ Moderate ☐ Light

Do you have bleeding between periods?  ☐ Yes ☐ No  Do you have cramps/pain with your periods?  ☐ Yes ☐ No
If yes, do you use pain med?  ☐ Yes ☐ No  Do you have pain or bleeding with intercourse?  ☐ Yes ☐ No
Do you use; ☐ Pads, ☐ Tampons, ☐ Both Are you having problems with your sex drive?  ☐ Yes ☐ No
Are you currently sexually active?  ☐ Yes ☐ No  Is your partner: ☐ Male ☐ Female ☐ Both (bi-sexual)
Number of lifetime sexual partners: ________ Number of partners in past year:_______ (for risk factors)

PERSONAL HISTORY

<table>
<thead>
<tr>
<th>Menstrual Dysfunction</th>
<th>Lung Problems</th>
<th>Cancer</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, what type?</td>
<td>If yes, what type?</td>
<td>If yes, what type and year diagnosed:</td>
<td>High Cholesterol</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Abnormal Pap Smear</th>
<th>Heart Problems</th>
<th>Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, Treatment?</td>
<td>If yes, what type?</td>
<td>Treatment:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chemotherapy</td>
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<tr>
<td></td>
<td></td>
<td>Radiation</td>
</tr>
<tr>
<td>STD Exposure</td>
<td>Liver Disease</td>
<td>Cancer</td>
</tr>
<tr>
<td>If yes, what type?</td>
<td>If yes, what type?</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hemorrhoids</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vaginal Problems</th>
<th>Hepatitis A, B or C</th>
<th>Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, what type?</td>
<td>If yes, what type?</td>
<td>If yes, what type?</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual Dysfunction</th>
<th>Blood Disorder</th>
<th>Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, what type?</td>
<td>If yes, what type?</td>
<td>If yes, where?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Uterine Fibroids</th>
<th>Blood Transfusion</th>
<th>Cancer</th>
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<tbody>
<tr>
<td>If yes, year given:</td>
<td></td>
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</tbody>
</table>

Please add other pertinent diagnoses or more information if needed: ________________________________________________________________

MEDICATION ALLERGIES: Please specify reaction

☐ Penicillin  ☐ Sulfa  ☐ Codeine  ☐ Morphine  ☐ Latex  ☐ Aspirin  ☐ Tylenol  ☐ No Known Drug Allergies
Other ________________________________________________________________________________

Reaction: ________________________________________________________________________________
**IMMUNIZATIONS:** Please check all that are current

- ☐ Diphtheria/Tetanus (every 10 years)
- ☐ Hepatitis B
- ☐ Hepatitis A
- ☐ MMR (Measles, Mumps, Rubella)
- ☐ Flu (yearly)
- ☐ Varicella (Chicken Pox)
- ☐ Pneumonia
- ☐ Tdap (As adult or with every pregnancy)

**FAMILY HISTORY:** Please check the box and write which family member and what side of your family they are on (Maternal or paternal)

<table>
<thead>
<tr>
<th>Family Member(s)</th>
<th>Family Member(s)</th>
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<tbody>
<tr>
<td>Breast cancer</td>
<td>High blood pressure</td>
</tr>
<tr>
<td>Cervical cancer</td>
<td>Heart Attack</td>
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<tr>
<td>Ovarian cancer</td>
<td>Stroke</td>
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<tr>
<td>Uterine cancer</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Colon cancer</td>
<td>Osteoporosis</td>
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<tr>
<td>Other cancer</td>
<td>Thyroid</td>
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</tbody>
</table>

**SOCIAL AND EMOTIONAL HISTORY:**

- **Tobacco use:** ☐ Never
- ☐ Now: Packs per day: _____ How many yrs.: _____ ☐ Past: Packs per day: _____ How many yrs?: _____ Date quit: _____
- **Alcohol use:** Drinks per week: _____ Type: ____________________________
- **Marijuana use:** How much: _____ How often: _____
- **Caffeine use:** Quantity per day: _____ Type: ____________________________
- **Do you exercise?** ☐ Yes, ☐ No. If yes, how often and what type? ____________________________
- **Do you have History of Depression?** ☐ Yes, ☐ No, ☐ Anxiety? ☐ Yes, ☐ No
- **Do you have a History of Abuse?** ☐ Yes, ☐ No, ☐ Domestic ☐ Sexual If yes, Do you want to discuss? ☐ Yes, ☐ No

