



Thank you for scheduling your gynecologic appointment with Medford Women's Clinic. By following the suggested guidelines below, you will help us provide you with the best care and save you time at your appointment.

**Things to do before your appointment:**

- ✓ Fill out the enclosed information sheets. Remember to complete both sides. Answer all questions to the best of your ability.
- ✓ Contact your health plan insurance. In some cases, **preventive services are not covered by health insurance. Medicare is one example.** Ask your health plan to see if they cover "preventive services."
- ✓ Please check with your Primary Care Provider to be sure a **referral** is sent to us prior to your appointment if one is needed.

**The day of your appointment:**

- ✓ Arrive **fifteen minutes** before your scheduled appointment.
- ✓ Have your insurance card and photo ID with you.
- ✓ Have your forms completed and here with you on your visit.
- ✓ Bring any pertinent medical records with you, such as a medication list.
- ✓ If you are Private Pay, payment is due on the day of service.

If you are unable to keep this appointment, please give our office at least a twenty-four hour notice. Should you have any questions or need assistance in completing any of the forms, please contact our office. Thank you for selecting us to help you with your health care needs.



3170 State Street  
 Medford, OR 97504-8450  
 (541) 864-8900

# PATIENT REGISTRATION

TODAY'S DATE \_\_\_\_\_

## PATIENT

LEGAL NAME: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
last, first, middle

ADDRESS: \_\_\_\_\_  
Street, P.O. Box city state zip

E-MAIL: \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ SEX \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

HAVE YOU EVER RECEIVED MEDICAL TREATMENT UNDER ANOTHER NAME? Yes \_\_\_\_\_ No \_\_\_\_\_ CELL PHONE # \_\_\_\_\_

IF YES, UNDER WHAT NAME? \_\_\_\_\_

EMERGENCY CONTACT: NAME: \_\_\_\_\_ /RELATION \_\_\_\_\_ PHONE \_\_\_\_\_

## GUARANTOR (RESPONSIBLE PARTY if different from patient) OR CUSTODIAL PARENT

NAME \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
last, first, middle

ADDRESS (If different) \_\_\_\_\_  
Street, P.O. Box city state zip

SOCIAL SECURITY # \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

## SPOUSE/PARENT/RELATIVE/CLOSE FRIEND (please circle one) (Different person from above, please)

NAME \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
last, first, middle

ADDRESS (If different) \_\_\_\_\_  
Street, P.O. Box city state zip

## INSURANCE INFORMATION (Please check those which apply)

I HAVE: Medicare \_\_\_\_\_ Medicaid Card \_\_\_\_\_ Health Insurance \_\_\_\_\_ No insurance \_\_\_\_\_

MEDICARE: ID # \_\_\_\_\_

MEDICAID CARD. Present Card to Receptionist. **Oregon Health Plan?** Yes \_\_\_\_\_ No \_\_\_\_\_ Oregon Health Plan Type (As listed in right-hand column on card) \_\_\_\_\_

PRIMARY HEALTH INSURANCE: Company \_\_\_\_\_ ID/ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
PLEASE PRESENT CARD TO RECEPTIONIST

INSURED NAME \_\_\_\_\_ DOB \_\_\_\_\_ SEX \_\_\_\_\_

EMPLOYER \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_

SECOND HEALTH INSURANCE: Company \_\_\_\_\_ ID/Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
PLEASE PRESENT CARD TO RECEPTIONIST

INSURED NAME \_\_\_\_\_ DOB \_\_\_\_\_ SEX \_\_\_\_\_

EMPLOYER \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

I am receiving medical treatment as a result of an accident: Yes \_\_\_\_\_ No \_\_\_\_\_ **(Please complete accident report form)**

If Yes, what type of accident? Motor Vehicle \_\_\_\_\_ Work Accident \_\_\_\_\_ Other \_\_\_\_\_

I authorize the medical treatment of this patient. \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Parent or Guardian

## ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents under 18, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

\_\_\_\_\_  
(patient signature) (date)

I \_\_\_\_\_ hereby authorize \_\_\_\_\_  
(authorized signature of subscriber) (name of ins. co.)

to pay and hereby assign Medford Women's Clinic, LLP all benefits, if any, otherwise payable to me for my physician's services.



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Med Rec #: \_\_\_\_\_
Name: \_\_\_\_\_
Birthdate: \_\_\_\_\_ Age \_\_\_\_\_
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_
PCP \_\_\_\_\_

Date \_\_\_\_\_ Referring physician \_\_\_\_\_

Occupation (past and present) \_\_\_\_\_

Reason for coming to the Clinic \_\_\_\_\_

Marital Status \_\_\_\_\_ Next of Kin \_\_\_\_\_ Phone # \_\_\_\_\_

PAST MEDICAL HISTORY: Have you had any of the following problems?

