
Women's Health Specialists

Dr. Lizy Andrews • Dr. Jeffery W. Nemec • Dr. Deborah A. Kasica • Dr. Devin G. Trevor • Leigh Lindsey, CNM, FNP
Medical Arts Building • 350 Park Street, Suite 203 • Bowling Green, KY 42101
Phone: (270) 781-0075 • Fax: (270) 781-0143 • Toll Free: 1-866-997-5784
www.WomensHealthSpecialists.net

GYNECOLOGICAL PATIENT PACKET

Dear New Patient:

Welcome to Women's Health Specialists. Your health and well-being are very important to us, and we are proud to be a part of your healthcare team.

At your appointment, we set aside time to devote our attention totally to you and to understanding your healthcare needs. We view good health as a partnership, which requires close involvement between you and your physician.

Early detection of any disease or illness usually means early treatment and a higher success rate. Thus, appointments that are not kept pose an increased risk to your health. If you are unable to keep an appointment, please notify us as soon as possible and preferably in at least 24 hours in advance.

It is important you arrive on time for your scheduled appointment. Arriving late causes us to get behind schedule, which in turn makes all other patients late for their appointments. If you are more than 15 minutes late, unfortunately we will have to reschedule your appointment.

Because of our concern with closely monitoring the health of all of our patients, patients who fail to show up for an appointment or fail to call and reschedule more than two times may be discharged from the practice. A \$20.00 no show fee will be charged to all patients who fail to cancel or reschedule their appointment.

All co-pays, deductibles, lab collection/processing fees and other charges are due at the time of service.

Please complete the attached paperwork, and bring with you to your appointment. Completing all paperwork will expedite your appointment. If you are unable to complete the enclosed paperwork, please arrive at least 30 minutes early for processing. If you have any questions or concerns, please call our office.

We look forward to seeing you in the office soon.

Appointment Date: _____

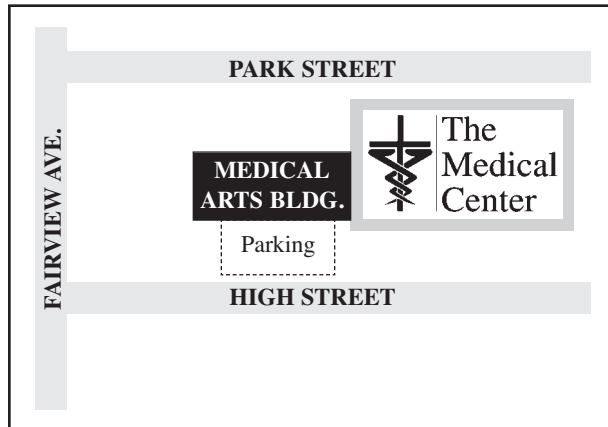
Time: _____

Physician: _____

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Parking and Entrance



Women's Health Specialists is located in the Medical Arts Building which is connected to The Medical Center. Although our address is Park Street, the Medical Arts Building Entrance is on High Street. Designated parking for the Medical Arts Building is available on High Street.

Women's Health Specialists is located in Suite 203, on the second floor of the Medical Arts Building.

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PATIENT INFORMATION *(Please print)*

PATIENT'S NAME	LAST	FIRST	MIDDLE INITIAL	MARITAL STATUS					DATE OF BIRTH	AGE	SOCIAL SECURITY NO.
				S	M	W	D	SEP			
STREET ADDRESS			<input type="checkbox"/> PERM. <input type="checkbox"/> TEMP. (CHECK ONE)		CITY AND STATE				ZIP CODE	HOME PHONE NO.	
EMPLOYER			<input type="checkbox"/> PATIENT'S <input type="checkbox"/> PARENT'S (CHECK ONE)		OCCUPATION (INDICATE IF A STUDENT)				BUS. PHONE NO.		

NAME OF INSURED OR PARENT	OCCUPATION (INDICATE IF A STUDENT)	INSURED'S SOCIAL SECURITY NO.
INSURED OR PARENT'S EMPLOYER		INSURED'S DOB BUS. PHONE NO.

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

KRS 194A.505 REQUIRES EVERY PERSON TO DISCLOSE ALL SOURCES OF INSURANCE, AT EACH VISIT. FAILURE TO DO SO IS FRAUDULENT. OUR OFFICE IS REQUIRED AND WILL REPORT ALL SUCH MISREPRESENTATIONS.

INSURANCE AUTHORIZATION (PLEASE READ AND SIGN)

I HEREBY AUTHORIZE WOMEN'S HEALTH SPECIALISTS TO FURNISH TO INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONCERNING MY (MY DEPENDENT'S) ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO WOMEN'S HEALTH SPECIALISTS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

SIGNATURE OF PATIENT OR PARENT DATE _____

Who should we notify in the event of an emergency?

