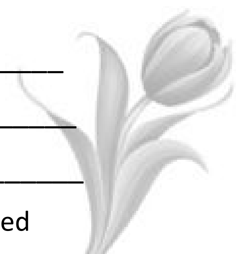
NEW RIVER WOMEN'S HEALTH – UPDATE FORM



Patient Name: ____DOB: ____/____/_____

Phone: _________________________ Address: _____________________________________

City/Town: _______________________ State: _____________ Zip code: _____________

Marital Status: (Circle One) Single Married Widowed Divorced Domestic Partner Separated

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

Your Employment / Profession: ____

Spouse / Partner's Name: ____

Preferred Pharmacy: ____

Family Physician or Primary Care Provider: ____

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Date of Last Menstrual Period: ____

Form of Contraception: ________________________________

Allergies: ____

List all Current Medications and the dosage (including over the counter):

____

____

____

____

Current Tobacco Use: ☐Yes ☐No

If YES, how much: _____________ how long: _____________

Former Tobacco Use: ☐Yes ☐No

If YES, how much: _____________ how long: _____________

Alcohol Use: ☐Yes ☐No

If YES, how many drinks per week: ____

Recreational Drug Use: ☐Yes ☐No

If YES, What: ______________________ how much: _________________

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Date of last Women's Health Exam / Pap smear: ____

Do you have a history of an abnormal pap? ☐Yes ☐No

If so when? ___________________________________

Date of last mammogram: ____________________ Location of last mammogram: ______________________

Date of last colonoscopy: _____________________

Date of last bone density: ____________________

Date of last cholesterol check: _____________ ☐Normal ☐High

Pregnancy History: please check all that apply and how many of each:

Pregnancies: #_________ Vaginal Births: #_________ Cesarean Sections: #_________

Miscarriages: #_________ Elective Abortion: #_________

Past Medical History: Please check all that apply

☐ Acid Reflux ☐ Anemia ☐ Anxiety ☐ Arthritis ☐ Asthma/Emphysema/Lung Disease ☐ Cancer – What kind: ___________________________ ☐ Chronic Kidney Disease ☐ Crohns/Ulcerative Colitis ☐ Depression ☐ Diabetes	☐ Heart Attack ☐ Heart Disease ☐ High Cholesterol ☐ History of Blood Transfusion ☐ Hypertension ☐ Leukemia ☐ Liver Disease/Hepatitis ☐ Lymphoma	☐ Migraines ☐ Mitral Valve Prolapse ☐ Osteopenia ☐ Osteoporosis ☐ Seasonal Allergies ☐ Seizure Disorder ☐ Stroke ☐ Thyroid Disorder ☐ Other: Details: _______________________________ _________________________ _______________________________ _________________________

Past Surgical History: Please check all that apply

Procedure	Date if Known	Procedure	Date if Known
Appendix		Tonsillectomy	
Gall Bladder		D&C	
Hysterectomy		Endometrial Ablation	
C-Section		Hernia	
Incontinence Procedure		Right of Left Ovary Removal	
Sterilization: ☐ Tubal ☐Essure ☐ Partner Vasectomy			

Other surgeries:____
____

Family History: Please check all that apply

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ High Cholesterol
- ☐ Mental Health Disorder
- ☐ Melanoma
- ☐ Osteoporosis
- ☐ Breast Cancer: Family Member: ____________________ Age Diagnosed: _______
- ☐ Ovarian Cancer: Family Member: ____________________ Age Diagnosed: _______
- ☐ Uterine Cancer: Family Member: ____________________ Age Diagnosed: _______
- ☐ Colon Cancer: Family Member: _________________ Age Diagnosed: _______
- ☐ Other: Details: ____

New River Women's Health

Office Policies

- Collection Agency/Attorney Fees - In the event that your account is turned over to a collection agency or attorney, you agree that you will be responsible for a collection fee equal to 33.3% of the outstanding balance due on the date the account is turned over for collection.
- Collection Costs - In the event that the account becomes delinquent and is necessary to expend costs for the collection of the account, you understand that you will be responsible for the costs. These costs could include court costs for filing suit against you.
- Cancellation / No Show for Scheduled Appointment: We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.
- If an appointment is not cancelled at least 24 hours in advance you will be charged a Thirty Five Dollar ($35) fee; this will not be covered by your insurance company. This appointment will also be marked as a No Show since adequate cancellation notice was not given.
- We will limit the number of No Shows or late cancellations allowed per patient. If you are a No Show three (3) times, we will no longer schedule appointments for you at our practice.
- Late Arrival for Scheduled Appointments: We understand that delays can happen; however we must try to keep the other patients and doctors on time. If a patient arrives 15 minutes past their scheduled time we will have to reschedule the appointment.

Patient/Guardian Printed Name: ____

Patient/Guardian Signature: ____

Date: ______________

New River Women's Health

Appointment Notifications

New River Women's Health now offers multiple options for appointment notifications.

How would you prefer we contact you for regarding appointment notifications?

- ☐ Any
- ☐ Voice
- ☐ Text
- ☐ E-mail

You may opt out of automated voice, text and e-mail at any time.

By signing this I authorize New River Women's Health to contact me regarding appointment notifications in the manner that I have selected above.

Patient/Guardian Printed Name: _____________________________

Patient/Guardian Signature: _________________________________

Date: ______________

Preventive Medical Visit Patient Information

Patient,

You are seeing your provider for a preventive medical visit. This is a comprehensive, preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/ risk factor reduction interventions, and the ordering of laboratory/ diagnostic procedures. Insurance carries may or may not provide coverage for screening laboratory and diagnostic studies; rules are carrier specific. Preventive medical visits are exempt from copayments.

If an abnormality is encounters or a pre-existing problem is address during the process of performing your preventive medical evaluation and management service, and if the problem or abnormality is significant enough to require additional work to perform key components of a problem-oriented evaluation and management service, then a separate office visit code may be charged. The use of this additional code will require a co-payment, coinsurance, or deductible if one is charged by your insurance plan.

If you have any questions regarding this matter, we advise you to contact your insurance carrier directly to discuss your coverage for these services.

New River Women's Health

I certify that I have read and understand the difference between preventive and problem-oriented visits and agree to pay the associated copay should the nature of my visit change.

Signature ____ Date: __________________

Printed Name: ____

At New River Health and Wellness, we provide different services ranging from annual exams, problem visits, lab tests, and imaging services. We unfortunately do not know the coverage for these services for each insurance company. We ask that you reach out to your insurance company if you have any specific questions regarding coverage, benefits, or payments that may be due. We also are happy to provide you with services, labs, or imaging at your request, but we do ask for the patient to take the responsibility of contacting your insurance company about coverage, eligibility, payments, etc.

Thank you for understanding.

Patient Signature: ____

Date: ____