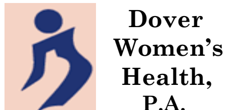

PATIENT INFORMATION

(Confidential)

Home Phone__________________ Cell Phone____________________

Name____________________________________Birth Date _______________Soc. Sec.#______________

Address____City ____________State________Zip___________

Employer____ Work Phone___________________

Pharmacy Name and Location____

Primary Care Physician____Phone#__________________

How did you hear about us?____

Person to contact in case of emergency __________________________________Phone_______________

May we leave a message with this person? Y N Relationship to patient?_________________________

You have permission to confirm my appointments (please check all that apply):

Leave message at home with partner/spouse or other:___________Y N Leave message at work: Y N

Leave message on voicemail or answering machine: Y N Don't confirm appt, I will call you: Y N

We may discuss your medical condition with the following individuals: (They must know your date of birth)

Name	Relationship	Name	Relationship

PRIMARY INSURANCE COMPANY

Name of Company ____________________________________Co-Pay$__________Effective Date:____________

ID or Certificate#____________________________________Group #___________________________________

Policy Holder Name_____________________________________Policy Holder Soc. Sec#_________________

Policy Holder Address ____

Policy Holder Date of Birth_____________________Policy Holder Sex M F

Relationship to patient________________________Employer_____________________________________

SECONDARY INSURANCE COMPANY

Name of Company _____________________________________Co-Pay$__________Effective Date:___________

ID or Certificate#____________________________________Group #___________________________________

Policy Holder Name ____________________________________Policy Holder Soc. Sec# ________________

Policy Holder Address ____

Policy Holder Date of Birth_____________________Policy Holder Sex M F

Relationship to patient________________________Employer_____________________________________

RESPONSIBLE PARTY (IF PATIENT IS UNDER 18)

Name____Home phone_________________

Address____Work phone_________________

Relationship to patient__________________Date of Birth______________Soc. Sec.______________Sex M F

Employer name and address____

It is the patient's responsibility to know the benefits available under their insurance plan prior to receiving care.

****_**PLEASE NOTIFY US OF ANY CHANGES TO YOUR INSURANCE PLANS OR STATUS**_****

I authorize medical treatment by Dover Women's Health, P.A. for myself or my legal dependent. I understand and agree that regardless of insurance status, I am ultimately financially responsible for charges related to this treatment. I authorize my insurance company to make any benefit payments directly to Dover Women's Health, P.A. . I authorize Dover Women's Health, P.A., to release any medical information necessary for the processing of my claims, further treatment by another provider, or for Health Care Operations. If my insurance company requires a co-payment, I agree to pay the co-payment at the time of the visit. I have received a copy of the Joint Notice of Privacy Practices, which describes how my health information may be used or disclosed. I understand that I should read it carefully and am aware that the Joint Notice of Privacy Practices may be changed at any time.

SIGNATURE____________________________________**Date**________________ **(8/08)**

Dover Women's Health
OB/GYN QUESTIONNAIRE

Name:______________________
Date of birth:______________________
Today's Date:______________________

Please answer the following questions to the best of your ability and bring the form to your appointment. This information is confidential and simply helps us get to know you and your health care needs.

What is your biggest concern today? ______________________

Please list all allergies and reactions to Medications:______________________

____

General:

How would you describe your state of health? ______________________
Have you had any recent weight loss or weight gain? ______________________
Are you up-to-date on immunizations? __________When was your last tetanus booster? __________
Any changes in your breasts that you are concerned about today? ______________________
Any pelvic pain or unusual discharge that is concerning you today? ______________________
Any leaking of urine that is bothersome to you? ______________________
Any problems with your GI system or bowels? ______________________

Gyn/menstrual history: (Not all questions may apply to you. Please answer only those that do.)

First day of Last Menstrual Period. ______________ Age at your 1st period__________
Are your cycles regular?__________ Cycle length (start to start)______________
Any problems or discomfort before or with your periods? ______________________
How do you handle them?______________________
Current method of pregnancy prevention (birth control)______________________
Current method of Hormone Replacement Therapy (HRT), if any. ______________________
Are you satisfied with current HRT/birth control method? ______________________
Are you satisfied with your sexual activity?______________________
Number of sexual partners in the past year? __________ Lifetime? __________
Have you ever had a sexually transmitted infection (STI)? ______________________
How do you protect yourself from STIs and HIV? ______________________
Have you had any yeast infections within the past year? ______________________
Date of last pap smear? ______________ Have you ever had an abnormal pap? __________
Date of last mammogram? ______________ Result? __________
Are you comfortable doing breast self-exams? __________How often do you do them? __________

Past Medical History: Please place a check mark by any illness you have ever had.

