Woman's

P.P.M. Patient Information

PERSONAL INFORMATION - *Please Print*

Last Name	First Name	Middle or Maiden	Age	Date of Birth	Social Security No.

Address	City	State	Zip Code	Home Phone	Cell Phone

Name & Address of Employer or School	Work Phone	Occupation	☐ Full Time ☐ Part Time

Referring Physician	Religious Preference	Marital Status	If Married, Spouse's Name

Spouse's Employer and Address	Spouse's Cell or Work Phone	Spouse's Occupation	☐ Full Time ☐ Part Time

RESPONSIBLE PARTY - *Please Print*

Last Name	First Name	Middle or Maiden	Social Security No.

Address	City, State, Zip Code	Phone

Name of Employer	Work Phone/Cell Phone

Employer's Address

Please list two (2) Emergency Contacts:

	Name	Address	Phone	Relationship
1)				
2)				

INSURANCE INFORMATION - *Please Print*

***** NOTE *****

Due to HIPPA requirements, we are required to obtain the subscriber's date of birth and social security number in order to file claims. Failure to submit this information will result in a denied claim for which you will be responsible.

Primary Insurance Name	Insurance Address	Insurance Phone Number

Subscriber	Subscriber's Date of Birth (See above NOTE)	**Subscriber's Social Security Number

Relationship to Subscriber	Policy Number	Group Number

Employer	Employer Address	Employer Phone

Amount of Co-Payment $_____

SECONDARY INSURANCE INFORMATION - *Please Print*

Primary Insurance Name	Insurance Address	Insurance Phone Number

Subscriber	Subscriber's Date of Birth (See above NOTE)	**Subscriber's Social Security Number

Relationship to Subscriber	Policy Number	Group Number

Employer	Employer Address	Employer Phone

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Intake Questions

Please examine the following list of illnesses and conditions and check if a doctor has ever told you had the condition. (Check all that apply):

Head/Neck
- Dental Problems ☐
- Headaches ☐

Respiratory
- Asthma ☐
- Lung disease ☐
- Shortness of breath ☐
- Snoring ☐
- Chronic cough ☐

Heart
- Irregular heartbeat ☐
- High blood pressure ☐
- High Cholesterol ☐
- Chest pain ☐
- Heart attack ☐
- Heart disease (blockage) ☐
- Heart failure (enlarged) ☐
- Leg swelling ☐
- Poor circulation (legs) ☐
- Stroke ☐

Endocrine/Hormones
- Diabetes ☐
- Thyroid problem ☐
- Polycystic ovaries ☐
- Steroid use ☐
- Insulin Resistance ☐
- Gestational Diabetes ☐

Musculoskeletal
- Low back pain ☐
- Joint pain/swelling ☐
- Arthritis ☐
- Gout ☐
- Osteoporosis ☐

Neuro/Psych
- Dizziness ☐
- Fainting ☐
- Seizures ☐
- Depression ☐
- Psychiatric condition ☐
- Eating disorder ☐

Digestive
- Heartburn ☐
- Stomach ulcers ☐
- Trouble swallowing ☐
- Intestinal/Celiac disease ☐
- Abdominal pains ☐
- Irritable Bowel ☐
- Liver disease ☐
- Gallbladder disease ☐
- Milk intolerance ☐

Genitourinary
- Infertility ☐
- Kidney disease ☐
- Kidney stones ☐
- Bladder weakness ☐
- Skipped periods ☐
- Abnormal/Heavy periods ☐

Skin/Hair
- Abnormal hair growth ☐
- Hair thinning ☐
- Heat/Cold Intolerance ☐
- Dry skin ☐
- Acne ☐
- Skin tags ☐
- Skin discoloration ☐

Other
- Daytime sleepiness ☐
- Sleep apnea ☐
- Blood clots ☐
- Immune disorder ☐

Do you take eye medications for Glaucoma? Yes ☐ No ☐

Are you currently taking? (check if yes)
- Isocarboxazid (Marplan) ☐
- Phenelzine (Nardil) ☐
- Selegiline (Emsam) ☐
- Tranylcypromine (Parnate) ☐

Form of Birth Control if Any?

_____

Please List Any Drug Allergies:

_____

_____

_____

_____

Has anyone in your immediate family (Parent, grandparents, brothers, or sisters) had any of the following? Check all that apply)
- Heart Attack ☐
- Stroke ☐
- High blood pressure ☐
- Diabetes ☐
- High Cholesterol ☐
- Obesity ☐
- Alcoholism ☐
- Thyroid disease ☐
- Osteoporosis ☐
- Colon Polyps ☐
- Colon Cancer ☐
- Lung cancer ☐
- Breast cancer ☐
- Prostate cancer ☐

Any special medical/social/ religious considerations we should know about?