Medical Illnesses

- Diabetes, Heart disease, High blood pressure, Cholesterol problem, Lung disease, Ulcers, Brain or nerve disease (stroke), Liver disease or hepatitis, Arthritis, Tuberculosis, Cancer, Blood clots or phlebitis, Depression/Anxiety, Kidney disease/stones, Acid reflux or hiatal hernia, Migraine, Environmental allergies, Seizures, Asthma, Tuberculosis or abnormal skin test, Osteoporosis, Thyroid disorder, Sexually transmitted disease, Other

Operations/Hospitalizations (includes tonsillectomy and apendectomy)

Table with 3 columns: Date, Operation/Hospitalization, Complications

Severe Accidents and Injuries

\_\_\_\_\_

Do you regularly wear a seat belt? [ ] No [ ] Yes Do you regularly wear a helmet when bicycling or motorcycling? [ ] No [ ] Yes

Allergies and Adverse Medication Reactions (please list reaction)

\_\_\_\_\_

Tobacco Use? [ ] No [ ] Yes Pkgs/day \_\_\_\_\_ # years \_\_\_\_\_ Quit? \_\_\_\_\_ Year quit \_\_\_\_\_

Alcohol Use? [ ] No [ ] Yes Drinks/day \_\_\_\_\_ Drinks/week \_\_\_\_\_ [ ] Beer [ ] Wine [ ] Hard liquor

Have you ever felt you should cut down on your drinking? [ ] No [ ] Yes
Have you ever been annoyed by people criticizing your drinking? [ ] No [ ] Yes

Recreational drugs? [ ] No [ ] Yes IV drug test? [ ] No [ ] Yes Last HIV test? \_\_\_\_\_

Female Patients

Last menstrual period \_\_\_\_\_ Last pap smear \_\_\_\_\_ Last mammogram \_\_\_\_\_

Number of pregnancies \_\_\_\_\_ Number of births \_\_\_\_\_ [ ] Contraception \_\_\_\_\_

[ ] Irregular periods [ ] Abnormal pap smear [ ] Painful periods [ ] Heavy periods

MEDICATIONS CURRENTLY TAKEN regular or occasionally. Include vitamins, birth control pills, sleeping pills, pain pills, laxatives, aspirin - with dosage.

\_\_\_\_\_

Glasses milk/day? \_\_\_\_\_ Last osteoporosis scan \_\_\_\_\_ Calcium supplements (mg/day)? \_\_\_\_\_

Flu shot [ ] No [ ] Yes When \_\_\_\_\_ How often do you exercise? \_\_\_\_\_
Tetanus booster [ ] No [ ] Yes When \_\_\_\_\_ What is your workout? \_\_\_\_\_
Pneumonia vaccine [ ] No [ ] Yes When \_\_\_\_\_
Hepatitis B vaccine [ ] No [ ] Yes When \_\_\_\_\_ Last lower GI or lower scope? \_\_\_\_\_

SEE REVERSE SIDE

## FAMILY HISTORY

	Age of death	Age if alive	General health; major health problems & illnesses, OR age and cause of death
Mother			
Father			
Brothers			
Sisters			
Significant Illness in Grandparents, Cousins, Aunts, Uncles or Children?			

Remember, most diseases that "run in the family" are *not* genetic, but rather reflect lifestyle or behavior patterns that we learn in our families.

	No	Yes
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
TB	<input type="checkbox"/>	<input type="checkbox"/>

**REVIEW OF SYSTEMS: Do you have, or have had in the past month, any of the following? (Place a check mark next to those you have experienced).**

**General**

- Recent fever
- Weight loss
- Night sweats
- Loss of energy
- Change in lymph nodes
- Snoring
- Trouble sleeping

**Skin**

- Rashes
- Changes in mole

**Blood**

- Easy bruising
- Excessive bleeding
- Transfusions

**Ears**

- Ringing
- Deafness

**Eyes**

- Cataracts
- Blind spots
- Double vision
- Trouble seeing
- When was you last eye exam?  
by eye DR? \_\_\_\_\_

**Nose and Mouth**

- Nosebleeds
- Tooth pain
- Sore throat
- Sinus pain
- Nasal congestion

**Neck**

- Goiter
- Difficulty swallowing

**Breasts**

- Discharge from nipples
- Lumps

**Cardiovascular**

- Chest pain
- Shortness of breath
- Leg swelling
- Heart murmur
- Palpitations
- Varicose veins

**Pulmonary**

- Wheezing
- Cough
- Pain when you breathe
- Excessive sputum
- Cough up blood

**Digestive**

- Poor appetite
- Gas or heartburn
- Nausea
- Vomiting
- Vomiting blood
- Abdominal pain or cramping
- Constipation
- Diarrhea
- Hemorrhoids
- Hernia
- Jaundice
- Rectal bleeding

