R.A. Pastoriza, M.D.

Laura McCully, C.N.M., M.S.

www.womenfirsthealth.com

Women first health services

1100 east michigan avenue
suite 205
jackson, michigan 49201
phone 517.787.6838
fax 517.787.5623

Welcome to Women First Health Services! Your appointment is scheduled for [] at []. If you cannot make this appointment, please notify our office at least 24 hours in advance to avoid being charged a missed appointment fee. You may reach our office between the hours of 8am-12pm and 1pm-5pm Monday-Friday. Please note that we have summer hours (Memorial Day-Labor Day) of 7am – 11am and 12pm – 4pm.

Please bring the following to your appointment:

**All Medical Records pertinent to this visit**. Please call your referring doctor to obtain copies of your records prior to your appointment with us.

**Insurance card(s)**. If you have insurance that we do not participate with, or if you do not have office visit coverage, payment for services is expected at the time of your visit. Some insurance plans require an authorization from your primary care physician. If you are unsure whether you need a prior authorization, please contact your primary care physician or insurance company. It is your responsibility to get authorization and to know your benefits.

Should you have a medical question that needs to be directed to the nursing staff or physician, please call our office at 517-787-6838. A message will be taken and a return call will be made as soon as possible. For prescription refills, please leave a message with your name, the prescription and the name of the pharmacy you would like us to call. Please allow 24 hours for your prescription to be refilled.

In case of an after-hours emergency, please call 517.787-6500 for the on-call physician or head directly to Allegiance Hospital.

Please note that due to the obstetrical nature of our practice, Dr. Pastoriza may get called out during office hours for emergent deliveries. We make every effort to keep appointment times on schedule, and will do our best to notify you ahead of time should such an instance occur.

We look forward to meeting you.

-The Staff of Women First Health Services

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**Today's Date**:_____ **Primary Care Physician**:_____

**Patient's Name**:_____Patient Name_____ **Date of Birth**:_____

**Race**: ☐American Indian or Alaska Native ☐Asian ☐Black or African America ☐ Native Hawaiian or Other Pacific Islander ☐White

**Ethnicity**: ☐Hispanic or Latino ☐Not Hispanic or Latino **Marital Status**: ☐Married ☐Single☐Widow

**Preferred Language**:_____ **Social SecurityNo**.:_____

**Address**:_____ **City**:_____ **Zip**:_____

**Home Phone No**.:(_____)_____ **Cell Phone No**.:(_____)_____

**Email**:_____**Preferred Method of Contact**: ☐Home ☐Mobile ☐Email ☐Mail

**Employer Name**:_____ **Employer Phone No**.:(_____)_____

**Emergency Contact**:_____**Emergency Phone No**.:(_____)_____ ____

**Allergies**:_____

**Preferred Pharmacy:**_____**Pharmacy Phone No.:(_____)**_____

**Pharmacy Address:**_____

**MEDICAL INSURANCE #1:**_____ **Phone No.:(_____)**_____

**Policy No.:**_____ **Group No.:**_____

**Subscriber Name:**_____ **Subscriber Date of Birth**_____

**Subscriber's Employer:**_____ **Employer Phone No.**_____

**MEDICAL INSURANCE #2:**_____ **Phone No.:(_____)**_____

**Policy No.:**_____ **Group No.:**_____

**Subscriber Name:**_____ **Subscriber Date of Birth**_____

**Subscriber's Employer:**_____ **Employer Phone No.**_____

WFHS EMPLOYEE VERIFICATION INITIALS_____

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# AUTHORIZATION / RESPONSIBILITY AGREEMENT

I give Women First Health Services the legal authorization to bill my medical insurance company for services provided by Women First Health Services on my behalf. I authorize payment directly to Women First Health Services. I understand it is still my responsibility to make sure the bill is paid in a reasonable time and if, for any reason, any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill. I understand that I am financially responsible to Women First Health Services for charges not covered by this assignment. I understand that it is my responsibility to obtain referrals as required by my insurance plan. I further agree in the event of non-payment, to bear the cost of collection, and / or court costs and reasonable legal fees should this be required. I authorize Women First Health Services to release any information regarding my medical history, symptoms, treatment, examination results or diagnosis to any of my insurance companies in order to process a claim for benefits and payment. A photocopy of this authorization shall be considered as effective and valid as the original.