Name: _____

Phone number: _____

Relationship: _____

Women's Health Specialists

HEALTH PROFILE

Date _____ Home Phone Number _____

Name _____ Date of Birth _____ Age _____

Why are you seeing the doctor? _____

When was the first day of your last menstrual period? _____

How often do you get your period? _____

How long does the bleeding last? _____

How severe is the cramping with your period (none, mild, severe)? _____

Are you doing anything for birth control? _____ If so, what? _____

When was your last pap smear? _____

Have you ever had an abnormal pap? _____

When was your last mammogram? _____

Have you ever had an abnormal mammogram? _____

What medications are you currently taking? (name and dosage) _____

Do you smoke? _____ How many packs of cigarettes per day? _____

Do you use alcohol (beer, wine, etc.)? _____ Marijuana? _____

Are you allergic to anything? _____ If so, what? _____

How many times have you been pregnant? _____

How many babies have you delivered? _____

How many miscarriages have you had? _____

How many abortions? _____

Have you ever had a Cesarean section? _____

What surgeries have you had? _____

Do you have any medical problems (i.e. diabetes, thyroid disease, high blood pressure, heart disease, asthma or other lung disease, arthritis or other joint problem, etc.) _____

Do you have a history of seizures? _____

Has anyone in your family had any of the following problems:

Cancer _____ Who _____ What kind (breast, colon, etc.) _____

Diabetes _____ Who _____ High Blood pressure _____ Who _____

Heart Disease _____ Who _____ Asthma _____ Who _____

Any other major medical problems? _____

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HEALTH HISTORY

Name: _____ DOB: _____

Have you had any of the following problems: (check all that apply)

	<i>Yes</i>	<i>No</i>	<i>Approximate Date</i>
More than 10 pound change in weight	_____	_____	_____
Loss of appetite	_____	_____	_____
Unusual fatigue	_____	_____	_____
Difficulty sleeping	_____	_____	_____
Fevers, chills, night sweats	_____	_____	_____
Dizziness, blurred vision	_____	_____	_____
Nausea, vomiting	_____	_____	_____
Diarrhea	_____	_____	_____
Blood in stool or black, tarry stools	_____	_____	_____
Blood in urine, cloudy urine, painful urination	_____	_____	_____
Leakage of urine	_____	_____	_____
Shortness of breath, cough, wheezing	_____	_____	_____
Chest pain, pounding in chest	_____	_____	_____
Joint pain, unusual muscle stiffness	_____	_____	_____
New or changing growths or moles	_____	_____	_____
Unusual nervousness	_____	_____	_____
Feelings of depression	_____	_____	_____

Anything else you would like to discuss today? _____

FOR OFFICE USE ONLY

Weight _____ Blood Pressure _____ Pulse _____

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TB Screening Tool

Patient Name: _____

All healthcare facilities are required to screen patients for tuberculosis when they enter for inpatient, outpatient, or emergency treatment. Please answer the following questions:

- a. Do you have active tuberculosis or have you recently been exposed to tuberculosis?
Yes___ No___
- b. Do you have a productive cough of more than three (3) weeks duration?
Yes___ No___
- c. Do you cough up blood?
Yes___ No___
- d. Have you had a fever recently?
Yes___ No___
- e. Have you been having night sweats?
Yes___ No___
- f. Have you recently experienced any unplanned weight loss?
Yes___ No___

Attention: If the patient answers yes to question “a” or yes to at least three (3) other questions, place a mask on the patient and keep the patient in a separate, well ventilated room with windows (if possible). Instruct the patient to cover their mouth when coughing. Staff will wear particulate respirator mask while in the room. The nurse will notify the patient’s physician. If the physician has confirmation of another diagnosis that manifests these symptoms, isolation need not be initiated and the patient’s mask will be removed.

Latex Allergy Screening Tool

1. Do you have a confirmed latex sensitivity, or do you have spina bifida?
Yes___ No___
2. Have you ever had a reaction after handling/using poinsettia plants, balloons, rubber products, or spandex?
Yes___ No___
3. Have you ever had one of the following after a medical or dental appointment: itching, tearing, fatigue, sneezing, runny nose?
Yes___ No___
4. Have you ever reacted after eating bananas, avocados, kiwi, or chestnuts?
Yes___ No___

For patients who have responded in the affirmative to most of these questions, latex precautions will be utilized, unless otherwise stipulated by the physician. The suspected allergy will be documented in the patient’s chart, an orange label will be placed on the chart and the referring physician will be contacted.

Date

Employee Signature

Patient Signature