Anemia	❑	Hospital stay (overnight)	❑
Anesthesia problems	❑	High blood pressure	❑
Anxiety or depression	❑	Hepatitis	❑
Asthma	❑	Kidney disease	❑
Birth defects	❑	Lung disease	❑
Bladder infection	❑	Migraines	❑
Breast mass/tumor/biopsy	❑	Phlebitis	❑
Cancer	❑	Rheumatic fever	❑
Chicken pox	❑	Rubella (German Measles)	❑
High Cholesterol	❑	Seizures	❑
Clotting disorders	❑	Skin disorders	❑
Diabetes	❑	Thyroid problems	❑
Problem with drugs/alcohol	❑	Transfusions	❑
Gallbladder disease	❑	Tuberculosis	❑
Heart disease	❑	Ulcers	❑

Family history: Please list any relatives who have had any of the following conditions.

- ❑ Alcoholism ____________
- ❑ Psychiatric disorder ____________
- ❑ Genetic disorder ____________
- ❑ Birth defects ____________
- ❑ Breast cancer ____________
- ❑ Gynecological cancer (specify: ovarian, cervical, uterine?) ____________
- ❑ Colon cancer ____________
- ❑ Diabetes ____________
- ❑ Heart disease ____________
- ❑ High blood pressure ____________
- ❑ Blood clots/DVT ____________
- ❑ Stroke ____________
- ❑ Other ____________

Surgeries and Hospitalizations: Please list any occasion you have spent the night in the hospital

	Reason for admission	Date	Outcome	Location
1.				
2.				
3.				

Obstetrical/pregnancy History: Please list all pregnancies and their outcome.

	Child's name	Place of birth	Date of birth	Birth weight	Problems?	Vaginal/Cesarean?
1.						
2.						
3.						
4.						

	Dates	Complications
Stillbirths		
Miscarriages		
Ectopic Pregnancies		
Abortions		

Social History: Please share with us a bit about your daily life and habits...

What is your occupation or primary activity? ____________
From 1 to 10, how stressful is your job? ____________
Who is currently living with you? ____________
Who do you talk to when you need support? ____________
Do you feel safe in your home? ____________ Do you feel safe at work? ____________
Is there a firearm in your home? ____________
What is the last grade of school you completed? ____________
What do you do for exercise on a regular basis? ____________
Do you follow any special type of diet? ____________ How many meals do you eat each day? ____
How much water do you drink each day? ____________ Do you take a calcium supplement? ____
How do you feel about your weight? ____________ How often do you eat at a restaurant? ____
Do you smoke? ____________ How much do you smoke each day? ____________
Do you drink alcohol? ____________ How much do you drink in one week? ____________
Have you ever tried to cut back on the amount of alcohol you drink? ____________
Have you used street drugs in the past? ____________ Are you currently using street drugs? ____________
Have you ever been concerned that you have an eating disorder? ____________
Has anyone ever hurt you in any way? ____ Has anyone ever touched you inappropriately? ____
Do you wear a seatbelt every time you get in a car? ____________
Do you wear a helmet when riding a bike/rollerblading? ____________

How did you hear about us?: ____________

Dates Reviewed:

Consent For Photographing

For identification purposes and adherence to federal laws regarding identity theft prevention, I, _______________________________, authorize staff members at Dover Women's Health to obtain a photograph of me. This photograph will become a permanent part of my computerized medical account, which will be filed in a secure manner to protect my privacy. The photo will not be released or used for other purposes without my specific consent, unless required under applicable state law, regulation, or court order.

I understand I can refuse to have my photo taken, in which case I will need to present a photo ID at every visit.

I **agree** to photographing: _____________________ Date: __________

I **refuse** photographing: _______________________Date:__________

Rev. 09/09 bkv

DOVER WOMEN'S HEALTH, P.A.

FINANCIAL POLICY

We participate with the following insurance plans: Aetna, Anthem Blue Cross & Blue Shield of NH, CBA/EBPA, Cigna/Great West, Coventry Health Care, Federal Blue Cross & Blue Shield, Harvard Pilgrim Health Plan, Medical Network, Medicare, MVP, NH Medicaid ***for Gyn Services only***, and the following US Family Health Plans: Tricare Standard & Martin's Point. We bill these companies for your services, and receive payment directly from them. ***You are required to present your current insurance card at each visit.***

Co-Payments are due at the time of the service. If you are enrolled in a high-deductible plan, you may be asked for payment of the deductible at the time of the appointment, otherwise you will be billed by our office for any co-insurance and/or deductible due once your insurance claim has been processed. If you are a member of an HMO and need a referral, it is your responsibility to bring it with you. If we do not receive the referral and you still desire to be seen, you will be required to sign a referral waiver form accepting financial responsibility.