_____

_____

_____

_____

Woman's

Assignment of Insurance Benefits

ASSIGNMENT OF INSURANCE BENEFITS

I assign to Woman's Hospital and/or Physician Practice Clinics any and all benefits due for services under any applicable health plan or the Social Security Administration or its intermediary/carrier due to an admission or treatment provided at the hospital. I certify that the information I have given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize and request that payment of benefits be made on my behalf to the hospital.

ASSIGNMENT OF INSURANCE BENEFITS TO DOCTORS

I assign to any doctor providing anesthesia, pathology, radiology, neonatology, emergency or other services given in connection with my admission all benefits due for such services under any applicable health plan. I also authorize and request my health plan or the Social Security Administration or its intermediary/carrier to pay the doctors involved in my care.

PERSONAL RESPONSIBILITY FOR PAYMENT OF BILL

I understand that I am personally financially responsible for charges related to the service(s) I receive under the following circumstances:

- The service provided is not covered by my health plan
- Woman's Hospital and/or Physician Practice Clinic is not a network provider with my health plan for this service (example: outpatient lab)
- I did not receive the required referral/authorization/pre-certification to use this facility/specialist
- My health plan does not approve additional hospital day(s) or services rendered In office by my provider
- I have certain financial responsibility as decided by my health plan (co-pay, deductibles, etc,)
- I do not have health plan coverage at the time the hospital/clinic provided the service

I understand that bills for hospital/clinic services are payable within thirty (30) days of the date of service. I understand that any refunds will first be applied to any existing balance(s) for which I am responsible. If it becomes necessary for the account to be given to an attorney or collection agency for a lawsuit or collection, I agree to pay any associated attorney fees or collection expenses, I agree to be responsible for the payment of all charges of this admission for hospital and hospital-based doctors' services provided to me/ dependant I further understand that, in addition to the hospital bill, I will receive a separate bill from those doctors involved in my care, I understand that I am financially responsible to doctors for all charges and services my health plan does not pay and promise to pay any remaining balance.

GENERAL ACKNOWLEDGEMENTS

I understand that I am to remain in the hospital until my doctor releases or discharge me. If I leave the hospital before release or discharge, I assume complete responsibility. I release the doctors and hospital from all responsibility for all ill effects that may result

I UNDERSTAND that state law requires the hospital and/or physician to report certain infectious diseases including sexually transmitted diseases to the state Department of Health.

I UNDERSTAND and agree that all reference to myself as the patient shall apply as if rewritten in their entirety to a dependant for whom I am responsible and/or who is unable to give consent

My signature below indicates that:

- I received the Medicare/Tricare Important Message from Woman's Hospital on the date below (ifapplicable),
- I received/was offered Your Responsibilities and Rights booklet
- I received/was offered the Woman's Hospital Notice of Health Information Privacy Practices __ (Initials).
- I understand the information contained herein and agree that the information I provided is true and correct to the best of my knowledge. I have had a chance to ask any questions that I might have.

Patient/Parent/Guardian Signature _____ Date_____

Person responsible for bill (if different from signature above)_____ Relationship_____

Patient is not able to consent because_____

Witness_____ Date_____

Patient Name_____ Account#_____

Woman's

Medication / Problem List

Date Originated: _____

Revised: _____

Name (Last, First, M.I.): ☐ M ☐ F D.O.B.: AGE:

Date: _____

Allergies: _____

MEDICATIONS

(Include all over-the-counter drugs, vitamins and inhalers)

Name of Drug	Strength	Frequency Taken	Review Date	Update Initials

Primary Physician: _____ GYN Physician: _____

What desires do you have from our clinic? _____

Questions for providers: _____

☐ Copy given to the patient - Initials _____ Date: _____

Drug Allergies: _____

Smoke ☐ Yes ☐ No Frequency _____ Alcohol ☐ Yes ☐ No Frequency _____

MEDICAL PROBLEMS: *FOR PROVIDER USE*			
MEDICAL PROBLEMS	Date of onset	Past Surgeries	Date on onset

Woman's

100 Woman's Way
Baton Rouge, Louisiana 70817
(225) 927-1300
www.womans.org

Involvement of Care and Notification Purposes

Patient Name:_____

Date of Birth:_____ Expected Delivery Date:_____

Woman's Physician Practices may disclose protected health information to a family member, close personal friend, or any other person identified by the patient below, if the information is relevant to that person's involvement with the patient's care or payment of the patient's health care services.

Woman's Physician Practices may also use or disclose protected health information to notify a family member, close personal friend, or any other person identified below by the patient of the patient's location, general condition, or death.

I have read and agree with the above statements, and hereby identify the following persons:

Name	*Relationship to the Patient*	*Date of Birth*	*Phone Number*

I have had the opportunity to object to this disclosure and do not have any objections at this time. In the event that I do have an objection to this disclosure in the future, I will express that objection in writing to the Physician Office Practice Manager.

_____ _____

Signature of Patient Date