GETTING TO KNOW YOU!

What goals do you have for your body or health?

What do you value most from your doctor or provider?

What is the reason for your visit?

- ○ Pregnancy
- ○ Annual Exam
- ○ Other
- ○ Medical Problem
- ○ New to Area

How did you hear about us?

(please mark all that apply)

- ○ **Friend/Family:** _____ Please print their name clearly so we may send them a thank you card.
- ○ **Doctor:** Did a doctor recommend you to us? If so, which doctor? _____

Internet:

- ○ Google
- ○ RealSelf
- ○ YouTube
- ○ Facebook
- ○ Instagram
- ○ Other _____
- ○ Twitter
- ○ Pinterest

Other:

- ○ Insurance
- ○ Dr. Litrel's articles
- ○ Hospital
- ○ Magazine/Newspaper/Advertisement

If so, which publication?

_____

PATIENT REGISTRATION FORM

Name (Last, First, Middle):	Date of Birth:
Maiden Name:	Marital Status (circle one): S M D W
Address: Street: City, State, Zip:	Put a check by your preferred primary # ____ Home Ph #: ____ Cell Ph #: ____ Work Ph #:
Employer/Occupation:	Email:
Your doctor recommends that you sign up for the Follow My Health patient portal to access your medical records, request prescription refills and schedule appointments. Please check here to request an email invite ☐	You will be subscribed to the Cherokee Women's Health Specialists e-newsletter for updates in women's health, articles, and the latest news about our practice. Please check here if you do not want our updates. ☐
Spouse/Parent/Guardian:	Ph #:
Emergency Contact:	Relationship:
Emergency Contact Ph #:	

Insurance Information	
Primary Insurance:	
Name of Insured:	Insured's Date of Birth:
Relation to Insured (circle one): Self Spouse Child	
Secondary Insurance:	
Name of Insured:	Insured's Date of Birth:
Relation to Insured (circle one): Self Spouse Child	

PROVIDE COPY OF YOUR INSURANCE CARD

* Payment is Due at Time of Service*

Assignment and Release: I assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans to Cherokee Women's Health Specialists, PC. I understand that I am fully responsible for all charges not paid by insurance. I hereby authorize this practice to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all submissions. **I understand that any lab work performed will be billed directly to me by that lab**. This assignment will remain in effect until revoked by me in writing. I consent to the taking of photographic images for treatment purposes only as ordered by attending physicians.

Patient Signature: _____ Date: _____

NEW PATIENT MEDICAL HISTORY

Please answer ALL questions to be seen today by your provider.

WARNING: If you want your friend or family member present during your visit today, you must know that your doctor or medical assistant will be asking you highly personal and confidential medical questions that you may not be comfortable answering in the presence of others.

Patient Name: _____

Date of Birth: _____

Last menstrual period date: _____

Briefly state your reason for visit: _____

_____

ALLERGIES/REACTIONS: Please list any drug, food or environmental allergies and your reaction	

FAMILY HISTORY: Please list any family medical history. i.e.; heart disease, diabetes, cancer, etc.			
Disease	Family Member	Disease	Family Member

PATIENT'S MEDICAL HISTORY:	
Date of last pap:	Abnormal (circle one): Yes No
History of abnormal pap (circle one): Yes No	If yes, list treatment
Date of last mammo:	Abnormal (circle one): Yes No
History of abnormal mammo: (circle one): Yes No	If yes, list treatment
Date of last bone density:	Abnormal (circle one): Yes No

NEW PATIENT MEDICAL HISTORY

Medical history must be completed before you can be seen.
Please answer ALL questions.

GYN HISTORY:		
Age period began:	# of days between periods:	
Flow/duration of period:	Painful periods (circle one): Yes No	
Age menopause began:	Painful intercourse (circle one): Yes No	
Do you ever experience leaking of urine? (circle one): Yes No		
Blood transfusion (circle one): Yes No		
List Past GYN Problems:	List Other Medical Problems:	List Surgeries:

PREGNANCY HISTORY:		
# of pregnancies:	# of abortion(s)/miscarriage(s):	# of living children:

PREGNANCY DETAILS:					
	1st Pregnancy	2nd Pregnancy	3rd Pregnancy	4th Pregnancy	5th Pregnancy
Date					
GA Weeks					
Complications					
Delivery Type					
Length of Labor					
Birth Weight					
Sex					
Analgesia/ Anesthesia					
Treatment of Preterm Labor					
Induction					
Laceration/ Episiotomy					
Place of Delivery					

NEW PATIENT MEDICAL HISTORY

Medical history must be completed before you can be seen.
Please answer ALL questions.

SOCIAL DETAILS:			
Marital Status (circle one): M S D W			
Primary Occupation:			
Primary Birth Control Method:			
Are you sexually active? (circle one): Yes No			
Do you exercise? (circle one): Yes No Days per week:			
Tobacco Use? Yes No	Alcohol Use? Yes No	Drug Use? Yes No	Caffeine Use? Yes No
Amount:	Amount:	Amount:	Amount:
Medications: Please list any medications the patient is currently taking.			
Medication Name	Strength/Dose	Medication Name	Strength/Dose

PHARMACY INFORMATION:		
Name	Location	Ph #:

PATIENT HEALTH SURVEY

PLEASE CIRCLE YOUR ANSWER
1 =No
2 = Yes, but it doesn't bother me
3 = Yes, I would like more info about treatment options

