Pamela Campbell, DO, FACOG
Salina Green, MD, FACOG
Jamie Joyce, MD, FACOG
Madeline Giacalone, DO
Kristin Wald, WHNP-BC
Janice Eisleben, WHNP-BC

Women's Health Partners
A Division of Signature Medical Group
10012 Kennerly Road, Suite 405
St. Louis, MO 63128

Phone 314-525-4880
Fax 314-525-4881
Exchange 314-364-5350

Dear Patient,

Welcome to our practice. We have enclosed a packet of information that will need to be completed and returned at the time of your appointment.

THIS PAPERWORK MUST BE COMPLETED PRIOR TO YOUR APPOINTMENT

If you were referred to our practice by another physician, please make sure your physician forwards copies of your records, relevant to your visit, prior to your appointment time. They will need your prior authorization to do so. Our fax number is 314-525-4881.

Thank you,

Staff of Women's Health Partners

Women's Health Partners Payment Policy

You will need to bring your insurance card at the time of your appointment. Failure to do so will result in having to reschedule. If your insurance requires a referral, please make sure you have a referral sent ahead of time or bring one with you at the time of your appointment.

Payment for co-pay is expected prior to seeing the doctor. We accept Cash, Check, Master Card, Discover, and Visa for your convenience

In the event that your account is turned over to a collection agency, you are responsible for any and all related attorney and collection fees.

I have read, and understand, all the above terms and assume full responsibility for paying any medical service charges, finance charges, and collection fees according to these terms

Signed: _____ Date: _____

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OBSTETRICS GYNECOLOGY

Women's Health Partners

A Division of Signature Medical Group

PATIENT DATA SHEET

○ New ○ Update

Referred by _____

Patient Information

Primary Care Physician_____

Last Name _____ First Name _____ Middle Initial _____

Social Security Number _____ Date of Birth _____ Gender: ○ Male ○ Female

Address _____ City _____ State _____ Zip _____

Home Phone Number _____ Cell Phone Number _____ Marital Status: ○S ○M ○W ○D ○Separated

Patient's Employer _____ Work Phone _____

Spouse's Name _____ Spouse's Birthdate _____

Emergency Contact Person _____ Phone Number _____

Emergency Contact's Relationship to Patient _____

Person Responsible for Balance _____ Responsible Party's Date of Birth _____

Responsible Party's Address _____ Social Security Number _____

Phone _____ Relationship to Patient: ○ Father ○ Mother ○ Stepfather ○ Stepmother ○ Spouse ○ Other

Primary Insurance _____ Effective Date _____

Name of Insured _____ Relationship to Patient _____

Insured's Date of Birth _____ Insured's I.D. Number _____ Group Number _____

Insured's Home Address _____ Phone Number _____

Insured Party Employed by _____

Employer Address _____ Phone Number _____

Secondary Insurance _____ Effective Date _____

Name of Insured _____ Relationship to Patient _____

Insured's Date of Birth _____ Insured's I.D. Number _____ Group Number _____

Insured's Home Address _____ Phone Number _____

Insured Party Employed by _____

Employer Address _____ Phone Number _____

ASSIGNMENT OF INSURANCE & BENEFITS/RELEASE OF MEDICAL INFORMATION: I hereby authorize Women's Health Partners physicians to administer/perform any medical and/or surgical procedure deemed necessary, and authorize release of information needed to secure payment. I authorize that all benefits by my insurance company to be paid directly to Women's health Partners, and understand that I am financially responsible to all charges that are not covered by my insurance.

Signature of Responsible Party _____ Date _____

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Name: _____ **Date of Birth**: _____ **Age**: _____

Please briefly state the reason for your visit: _____
Date of last menstrual cycle: _____

Medical History: Do you have now or have you ever had

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disorder (lupus, rheumatoid arthritis) _____
- ☐ Bipolar disorder
- ☐ Bleeding disorder
- ☐ Blood transfusion
- ☐ Cancer (type) _____
- ☐ Chicken pox
- ☐ DVT (blood clot in leg)
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Elevated cholesterol
- ☐ GERD/Reflux
- ☐ Gastrointestinal illness (Crohn's, diverticulitis) _____
- ☐ Gestational diabetes
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Infertility
- ☐ Irritable bowel syndrome
- ☐ Heart Attack
- ☐ High blood pressure
- ☐ Hyperthyroidism (high)
- ☐ Hypothyroidism (low)
- ☐ Kidney infection
- ☐ Liver Disease
- ☐ Migraines
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ PE (blood clot in lung)
- ☐ Recurrent bladder infection
- ☐ Seizures
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Tuberculosis

Surgical History: Please list ALL surgical procedures **Year**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List below medications, latex or foods causing an allergic reaction (rash, swelling) or intolerance (nausea)

Medication/Food	**Reaction**

Name: _____ Date of Birth: _____

Current Medications: Please also include vitamins and supplements

Medication	Dose	Frequency	Prescribed by

Family History

Illness	Mother	Father	Brother	Sister	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Other
Diabetes									
Stoke									
Heart attack									
High Blood pressure									
Alcoholism									
Breast Cancer									
Ovarian Cancer									
Uterine Cancer									
Colon Cancer									
Blood clot in leg or lung									

Social History

Occupation _____

Do you smoke? ☐ Never ☐ Currently___ # cigarettes/day _____# years ☐ Former _____ Age you quit

