FEMALE PATIENT INFORMATION

Patient Name: ____
Last First Middle "Nickname"

DOB: ________ Sex: _______ SSN: ____________________ Marital Status: ______ Drivers Lic #: ______________

Ethnicity (circle one): African American American Indian Asian
Caucasian/White Hawaiian Hispanic/Latino Other
Primary Language: ________________

Address: ____
Street Apt # City State Zip Code County

Phone #: ____
Home Work Cell/Other Primary

Email Address: ____

Emergency Contact: ____
Name Relationship DOB Phone #

Insurance Information: Insurance Company Name: ____

Insurance ID #: _____________________________________ Group #: ______________________________________

Insurance Claim Address: ____

Policy Holder: ____
Last First Middle DOB

Address: ____ SAME? □ (check here)
Street Apt # City State Zip Code

Phone #: ____
Home Work Cell/Other

SSN: _______________________________________ Employer: _____________________________________

How did you hear about us?

- □ Word of Mouth
- □ Facebook
- □ Insurance Company
- □ Yelp
- □ Health Grades
- □ Radio
- □ Web Search
- □ Community Newsletter
- □ Other: _______________________

PATIENT AGREEMENT

Thank you for selecting Kelliwood Family Practice (KFP) as your healthcare provider. Please take a moment to review our financial policy.

By signing below, you agree to and understand the following policies:

HIPAA – Privacy Notice
I am aware that I may review Kelliwood Family Practice HIPAA privacy notice at any time and understand that I may request a copy.

____
Initials

KFP Medical Care Agreement
I authorize the physicians of KFP to administer medical treatment as deemed necessary. I understand that the primary insured is financially responsible for any balance not covered by my insurance, including co-pay, deductible/co-insurance, and any services excluded by my policy. Although the doctors are participating providers with many insurance companies, it is the responsibility of the patient or guarantor to be familiar with his/her plan. We make every attempt to verify insurance eligibility and benefits prior to your visit; however, all insurance carriers state that verification is not a guarantee of payment. I also understand the primary insured will be held responsible for any and all charges incurred by myself or covered dependents should there be no coverage on the date of service. Furthermore, I hereby authorize release of medical information necessary to file a claim with my insurance and assign benefits to otherwise payable to me to Kelliwood Family Practice. If we are unable to verify your benefits, payment will be due at the time of service. I understand that there will be a $25.00 charge for appointments not cancelled 24 hours in advance.

____
Initials

Medical Care Agreement
I authorize the physicians of KFP to instruct their Physician Assistant/Nurse Practitioner and Physical Medicine Providers to assist in certain aspects of my medical care.
I understand that a Physician Assistant/Nurse Practitioner is not a licensed physician and may not treat or diagnose any illness or medical condition except under the supervisions/direction of a licensed physician. I understand that each time I make an appointment, if my physician is not available in a timely manner, I will be given the choice to be seen by the Physician Assistant/Nurse Practitioner. I acknowledge it is my responsibility to inform the staff of KFP if I wish not to see the Physician Assistant/Nurse Practitioner and be scheduler with my assigned physician accordingly. I understand that I may revoke this authorization at any time.

____
Initials

Patient Name (please print): ____ DOB: ____________________

Patient Signature: ____ Date: ____________________

Kelliwood Family Practice Fees & Services

In order to help you clearly understand our policies and services, please read the following statements, and sign the bottom indicating you accept these rules:

- I understand the clinic normally uses Genesis Laboratories (GL). If I or my insurance company prefers another lab, it is my responsibility to inform a medical staff member before the specimen is being taken so I am not billed for having lab work processed by GL, instead of another lab.
- I understand there can be a fee for controlled substance prescriptions written without an appointment.
- I understand there may be a fee for missed appointments or appointments not cancelled within 24 hours. Please notify us as soon as possible if you cannot make your scheduled appointment.
- I understand there is a $35 fee for bounced checks and an additional $20 processing fee for balances that go in to collections.
- I understand a fee may be assessed for any paperwork or forms to be completed without an appointment and that it may take up to 10 days to be completed.
- I understand prescription renewals are to be processed through the requested pharmacy. If the prescription is mail order and requires a written prescription, it may take 3-4 business days to be processed.
- I understand that labs, x-ray reports, and other test results need to be reviewed and it may take between 3-4 business days to be reviewed by the physician/PA. A staff member will contact you sooner if the results are urgent; otherwise, you will be contacted by phone, mail or via our secure patient web portal with the results.