**I understand I will be charged a no show fee for broken appointments without 24 hours notice.**

**IF PATIENT IS UNDER THE AGE OF 18, THIS FORM MUST ALSO BE SIGNED BY A PARENT OR LEGAL GUARDIAN!**

**PATIENT NAME:___Patient Name_____**

**PATIENT SIGNATURE:_____DATE:_____**

**PARENT/LEGALGUARDIAN SIGNATURE_____**

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NAME: Patient Name _____ BIRTH DATE: ____/____/_____ DATE: ____/____/____

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

HOME TEL: ( ) _____ WORK TEL: ( ) _____

INSURANCE: _____ PHARMACY _____

NAME OF SPOUSE/PARTNER: _____ REFERRED BY: _____

REASON FOR TODAY'S VISIT: _____

REVIEW OF SYSTEMS

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN

| 1. CONSTITUTIONAL | CURRENTLY | PAST | NOTES |
|---|---|---|---|
| Weight loss | ☐ | ☐ | |
| Weight gain | ☐ | ☐ | |
| Fever | ☐ | ☐ | |
| Fatigue | ☐ | ☐ | |
| **2. EYES** | | | |
| Double vision | ☐ | ☐ | |
| Spots before eyes | ☐ | ☐ | |
| Vision changes | ☐ | ☐ | |
| **3. ENT/MOUTH** | | | |
| Ear aches | ☐ | ☐ | |
| Ringing in ears | ☐ | ☐ | |
| Sinus problems | ☐ | ☐ | |
| Sore throat | ☐ | ☐ | |
| Mouth sores | ☐ | ☐ | |
| Dental problems | ☐ | ☐ | |
| **4. CARDIOVASCULAR** | | | |
| Painful breathing | ☐ | ☐ | |
| Chest pain | ☐ | ☐ | |
| Difficult breathing on exertion | ☐ | ☐ | |
| Swelling of legs | ☐ | ☐ | |
| Palpitations of heart | ☐ | ☐ | |
| **5. RESPIRATORY** | | | |
| Wheezing | ☐ | ☐ | |
| Spitting up blood | ☐ | ☐ | |
| Shortness of breath | ☐ | ☐ | |
| Cough, chronic | ☐ | ☐ | |

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PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN

| | | | |
|---|---|---|---|
| **6. GASTROINTESTINAL** | | | |
| Diarrhea, frequent | ☐ | ☐ | |
| Bloody stool | ☐ | ☐ | |
| Nausea/vomiting | ☐ | ☐ | |
| Constipation | ☐ | ☐ | |
| **7. GENITOURINARY** | | | |
| Blood in urine | ☐ | ☐ | |
| Pain with urination | ☐ | ☐ | |
| Urgency | ☐ | ☐ | |
| Frequency of urination | ☐ | ☐ | |
| Incomplete emptying | ☐ | ☐ | |
| Stress incontinence | ☐ | ☐ | |
| Abnormal periods | ☐ | ☐ | |
| Painful intercourse | ☐ | ☐ | |
| **8. MUSCULOSKELETAL** | | | |
| Muscle weakness | ☐ | ☐ | |
| **9. SKIN/BREAST** | **CURRENTLY** | **PAST** | **NOTES** |
| Pain in breast | ☐ | ☐ | |
| Discharge | ☐ | ☐ | |
| Masses | ☐ | ☐ | |
| Rash | ☐ | ☐ | |
| Ulcers | ☐ | ☐ | |
| **10. NEUROLOGICAL** | | | |
| Dizziness | ☐ | ☐ | |
| Seizures | ☐ | ☐ | |
| Numbness | ☐ | ☐ | |
| Trouble walking | ☐ | ☐ | |
| **11. PSYCHIATRIC** | | | |
| Depression | ☐ | ☐ | |
| Crying, frequent | ☐ | ☐ | |
| **12. ENDOCRINE** | | | |
| Dry skin | ☐ | ☐ | |
| Abnormal thirst | ☐ | ☐ | |
| Hot flashes | ☐ | ☐ | |
| **13. HEMATOLOGIC/LYMPHATIC** | | | |
| Bruises, frequent | ☐ | ☐ | |
| Cuts do not stop bleeding | ☐ | ☐ | |
| Enlarged lymph nodes | ☐ | ☐ | |
| **14. ALLERGIC/IMMUNOLOGIC** | | | |
| Allergies | ☐ | ☐ | |
| Drugs, other | ☐ | ☐ | |