Do you consume alcohol? ☐ No ☐ Yes/Drinks per day _____

Do you use street drugs? ☐ No ☐ Yes (drug of choice) _____

Do you wear your seatbelt? ☐ No ☐ Yes

Do you exercise regularly? ☐ No ☐ Yes Type of exercise _____How often _____

Any history of violence in your current household or in your past? ☐ No ☐ Yes

Do you have any cultural or religious considerations that need special attention ☐ No ☐ Yes

If yes, please describe _____

Are you ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Significant other

Date of last flu vaccine _____

Name: _____ Date of Birth: _____

Gynecologic History

Have you ever had sex (vaginal or anal)? ☐ No ☐ Yes

Do you have sex with ☐ Men ☐ Women ☐ Both

How many partners have you had sex with in your lifetime? _____ In the past 1 year? _____

Age at first period? _____ If menopausal, age of last period _____

How often do you get your menstrual cycle? Every _____ days, lasting _____ days

Last Mammogram _____

Last bone density exam _____

Last Colonoscopy _____

Have you completed the Gardasil Vaccine series (HPV)? ☐ Yes ☐ No

Date of last Pap smear? _____

Do you have any history of abnormal pap smears or cervical dysplasia? ☐ Yes ☐ No

If yes, any treatment (LEEP, laser, cryo, biopsy) _____

Method of contraception

- ☐ None
- ☐ Condoms
- ☐ Rhythm Method
- ☐ Pill
- ☐ NuvaRing
- ☐ DepoProvera
- ☐ Nexplanon
- ☐ IUD
- ☐ Tubal ligation
- ☐ Essure
- ☐ Vasectomy

Have you ever been treated for

- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ HIV
- ☐ Trichomonas
- ☐ Genital Herpes
- ☐ Oral cold sores
- ☐ Genital warts
- ☐ Pelvic inflammatory disease
- ☐ Uterine fibroids
- ☐ Ovarian cysts
- ☐ Endometriosis
- ☐ Infertility
- ☐ Heavy periods
- ☐ Irregular periods
- ☐ Polycystic ovarian syndrome

Obstetrical History

How many total pregnancies have you had? _____

Number of miscarriages _____ Ectopic pregnancies_____ Elective abortions _____

Deliveries

Birthdate	# Weeks when delivered	Baby's weight	Gender	Type of Delivery (vaginal, c/s, forceps, vacuum)	Epidural Yes or No	Hospital	Complications (BP, diabetes)

Name: _____ Date of Birth: _____

Please review the following and check those items that are <u>currently</u> a problem for you

- ☐ Weight gain
- ☐ Weight loss
- ☐ Fatigue
- ☐ Visions problems
- ☐ Hearing problems
- ☐ Sinus problems
- ☐ Dental problems
- ☐ Nose bleeds
- ☐ Chest pain
- ☐ Swelling of legs
- ☐ Palpitations of heart
- ☐ Painful breathing
- ☐ Shortness of breath
- ☐ Trouble swallowing
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Abdominal pain
- ☐ Nausea/Vomiting
- ☐ Blood in urine
- ☐ Frequency of urination
- ☐ Leaking urine
- ☐ Incomplete emptying of bladder
- ☐ Painful intercourse
- ☐ Breast discharge
- ☐ Breast mass
- ☐ Dizziness
- ☐ Crying frequently
- ☐ Depressed mood
- ☐ Abnormal thirst
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Easy bruising
- ☐ Cuts don't stop bleeding
- ☐ Arthritis
- ☐ Skin rash
- ☐ Fainting
- ☐ Headaches
- ☐ Difficulty sleeping

Signature_____ Date _____

Laboratory Policy and Procedure

It is the preference of our physicians that all specimens obtained in the office be processed by Bio Reference Lab (GenPath).

If you have an insurance plan that requires you to use a specific laboratory, please write the name on the line below.

_____

If you are unsure of your insurance plan specifications and/or your lab benefits, you may call your insurance company for further information.

I have read the policy.

_____ _____
Signature of Patient Date

Canceling Appointments

In the event you are unable to keep your scheduled appointment, please call our office 48 hours in advance to avoid a no-show fee.

Effective June 01, 2015

ALL PATIENTS THAT FAIL TO KEEP THEIR SCHEDULED APPOINTMENTS & DID NOT CANCEL 48 HOURS IN ADVANCE WILL BE CHARGED A NO SHOW FEE OF $50

I understand the no-show policy and will call to cancel my appointment 48 hours prior, or be responsible for the fee

Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

SIGNATURE MEDICAL GROUP, INC.

Acknowledgment of Receipt of
Notice of Privacy Practices

I, _____, have received a copy of Signature Medical Group, Inc.'s updated Notice of Privacy Practices.

_____
Signature of patient or parent/legal guardian/legally responsible person

_____
Description of relationship to the patient

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual/Representative refused to sign the form
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____
_____
_____

DIRECTIONS TO OUR OFFICE:

Traveling south on 270:

Exit Tesson Ferry Rd. At stoplight go right. Continue on Tesson Ferry Rd. for 1/2 mile. Turn right onto Schuessler Rd. Make first right into the hospital parking lot. We are located in the Physician Office Center in suite 405.

Traveling north on 270:

Exit Tesson Ferry Rd. At stoplight go left. Continue on Tesson Ferry Rd. for 1/2 mile. Turn right on Schuessler Rd. Make first right into the hospital parking lot. We are located in the Physician Office Center in suite 405. From 141: take Hwy 21 North to Schuessler Rd. Turn left onto Schuessler Rd. Make first right into the hospital parking lot. We are located in the Physician Office Center in suite 405.