**Genitourinary**

- Burning on urination
- Bloody urine
- Incontinence
- Infections
- Difficulty urination
- Urination at night: # times
- Difficulty with erections
- Sexually transmitted diseases
- Multiple sexual partners

**Skeletal**

- Fractures
- Arthritis
- Leg pain when you walk
- Back or neck pain

**Brain and nerves**

- Convulsions
- Dizziness
- Blackouts
- Weakness
- Stroke
- Headaches
- Depression, low motivation
- Numbness
- Anxiety, excessive worry

Is there anyone that you're afraid of? \_\_\_\_\_

Source of stress? \_\_\_\_\_

Do you have an Advanced Directive for end-of-life? \_\_\_\_\_



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Med Rec #: _____
Last Name (Print): _____
First Name (Print): _____ MI _____
Birthdate: _____

**POLICY ON PATIENT ACCOUNTS AND CONDITIONS OF TREATMENT**

Medford Women’s Clinic is a private institution that operates for the benefit of the people who seek the services of our medical staff. We provide quality care, at what we believe to be fair and reasonable fees. Since we do not receive financial assistance from any outside source, we must recover the cost of providing services from our patients.

It is Medford Women’s Clinic policy that the responsibility for pre-authorization and paying for care will be placed on those who receive it. Therefore, all accounts will be administered under the following guidelines:

- 1. INSURANCE VERIFICATION / PRE-CERTIFICATION.** Many insurance companies require pre-authorization or a second opinion for some medical procedures. The responsibility is the patient’s to determine the procedure and guide the Medford Women’s Clinic in obtaining necessary pre-authorizations or second opinions when needed. Failure to obtain necessary pre-authorizations or second opinions may result in a reduction or rejection of benefits by the insurance company.
- 2. FIRST-TIME PATIENT.** Any first-time patient at Medford Women’s Clinic is required to pay for her visit on the day of service if she has not met her annual deductible or the visit is not covered by health insurance. The obligation to pay for medical services may not be deferred for any reason. If the account is referred to any agency for collections, the patient pays all expenses.
- 3. ACCOUNT BALANCE.** If you have a balance on your account you will receive a monthly statement until the account is paid in full. Bills are due and payable upon receipt of this monthly statement. We will bill your insurance for you if you provide us with the appropriate billing information. Your insurance will make payment directly to Medford Women’s Clinic and you will be responsible for any deductible, co-payments, or other patient balances.
- 4. PAYMENT OPTIONS.** Payment options include cash, check, Visa, MasterCard, or Discover cards. If you have special financial needs, feel free to discuss this with our Patient Accounts Department to establish an extension of credit terms. Interest accrues on changes not paid after 90 days of the first bill at a rate of 1% per month ( 12% a year) until paid in full.
- 5. MEDICARE PATIENTS.** Medford Women’s Clinic is a participating provider with Medicare. Medicare will pay 80% of what they allow, minus your \$100.00 annual deductible if this has not been met. You will be responsible for the \$100.00 deductible and 20% through supplemental insurance or patient payment. Also, by signing this sheet, it will authorize any holder of medical or other information regarding the patient named above to release such information to the Social Security Administration or to its intermediate or carriers effective from this date.
- 6. HOSPITAL AND OTHER OUTSIDE CHARGES.** Hospital bills are separate from those of the providers at the Medford Women’s Clinic. Services provided by the hospital will be billed from there. It is also sometimes necessary to send some laboratory / pathology specimens to special laboratories. If this is necessary, you may receive billing for those services from a laboratory other than the Medford Women’s Clinic. Questions arising from bills from these outside services must be directed to the providers of those services.
- 7. AUTHORIZATION FOR DISCLOSURE OF INFORMATION FOR PURPOSE OF SERVICE REIMBURSEMENT.** I hereby authorize Medford Women’s Clinic to disclose all or part of the medical record of the above patient to any company that may be responsible for payment of all or part of that patient’s medical charges. Disclosure of the medical record may be necessary to determine eligibility for benefits and to obtain reimbursement for health care services. I hereby release Medford Women’s Clinic from all legal responsibility or liability that may arise from disclosure of these records. I understand that I may revoke this authorization at any time in writing except to the extent that Medford Women’s Clinic has already taken action on my claim.
- 8. OTHER OPTIONS.** I would like to be informed of any clinical studies that may enhance my medical treatment. I authorize my medical information, securely and confidentially, transferred to the Advanced Clinical Research department affiliated with the Medford Women’s Clinic.

Occasionally we may wish to contact you. Please let us know your wishes as to how you would like to authorize receiving information from us. This information will most likely be test results, or answers to your questions.

- Email, specify email address: \_\_\_\_\_
- Phone, specify preferred number: \_\_\_\_\_
- Via message left on answering machine or voice mail
- US Mail system
- All of the above

Please send me special offers or women’s health updates via email.