Fees for Services:

$10 Controlled substance prescriptions without an appointment
$25 School forms
$35 Disability forms
$45 FMLA
$25 Physician dictated letter
$25 Prior authorizations
$25+ for extensive medical records

Thank you for your cooperation.

Patient Name (please print): ____ DOB: ___________________

Patient Signature: ____ Date: ____________________

CONSENT FOR RELEASE OF INFORMATION

Patient Name: ______________________________ Date of Birth:_____________

Cell Phone#:_____________________Email:_____________________________

This office may use your information to notify you of any changes in your scheduled appointment, to inform you of your lab results and/or physician instructions and to discuss billing issues pertaining to your healthcare.

Please check the sections that apply, then sign at the bottom of the page:

_________**I do not give KFP permission** to release my information to anyone other than myself.

or

_________**I give KFP permission** to release my information with the following emergency contacts:

Name: _______________________ Relationship: _____________ Phone: ______________

Name: _______________________ Relationship: _____________ Phone: ______________

Please indicate how you would like to be notified with the information. (Check all that apply)

_________ Home phone #_____________________________

_________ Cell Phone #_____________________________

If you have and answering machine, may we leave a detailed message regarding appointments, treatments and/or other information pertinent to your healthcare and/or payment for your healthcare provided by Kelliwood Family Practice?
________ YES _________ NO

_________ Work Phone #_____________________________

If you have and answering machine, may we leave a detailed message regarding appointments, treatments and/or other information pertinent to your healthcare and/or payment for your healthcare provided by Kelliwood Family Practice?
________ YES _________ NO

Signature:____ Date:________________
(A signature is required for this form to be considered valid)

FEMALE HEALTH HISTORY FORM

Today's Date:___________________________
Name:____ DOB:___________________________
Previous Primary Care Physician:____
Other physicians (specialists) involved in your care:____
____
Preferred pharmacy:____

MEDICAL HISTORY:

Have you been diagnosed with any of the following?

Alcoholism Yes No
Allergies Yes No
Anemia Yes No
Anxiety Yes No
Arthritis Yes No
Asthma Yes No
Back pain Yes No
Blood clots Yes No
If yes: where?___________________________
Cancer Yes No If yes: what type?_________________________
Chrohn's / Ulcerative colitis Yes No
Depression Yes No
Diabetes Yes No
If yes: what type? 1 2
Emphysema / Lung disease Yes No
Endometriosis Yes No
Eye disease Yes No
If yes: what type?________________________
Fractures Yes No If yes: where?____________________________
Gout Yes No
Migraines Yes No
Hearing loss / Ear problems Yes No
Heart attacks Yes No
Heart disease Yes No
If yes: what type?________________________
Hepatitis Yes No
If yes: what type? (A, B, C)________________
Hernia Yes No
If yes: what type?________________________
High blood pressure Yes No
High Cholesterol Yes No
HIV Yes No
HPV infection Yes No
Incontinence Yes No
Insomnia Yes No
Kidney disease Yes No
Kidney stones Yes No
Osteoporosis Yes No
PCOS Yes No
Stomach Reflux Yes No
Seizures Yes No
Sleep apnea Yes No
STDs Yes No
Stroke Yes No
Stomach ulcers Yes No
Thyroid disease Yes No
If yes: what type?________________________
Tuberculosis Yes No
Urinary tract infections Yes No
Other medical history? ___________________
____

SURGICAL HISTORY:

Have you had any of the following?

Abdominal surgery Yes No
Appendectomy Yes No
Brain surgery Yes No
Back surgery Yes No
If yes: what type?____________________________
Bladder surgery Yes No
Breast biopsy Yes No
If yes: location Right Left
Breast surgery Yes No
If yes: location Right Left
C-Section Yes No
Cosmetic surgery Yes No
If yes: what type?____________________________
Eye surgery Yes No
If yes: what type?____________________________
Gallbladder removal Yes No
Heart surgery Yes No
If yes: what type? ___________________________
Hysterectomy Yes No
Hernia repair Yes No
If yes: what type? ___________________________
Ovarian Cyst removal Yes No
If yes: location Right Left
Thyroid surgery Yes No
If yes: what type? ___________________________
Tubal ligation Yes No
Other surgical history?__________________________

