# CARING CENTER FOR WOMEN, PA
## OF SAN MARCOS – NEW BRAUNFELS

PATIENT INFORMATION

DATE: _____

**ALL THE INFORMATION REQUESTED ON THIS PAGE IS NEEDED SO THAT WE CAN PROVIDE YOU WITH THE BEST POSSIBLE CARE. PLEASE COMPLETE EACH PART OF THIS FORM SO THAT WE CAN HAVE CURRENT INFORMATION.**

PATIENT NAME:_____ AGE:_____

ADDRESS:_____ ZIP:_____

BILLING ADDRESS: _____ ZIP:_____

HOME #: _____WORK #:_____CELL #:_____

DATE OF BIRTH:_____ MARITAL STAUS: ☐ S ☐ M ☐ W ☐ D

EMPLOYER:_____ EMAIL ADDRESS: _____

SOCIAL SECURITY #: _____ DRIVER'S LICENSE:_____

**RACE:**
Please check one of the following
- ☐ Decline
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Other Race

**ETHNIC GROUP:**
Please check one of the following
- ☐ Decline
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

My Insurance requires me to use: _____ lab._____( _____) Initials

PHARMACY:_____ LOCATION: _____

POLICY HOLDER NAME:_____ DATE OF BIRTH: _____

ADDRESS: _____ PHONE #: _____

CITY/ST/ZIP: _____ INSURED'S SS#:_____

IN CASE OF EMERGENCY, NOTIFY:

NAME:_____ PHONE #: _____

RELATIONSHIP _____

FAMILY PHYSICIAN: _____ SPECIALIST PHYSICIAN:_____

## NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

I acknowledge that Caring Center for Women, PA provided me with a written copy of the Notice of Health Information Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Personal Representative Signature (if applicable) Relationship to Patient

## PATIENT FINANCIAL RESPONSIBILITY POLICY

I acknowledge that Caring Center For Women, PA provided me with a written copy of the Patient Financial Responsibility policy and I have read, understand and agree to all provisions outlined. I hereby give my consent for Caring Center For Women, PA to file Insurance claims on my behalf. I also certify the information given by me regarding. claims filed on my behalf to a Commercial Insurance is correct.

_____ _____
Patient Signature Date

_____ _____
Personal Representative Signature (if applicable) Relationship to Patient

## ADVANCE PRACTICE NURSE

Caring Center For Women, PA has on staff an advance practice nurse to assist in OB/GYN care. An advance nurse is not a doctor. An advance practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advance practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care.

I have read the above, and hereby consent to the services of an advance practice nurse for my health care needs. I understand that at any time I can refuse to see the advance practice nurse and request to see a physician.

_____ _____
Patient Signature Date

Please list any individual who will be allowed to make inquiries about your health information

Name: _____ Relationship: _____

Name: _____ Relationship: _____

May we contact you at home? ☐ Yes ☐ No May we leave a message? ☐ Yes ☐ No
May we contact you on your cell phone? ☐ Yes ☐ No May we leave a message? ☐ Yes ☐ No
May we contact you at work? ☐ Yes ☐ No May we leave a message? ☐ Yes ☐ No
May we leave a detailed message on your voicemail? ☐ Yes ☐ No

Person(s) we may leave message with at home, on cell phone or at work: _____

_____ _____
Patient Signature Date

# Preferred Laboratory Acknowledgement

Routine Labs:

This office uses **LabCorp** as our default laboratory provider. Even though LabCorp may not be the preferred provider for certain Aetna, BCBS, or United Healthcare products, they either have a contract in place for in-network pricing, or they discount your lab services, so that you get the same in-network price you would have paid at Quest. The exception is certain HMO products which MUST use Quest Lab.

Specialty Labs:

There are a few specialty lab tests that may be sent to other laboratories. These lab tests are also discounted by the specialty lab so that you get in-network pricing even though the lab may not have a contract with your specific insurance plan.