	No	YES	
1. Do you spot or bleed longer than five days with your period?	1	2	3
2. Do you pass blood clots or clumps of tissue with your period?	1	2	3
3. Are you finished having children?	No		Yes
4. Are you interested in a 5-minute office procedure that stops your cycle?	No		Yes
5. Do you have cramps or pelvic pain associated with your cycle?	1	2	3
6. Did you have painful periods as a teenager?	1	2	3
7. Do you experience pain with sex?	1	2	3
8. Do you feel less sensation during vaginal intercourse than you desire?	1	2	3
9. Do you have problems with low sex drive or difficulties with orgasm?	1	2	3
10. Are you concerned about the appearance of your labia?	1	2	3
11. Do your labia cause you any discomfort?	1	2	3
12. Are you interested in Medical Weight Loss?	No		Yes
13. Do you have unwanted stubborn fat?	1	2	3
14. Are you interested in Liposuction and/or a Tummy Tuck?	No		Yes
15. Do you experience pelvic pressure or other pelvic discomfort or your bottom dropping out?	1	2	3
16. Do you lose urine when you cough or sneeze or jump?	1	2	3
17. Do you use pads because you cannot hold your urine?	1	2	3
18. Do you soil your clothing?	1	2	3
19. Do you experience leakage of gas, mucus or stool without control?	1	2	3
20. Do you have to apply pressure to your vagina to have bowel movements?	1	2	3

Date: _____ **Doctor You Are Seeing Today:** _____

Name (Last, First, Middle): _____

Address: _____

City, State, Zip: _____

Best Contact Ph #: _____Text/Cell Ph #: _____

Email: _____ Date of Birth: _____

PERSONAL & FAMILY CANCER HISTORY

Name: _____ Date: _____ Date of Birth: _____ Age: ____

Please Circle Provider:

Crigler Fischels Gandhi Goodson-Gerami Griggs Hale Haley Hurley Litrel Staab Zhukova

Complete the section below

Include **yourself and all 1st and 2nd degree male and female blood relatives on both your mother's and father's sides**.

Specify which relatives were affected with cancer and estimate ages of diagnosis to the best of your ability.

1st Degree Relatives: **Parents, Siblings, Children**
2nd Degree Relatives: **Grandparents, Aunts/Uncles, Nieces/Nephews**

Circle One		**CANCER HISTORY**	You	Siblings/ Children	Which relative on your Mother's side	Which relative on your Father's side	Age of Diagnosis
No	**Yes**	BREAST CANCER **before** age 50					
No	**Yes**	3 or more BREAST CANCERS on one family side **any** age					
No	**Yes**	OVARIAN CANCER **any** age					
No	**Yes**	ENDOMETRIAL(UTERINE) CANCER **before** age 50					
No	**Yes**	COLON CANCER **before** age 50					
No	**Yes**	3 or more COLON or ENDOMETRIAL on one side of family **any age**					

I understand if I answer yes to a single question (or more), I am eligible for hereditary (genetic) cancer screening. This is a simple blood test that is covered by most insurance. The results of this test may help my doctor diagnose cancer earlier or make me eligible for preventative surgery. I will tell me doctor if I am interested.

Patient Signature _____

FINANCIAL POLICY

_____ _____

PATIENT NAME (please print) Chart/Account Number

CWHS is committed to meeting your health care needs. Our goal is to keep your insurance and financial arrangements as simple as possible. We ask that you adhere to the following guidelines:

1. It is your responsibility to provide us with your current address, telephone number and insurance information at each visit.

2. You are responsible for payment of charges for services you receive from our office. All co-pays are due at the time of service. Any check payment dishonored by your bank will result in a $25.00 returned check fee being added to your account.

3. It is your responsibility to contact your insurance carrier to confirm that our physicians participate on your plan. If you see a doctor that is not currently on your plan, you will be responsible for the payment in full.

4. You will be charged a no-show fee of $25.00 for all missed appointments not cancelled 24 hours prior to scheduled appointment time.

5. Self-pay patients are responsible for charges and will be expected to make payment in full at the time services are rendered.

6. Laboratory services may be provided by a contracted outside reference lab. Lab charges not covered by your medical insurance will be billed to you. I accept responsibility for lab charges not covered by my medical insurance plan.

7. All medical record requests must be received in writing in our office 72 hours prior to the date needed. There will be a $25.00 administrative fee plus a $.25 copying fee per page.

8. We do accept Medicaid and will file your claims. However, you must bring a valid card in at each visit or you will be liable for the charges incurred during the visit.

I authorize the release of any medical information necessary to process insurance claims. I authorize and permit payment directly to the doctor. I recognize and accept responsibility for any balance remaining after payment of benefits.

Patient Signature _____ Date _____

PATIENT ID #_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Cherokee Women's Health Specialists, PC

I acknowledge receipt of Cherokee Women's Health Specialists, PC Notice of Privacy Practices.

PATIENT NAME _____ Date of Birth: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

I, the patient, authorize Cherokee Women's Health Specialists, PC to share all of my PHI including but not limited to labs, diagnoses, with the following people:

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

PATIENT SIGNATURE _____ Date: _____

For minor child patient, a parent's signature is required (or agent with healthcare power of attorney).

I may revoke this authorization by letter to Cherokee Women's Health Specialists, PC at 216 Riverstone Drive, Canton, GA 30114.

Cherokee Women's Health Specialists, PC policy is to provide to patient a copy of the signed form.