OBSTETRIC / GYNECOLOGIC HISTORY:

Age of first period _______yrs
Period cycle _______days
Period duration _______days
Pattern Regular Irregular
Flow Light Moderate Heavy
Have you ever been pregnant? Yes No
If yes: how many times? ___________________
Full term: ____ # Ectopic: ____
Preterm: ____ # Multiple (twins, triplets): ____
Miscarriages: ____ # Living children:____
Abortions: ____
Did you have any complications during pregnancy and/or delivery?
Yes No
If yes, please explain:______________________
Are you currently sexually active? Yes No
Partner(s): Male Female Both
Method of birth control:
Condom Pill Patch IUD Injection Implant
Ring Tubal ligation/sterilization Diaphragm
Spermicide None
If postmenopausal: Age of last normal period:______________
Are you / have you taken hormone replacement? Yes No
If yes, for how long? ______________________________________

ALLERGIES:

Are you allergic to any medications? Yes No

If yes, please list the name(s) and type of reaction

NAME	REACTION

MEDICATIONS:

Do you currently take any prescription medications: Yes No

MEDICATION NAME	STRENGTH & DOSE	FREQUENCY
		Daily 2xdaily 3xdaily 4xdaily As needed
		Daily 2xdaily 3xdaily 4xdaily As needed
		Daily 2xdaily 3xdaily 4xdaily As needed
		Daily 2xdaily 3xdaily 4xdaily As needed
		Daily 2xdaily 3xdaily 4xdaily As needed
		Daily 2xdaily 3xdaily 4xdaily As needed

Do you take any over-the-counter supplements? (Calcium, multivitamins, sleep aids, other supplements)
No Yes - ____

FAMILY HISTORY: Unknown / Adopted

Family Member	Alcoholism	Breast Cancer	Bleeding Problems	Colon cancer	COPD	Crohn's/ Ulc Colitis	Diabetes	Glaucoma	Heart attack	Heart failure	High cholesterol	High blood pressure	Kidney disease	Lung cancer	Lupus	Mental illness	Ovarian cancer	Pancreatic cancer	Prostate cancer	Rheum. arthritis	Stroke	Thyroid disease	Tuberculosis
Mother																							
Father																							
Sister																							
Brother																							
Maternal grandfather																							
Mat. grandmother																							
Paternal grandfather																							
Pat. grandmother																							
Aunt																							
Uncle																							
Other relatives																							

SOCIAL HISTORY:

Marital status:____________________________
Occupation:______________________________
Current tobacco use Yes No
Previously but quit: (date)___________
Packs per day ______________
Years of use: ______________yrs
Type: Cigarettes Cigars Chewing Dip Pipe E-cigarettes
Exposure to second hand smoke? Yes No
Alcohol use Yes No
If yes: # drinks / week ____________________

Type of alcohol ___________________________
Are you or others concerned about your drinking? Yes No
Drug use Yes No
If yes: type ______________________________
Do you practice any religion Yes No
If yes, which one?__________________________
Do you exercise? Yes No
How often? ____________ times/week
What type of exercise? ________________________

HEALTH MAINTENANCE:

If you've had any of the following please specify date last performed:

Pap smear ______/______/______
- Have you ever had an abnormal pap smear: No Yes: when? ______/______/______
- How was it treated? ____
Mammogram ______/______/______
- Have you ever had an abnormal mammogram? No Yes: __________________
- If yes, how long ago? ____
Colonoscopy ______/______/______
- Result: Normal Polyps Diverticula Hemorrhoids Other: _______________
Bone density scan ______/______/______
- Result: Normal Osteopenia Osteoporosis
CT for lung cancer screening ______/______/______
Dental exam ______/______/______
Eye exam ______/______/______
Tetanus shot ______/______/______
HPV series (3) ______/______/______
Flu shot ______/______/______
Pneumonia shot: Pneumovax ______/______/______ Prevnar 13 ______/______/______
Shingles vaccine ______/______/______
Hepatitis A vaccine ______/______/______
Hepatitis B vaccine series ______/______/______
Meningitis vaccine ______/______/______
MMR (measles, mumps, rubella) ______/______/______
Varicella vaccine ______/______/______