**CONTRACEPTIVE HISTORY**

- **Current method of birth control:** ☐ Vasectomy ☐ Tubal ligation ☐ Birth Control ☐ Diaphragm ☐ Foam/Gel ☐ Condoms
- ☐ Natural Family Planning/Rhythm ☐ Depo Provera Injections ☐ IUD: Type: ____________________________ ☐ Nexplanon ☐ Nuva Ring ☐ None

**CURRENT MEDICATIONS, SUPPLEMENTS, VITAMINS, OR HERBALs:**

<table>
<thead>
<tr>
<th>Med/Sup/Herbal</th>
<th>Dose &amp; Frequency</th>
<th>Med/Sup/Herbal</th>
<th>Dose &amp; Frequency</th>
<th>Med/Sup/Herbal</th>
<th>Dose &amp; Frequency</th>
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**Preferred Pharmacy:** ____________________________  **Address (City):** ____________________________

**SURGICAL HISTORY**

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<thead>
<tr>
<th>Year</th>
<th>Type of surgery</th>
<th>Reason</th>
<th>Complications</th>
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Rev. 1/27/2020
PREGNANCIES

Total # of Pregnancies: ________  Miscarriages: ________  Abortions: ________  Preterm Deliveries: ________  Term Deliveries ________

Include live, miscarriages and abortions below

<table>
<thead>
<tr>
<th>Year</th>
<th>Vaginal or Cesarean</th>
<th># Weeks at delivery</th>
<th>Length of labor</th>
<th>M/F</th>
<th>Birth Weight</th>
<th>Complications</th>
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SCREENINGS  Please specify month and year

Last Pap smear date: ________
Last mammogram date: ________
Last colonoscopy date: ________
Last cholesterol testing date: ________
Last DEXA (osteoporosis screening) date: ________

Is there anything specific that you would like to address today?:

____________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________

Signature: __________________________________________________________  Date: __________________________
**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Phone Number:</th>
<th>Date of Birth:</th>
<th>Last 4 digits SSN#:</th>
</tr>
</thead>
<tbody>
<tr>
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<td>(optional)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>Phone Number:</th>
<th>Fax Number:</th>
<th>E-mail:</th>
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I, ________________________________________________, hereby authorize disclosure of my protected health information as follows:

**RELEASE FROM:**

<table>
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<tr>
<th>Facility, Person, Provider:</th>
<th>Phone Number:</th>
<th>Fax Number:</th>
<th>E-mail:</th>
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*SHS DOES NOT FAX PERSONAL HEALTH INFORMATION TO HOME FAX MACHINES*

**Information to be released:** From (date) to (date)

- Treatment Records-Hospital
- Office Visit Notes - Clinic
- Consultation Reports
- Laboratory Reports
- Diagnostic Imaging Reports
- Operative Reports
- Emergency Room Records
- Discharge Summary
- Ambulance Run Reports
- History and Physical
- Pathology Reports
- Sleep Lab Reports

**Purpose of Release:**

- Medical Care
- Transferring Care
- Attorney
- Personal Records
- Other: 

**Sensitive Information:** I understand by checking any boxes below, I have given permission to release confidential information related to HIV, Mental Health Care, or Drug and Alcohol Treatment, which is protected by federal law 42 CFR Part 2. (If the boxes are not checked, this information will NOT be released.)

- Diagnosis and/or treatment relating to drug or alcohol abuse
- Diagnosis and/or treatment relating to mental health conditions
- Diagnosis and/or treatment relating to HIV testing, infection or diagnosis and/or treatment for AIDS

**Right to Revoke:** I understand that I may revoke this Authorization at any time by notifying Southwest Health System, Inc., in writing. I understand that revocation will not have any effect on actions taken prior to receipt of the revocation.

**Expiration:** This Authorization will automatically expire 180 days from the date of my signature, unless otherwise specified as follows: (date).

**Re-Disclosure:** I understand that the information used and/or disclosed according to this Authorization may no longer be protected by federal privacy law also known as HIPAA, and the recipient of the health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

With my signature below, I acknowledge and authorize Southwest Health System, Inc., to use and/or disclose my protected health information as described above. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this Authorization.

Patient name printed: ___________________________________________ Date of Signature: ____________/Time: _________________

Patient signature: _____________________________________________

Patient representative name printed: _______________________________

Patient representative signature: _________________________________ / Relationship to Patient: ____________________________