Private Pay Patients:

*We offer private pay patients a discount if labs are paid at the time of service, please check with the receptionist on your way out regarding what tests have been ordered during your office visit. In order to offer this discount, Caring Center For Women must pay the lab for your tests, so this offer is only available on the day of lab collection.*

**I have read and understand the above information regarding labs ordered at Caring Center for Women. I understand that I should call the office at any time if I have questions about my lab bill.**

_____ I want my routine labs sent to LabCorp.
INITIALS

_____ I want my routine labs sent to: □ QUEST □ CPL □ OTHER _____
INITIALS

Patient name: _____ Signature: _____ Date: _____

# CARING CENTER FOR WOMEN, PA

**NAME:** _____

**(Please Check Current Problems)**

**Constitutional**
- ☐ chills
- ☐ fatigue
- ☐ fever
- ☐ victim-domestic violence
- ☐ weight gain (unintentional)
- ☐ weight loss (unintentional)

**Gastrointestional**
- ☐ abdominal pain
- ☐ acid reflux
- ☐ lack of appetite
- ☐ bloating
- ☐ difficulty swallowing
- ☐ clay-colored stool
- ☐ constipation
- ☐ diarrhea
- ☐ heartburn
- ☐ vomiting blood
- ☐ blood in stool
- ☐ hemorrhoids
- ☐ leaking stools
- ☐ dark, tarry stools
- ☐ nausea
- ☐ vomiting
- ☐ stool caliber change

**Genitourinary**
- ☐ painful periods
- ☐ painful sex
- ☐ pain with urination
- ☐ decreased sex drive
- ☐ orgasm dysfunction
- ☐ high risk sexual behavior
- ☐ irregular menstrual cycle
- ☐ very heavy periods
- ☐ frequent bladder infections
- ☐ blood in urine
- ☐ frequent urination at night
- ☐ frequent urination
- ☐ leaking urine
- ☐ bleeding after sex
- ☐ bleeding after menopause
- ☐ rape (history of)
- ☐ sexual abuse
- ☐ frequent vaginal infections
- ☐ genital sores/bumps
- ☐ vaginal discharge
- ☐ vaginal itching

**Integumentary Breast**
- ☐ moles changing in appearance
- ☐ yellow colored skin/eyes
- ☐ chronic itching
- ☐ rashes
- ☐ breast mass
- ☐ breast skin changes
- ☐ breast tenderness
- ☐ nipple discharge

**Endocrine**
- ☐ hair loss
- ☐ heat/cold intolerance
- ☐ sweating, excessive
- ☐ abnormal hair growth
- ☐ darkening skin
- ☐ excessive thirst
- ☐ excessive hunger
- ☐ infertility
- ☐ hot flashes
- ☐ vaginal dryness
- ☐ night sweats

**Psychiatric**
- ☐ anxiety
- ☐ crying spells
- ☐ depression
- ☐ feeling stressed
- ☐ loss of interest in pleasurable activities
- ☐ mood swings
- ☐ personality change
- ☐ PMS (premenstrual tension)
- ☐ poor concentration
- ☐ recreational drug use
- ☐ sadness
- ☐ sleep disturbance
- ☐ suicidal thoughts

****** TURN PAGE OVER ******

Thank you for filling this out. If the question does not apply to you, please skip it or put NA in the blank.

**Do you have monthly periods?** Y N

First day of last two (2) menstrual periods? _____ _____

**Are you sexually active?** Y N **With** (please circle)? Men Women Both

**How long have you been with your current partner?** _____ **How many partners in the past year?** _____

**Type of birth control used:**

| | | | | |
|---|---|---|---|---|
| Abstinence | Natural Family Planning | Condoms | IUD (Mirena or Paragard) | Implanon/Nexplanon |
| DepoProvera | Nuva Ring | Tubal Ligation | Essure | Vasectomy |
| Diaphragm | Hysterectomy | Birth control pill (name) _____ | | |

**When was your last Pap Smear?** _____ **Have you ever had an abnormal pap?** **Y** **N**

If "Y", when? _____ Did you receive treatment? Colposcopy/biopsy LEEP/cone Cryotherapy

**Have you had an STD?** Y N

Chlamydia Gonorrhea Herpes Syphilis Trichomonas HIV Hepatitis HPV/genital warts