We do not currently participate with PHCS, Tufts, United Healthcare, and many other commercial insurance plans. These plans may or may not have benefits for services received at a non-participating practice. **It is your responsibility to verify your benefits prior to receiving services.** We do not bill any third party liability insurance plans, such as automobile insurance.

If you have a commercial insurance that we do not participate with, you will be expected to pay at the time of service. You will be given a bill with all of the necessary information on it so you can submit it to your insurance company. We would like to remind you that your insurance policy is a contract between you and your insurance company. We are not party to that contract, and **all charges are the responsibility of the patient from the date the services are rendered**. You are responsible for payment, regardless of your insurance company's determination of usual and customary rates.

Some services we provide may not be covered by your insurance. **It is your responsibility to verify your benefits prior to receiving services.**

For those ***patients with no insurance***, our policy is payment at the time of service. We do ***offer a 30% Prompt Pay Discount for payment in full at the time of service***. If you are unable to pay in full, please contact our billing department to set up a payment arrangement.

We accept MasterCard and Visa, as well as personal checks and cash. ***In the event your check is returned from the bank, you will be charged a $20 return check fee.*** Non-payment of your account shall result in your account being considered for placement with our collection agency.

In cases of divorced or separated parents, our policy is that the parent bringing the minor child into our office for services must be responsible for any balance. Minor children are required to have a parent or legal guardian present at the time of their appointment under most circumstances.

Our charges are reviewed annually to ensure they are set at a reasonable rate.

Signed____ Date_________________________

Rev. 4/20/10

D O V E R
W O M E N'S
H E A L T H
PROFESSIONAL ASSOCIATION

JOINT NOTICE OF HEALTH INFORMATION PRACTICES

This is a Joint Notice of Health Information that describes how we will use and disclose your health information. Health information includes medical records, invoices and payment forms. This applies to health information generated by us, and gathered from other organizations and/or health professionals participating in your care.

USES AND DISCLOSURE OF YOUR HEALTH INFORMATION

In some circumstances, we are permitted or required to disclose your health information without your consent. This includes purposes relating to treatment, payment and health care operations. We may disclose your health information for the purpose of providing, or allowing others to provide, treatment to you. We may contact you with appointment reminders or treatment information. We may use and/or disclose your health information for the purpose of allowing us, as well as other entities, to secure payment for the health care services provided to you. We may use and/or disclose your health information for the purposes of our day-to-day operations.

Additionally, these circumstances include disclosure when a) required by law; b) for public health purposes; c) victim of abuse, neglect, or domestic violence; d) audits, civil, administrative or criminal investigations; e) judicial & administrative proceedings; f) law enforcement purposes; g) assist coroners, medical examiners or funeral directors with official duties; h) to facilitate organ, eye or tissue donation;

i) certain research projects; j) to avert serious threat to health or safety; k) for specialized governmental functions such as military, national security, criminal corrections, or public benefit purposes; l) for workers compensation purposes, as permitted by law.

We may use or disclose your health information in the **following circumstances**. **Except in emergency situations**, we will inform you of our intended actions prior to making any such uses and disclosures and will, at that time, offer you the opportunity to object: a) We may disclose to your relatives or close personal friends any health information that is directly related to that person's involvement in the provision of, or payment for, your care. We may also use and disclose your health information for the purpose of locating and notifying your relatives or close personal friends of your location, general condition, death, and to Organizations that are involved in those tasks during disaster situations.

Except as previously described, disclosures of your health information will be made only with your written authorization. You may revoke your authorization at any time, in writing, unless we have taken action in reliance upon your prior authorization, or if you signed the authorization as a condition of obtaining insurance coverage.

YOUR RIGHTS

You have the right to request restrictions on the use and disclosure of your health information for treatment, payment, health care operation purposes or notification purposes. We are not required to agree to your request. If we do agree to a restriction, we will abide by that restriction unless you are in need of emergency treatment and the restricted information is needed to provide such treatment. To request a restriction, please submit a written request to our Practice Manager.

