PLEASE PRINT CLEARLY. Information is required for treatment and billing purposes and will remain strictly confidential. Missing information may result in patient being billed directly for services.

Full Legal Name____

Date of Birth____________________ Social Security Number_______-_____-_________

Mailing Address____

City/State________________________________ Zip Code______________________

Primary Phone____________________________ OK to leave detailed message? Y N

Alternate Phone___________________________ OK to leave detailed message? Y N

Work Phone______________________________ OK to leave detailed message? Y N

Employer________________________________Occupation______________________

Name of Spouse/Significant Other______________________ Spouse Phone____________

OK to discuss financial/insurance information with Spouse/S.O listed above? Y N

Primary Care Physician______________________Referring Physician________________

Primary Insurance Plan Name____

Policy Number_________________________________Group Number________________

Insurance Company Claims Address_____________________________________

Insurance Company Phone______________________________

Name of Subscriber__________________________ Subscriber Birth date______________

Subscribers relationship to patient_____Self _____Spouse _____Parent/Step Parent

Secondary Insurance Plan Name(if applicable)___________________________________

Policy Number_________________________________Group Number________________

Insurance Company Claims Address_____________________________________

Insurance Company Phone______________________________

Name of Subscriber__________________________ Subscriber Birth date______________

Subscribers relationship to patient_____Self _____Spouse _____Parent/Step Parent

NORTHWEST GYNECOLOGY ASSOCIATES, PLLC

CONSENT FOR TREATMENT:
I authorize Northwest Gynecology Associates, PLLC and its personnel to provide ongoing medical care, treatment and procedures as ordered by the physicians/and or health care providers. I acknowledge that no guarantee can or will be made as to the results of the care, treatment and medication prescribed.

FINANCIAL AGREEMENT:
I understand and agree that I (or parent, if patient is a minor) am financially responsible for all services provided. As a courtesy, Northwest Gynecology Associates, PLLC will bill my insurance carrier.
If my account is referred to a collection agency, I understand that I am responsible for reasonable collection expenses, including attorney's fees and court costs.

ASSIGNMENT OF BENEFITS:
I authorize my insurance benefits be paid directly to Northwest Gynecology Associates, PLLC. I certify that all information given in applying for payment under the Social Security Act or other health insurance plan is correct, and authorize verification of coverage by Northwest Gynecology Associates, PLLC. A photo static copy of this authorization shall be considered as effective and valid as the original.

CONSENT TO RELEASE OF INFORMATION:
I authorize Northwest Gynecology Associates, PLLC to release to my insurance carrier(s) – including Medicare, Medicaid and any other reimbursing agency – information about my identity, treatment, diagnosis, prognosis and/or services rendered (including drug and alcohol abuse treatment; mental health treatment; diagnosis and/or treatment of HIV, AIDS, AIDS-related illness or sexually transmitted disease) as permitted by state and federal law which may be required or requested, thus releasing Northwest Gynecology Associates, PLLC from any liability for furnishing such information. I understand information may be released through electronic or paper media.

MISSED APPOINTMENTS:
Your appointment time is valuable. If you are unable to keep your appointment we request a minimum notice of one full business day so that we may offer that appointment time to someone one else. You will be charged $35.00 for a missed appointment if we do not receive one full business days notice. This fee may be waived in the event of an emergency.

NOTICE OF HEALTH INFORMATION PRACTICES:
I acknowledge that I have been provided with a copy of the Notices of Privacy Practices, dated Nov 12, 2015.

Date ____________________

Signature of Patient or Legally Authorized Representative ____________________

Print Name ____________________

Name & relationship to patient if not signed by patient ____________________

Northwest Gynecology Associates, PLLC
A Balanced Approach

Jane L. Ahearn, MD • Bruce J. Andison, MD
406-C SE 131st Ave., Suite 304
Vancouver, WA 98683

INDIVIDUAL PATIENT AUTHORIZATION

Patient Name______________________________________

D.O.B.________________________

Address____

As required by HIPAA Privacy Regulations, this practice may not disclose your protected health information without your authorization.

Because we often deal with sensitive information, we will not provide this information to anyone other than yourself, unless you specifically permit us to, by giving your approval below. This consent may be revoked at any time by a written request from you.

I hereby authorize this office and any of its employees to disclose my Patient Health Information to the following person(s).

____

____

____

____ ________________
Signature of Patient or Patients Authorized Representative Date

____ ________________
Authorized Signature of Office Faculty Date

HEALTH HISTORY QUESTIONAIRE

LAST NAME	FIRST NAME	INITIAL	BIRTHDATE	TODAY'S DATE.

NICKNAME OR PREFERRED NAME: ____________________

 # Of Pregnancies: **# of Childeren:** **MARITAL STATUS (circle one) Single Separated Married Divorced Widowed**

First Day of Last Menstrual Period: ____________________

1. At what age did you begin having menstrual periods? ________
2. What is the usual number of days between your periods? ________
3. How long do your periods last? ________
4. Are your periods painful?.......... Yes No
5. Do you have bleeding between periods?.......... Yes No
6. Do you have pain with intercourse?.......... Yes No
7. Do you have any aspect of your sexuality or a sexual problem you would like to discuss?.......... Yes No
8. Do you use any means of birth control?.......... Yes No
   a. If so, what type? ________
   b. Please list any other forms you have used ________
9. Are you satisfied with your present form of birth control?.......... Yes No
10. Do you desire more children?.......... Undecided Yes No
11. Have you had difficulty becoming pregnant?.......... Yes No
12. Have you had a miscarriage or therapeutic abortion?.......... Yes No
13. Did you have any complications of pregnancy?.......... Yes No
    a. If so, what type? ________
14. Do you presently have any abnormal vaginal discharge?.......... Yes No
15. Do you have a history of urinary tract (bladder or kidney) infections?.......... Yes No
16. Do you have any trouble with uncontrolled loss of urine? (Especially with coughing, sneezing, laughing, etc.).......... Yes No
17. Do you have pelvic pressure or the feeling that your uterus, bladder or rectum are pushing down?.......... Yes No
18. Have you ever had an infection in your tubes or ovaries?.......... Yes No

* Do you prefer to have a female present at the time the doctor examines you?.......... Yes No

PAST OR PRESENT ILLNESS **DATE**

Illness		DATE
Diabetes	No Yes	
Thyroid Problem	No Yes	
Heart Disease, Heart Murmur	No Yes	
High Blood Pressure	No Yes	
Migraine Headaches	No Yes	
T.B. (Tuberculosis)	No Yes	
Asthma	No Yes	
Stomach Ulcers	No Yes	
Hepatitis	No Yes	
Bleeding Problems (Blood clotting problems)	No Yes	
Blood Transfusions	No Yes	
Abnormal Pap Smear	No Yes	
Genital Warts	No Yes	
Genital Herpes	No Yes	

Is your weight stable?.......... No Yes Usual Wt? ________

Previous Hospitalizations, Surgeries, or Serious Injuries:

TYPE:	YEAR:

CURRENT MEDICATIONS; including non-prescription drugs:

NAME of medication:	DOSE

DRUG ALLERGIES

____
____
____
____

DO YOU USE:

Cigarettes? ________ Amt/Day ________

Alcohol? ________ Amt/Day ________

Caffeine? ________ Amt/Day ________

Non-prescription drugs? ________ Amt/Day ________

- If there are any specific questions that you wish to discuss with the doctor, please feel free to list them below or bring them up during your examination.

____
____
____
____