You have the right to receive confidential communications about your health information by alternative means or at alternative locations. This means you may, for example, designate that we contact you only at a certain telephone number. To request this, you must indicate as such when completing the Dover Women's Health, P.A. Patient Information sheet.

You have the right to inspect and receive a copy of your health information. To arrange access to your records, you should submit a signed, written request to our office. If you request copies, you will be charged our regular copying fee. Despite your general right to access your Protected Health Information, access may be denied in some limited circumstances.

You may request your health information to be amended. Such requests must be made in writing to our office. Your request may be denied under certain circumstances.

You have the right to an accounting of certain disclosures of your health information made during the six-year period preceding the date of your request.

You have the right to obtain a paper copy of this Notice upon request.

OUR DUTIES

We are required by law to maintain the privacy of your health information and to provide you with this Joint Notice of our legal duties and privacy practices.

We are required to abide by the terms of this Joint Notice. We reserve the right to change the terms of this Joint Notice and to make those changes applicable to all health information we maintain. Any changes to this Joint Notice will be posted at our facility and be available upon request.

COMPLAINTS

You can complain to us and to the federal Secretary of the Department of Health & Human Services if your believe your privacy rights have been violated, by filing a written complaint.

Please contact our Practice Manager, Beth Voce, at (603) 742-2424 if you have questions regarding this Notice.

Patient Name:_________________________ Date of Birth:_________________

Medication List

Medication and dosage	Date start	Date D/C	Initials	Refilled by DWH

12/09

NOTICE TO OUR PATIENTS REGARDING OUR NO-SHOW/MISSED APPOINTMENT POLICY

A ***courtesy*** appointment reminder call to you is made/attempted 1-2 days prior to your scheduled appointment.

A ***minimum 24-hour cancellation notice is required*** for **ALL** appointments. ***If less than a 24-hour cancellation notice is given***, the appointment becomes a "**Missed**" appointment.

If you do not cancel in advance, and ***do not present to the office for your appointment***, this will be considered "**No-Show**" appointment.

- After the first "No-Show/Missed" appointment, Dover Women's Health, P.A. will attempt a telephone call to you to offer to reschedule your appointment. You will be reminded of our No Show/Missed Appointment Policy. A copy of this policy may be mailed to you.
- If you incur a **second "No-Show/Missed" appointment** ***within a six-month period***, you may face discharge from the practice.

I have read and understand Dover Women's Health, P.A. No Show/Missed Appointment Policy:

____ __________________

Patient Signature or Parent/Guardian if Minor Date

DOVER WOMEN'S HEALTH
PROFESSIONAL ASSOCIATION

NOTICE OF ORGANIZED HEALTH CARE ARRANGEMENT BETWEEN HEALTH PARTNERS OF NEW HAMPSHIRE AND PHYSICIANS ASSOCIATION OF STRAFFORD COUNTY

Your physician participates in Health Partners of New Hampshire and Physicians Association of Strafford County, organizations formed by physicians practicing at Wentworth-Douglass Hospital to help integrate the care you receive. The physicians participating in these arrangements have agreed, along with the Hospital, to share your health information among themselves as permitted by law for purposes of treatment, payment and health care operations. This enables us to better address your health care needs in a clinically integrated setting. This notice is being provided to you as a supplement to the Joint Notice of Privacy Practices already given to you.

NOTICE OF ORGANIZED HEALTH CARE ARRANGEMENT BETWEEN HOSPITAL AND MEDICAL STAFF

Wentworth Douglass Hospital, the independent contractor members of its Medical Staff (including your physician), and other health care providers affiliated with the Hospital have agreed, as permitted by law, to share your health information among themselves for purposes of treatment, payment or health care operations. This enables us to better address your health care needs. This Joint Notice is being provided to you as a supplement to the Joint Notices of Privacy Practices.

DOVER
WOMEN'S
HEALTH
PROFESSIONAL ASSOCIATION

ACKNOWLEDGMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES

I have received a copy of the Joint Notice of Privacy Practices. The Joint Notice describes how my health information may be used or disclosed. I understand that I should read it carefully.

I am aware that the Joint Notice may be changed at any time. I may obtain a revised copy of the Joint Notice by calling (603) 742-2424,

on this Practice's website at www.doverwomenshealth.com,

or by requesting one at the office.

____
(Please Print your Full Name)

_______________________________________ _____/_____/______
(Signature) **(Date)**

As the representative of the above individual, I acknowledge receipt of the Joint Notice on his or her behalf.

__________________________________ ________________________________
(Please Print your Name) **(Relationship)**

_______________________________________ _____/_______/______
(Signature) **(Date)**