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Patient Name

PERSONAL PAST HISTORY

| MAJOR ILLNESSES | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Asthma | | | Cancer | | |
| Pneumonia | | | Ulcers | | |
| Chronic Lung Disease | | | Depression/anxiety | | |
| Kidney Infections/stones | | | Anemia/Blood transfusions | | |
| Tuberculosis | | | Seizures/convulsions/epilepsy | | |
| Venereal Disease | | | Bowel trouble | | |
| Heart Trouble/murmur | | | Glaucoma | | |
| Diabetes | | | Arthritis/joint pain | | |
| High Blood Pressure | | | Fracture | | |
| Stroke | | | Hepatitis/Yellow jaundice | | |
| Rheumatic Fever | | | Thyroid Disease | | |

| OPERATIONS/HOSPITALIZATIONS | | | |
|---|---|---|---|
| Reason | Date | Reason | Date |
| | | | |
| | | | |
| | | | |

| INJURIES/ILLNESSES | | | |
|---|---|---|---|
| Type | Date | Type | Date |
| | | | |
| | | | |
| | | | |

| LAST IMMUNIZATION OR TEST | | | |
|---|---|---|---|
| | Date | | Date |
| Tetanus | | Pneumonia | |
| Flu Shot | | TB Skin Test | |

| OB/GYN HISTORY | | | |
|---|---|---|---|
| | Number | | Number |
| Births | | Abortions | |
| Miscarriages | | Living children | |

| CURRENT MEDICATIONS | | | |
|---|---|---|---|
| Drug Name | Dosage | Drug Name | Dosage |
| | | | |
| | | | |
| | | | |
| | | | |

Patient Name

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FAMILY HISTORY

| Illness | Yes | Relative | Illness | Yes | Relative |
|---|---|---|---|---|---|
| Diabetes | | | Drinking Problem | | |
| Stroke | | | Breast Cancer | | |
| Heart Disease | | | Colon Cancer | | |
| High Blood Pressure | | | Ovarian Cancer | | |

SOCIAL HISTORY

| Habits | | | | | | |
|---|---|---|---|---|---|---|
| Smoking | Yes ☐ | No ☐ | Packs per day_____ | Years_____ | | |
| Alcohol | Yes ☐ | No ☐ | Drinks per day_____ | Drinks per week_____ | | |
| Drug Use | Yes ☐ | No ☐ | | | | |
| Seat Belt Use | Yes ☐ | No ☐ | | | | |
| Regular Exercise | Yes ☐ | No ☐ | | | | |

| Personal Profile | | | | | | | |
|---|---|---|---|---|---|---|---|
| Marital Status | Married ☐ | Single ☐ | Widowed ☐ | Divorced ☐ | | | |
| Number of Living Children_____ | | | | | | | |
| Number of people in household_____ | | | | | | | |
| School Completed | High School ☐ | College ☐ | Graduate Degree ☐ | Other ☐ | | | |
| Current or most recent job_____ | | | | | | | |

Completed by: Patient ☐ Office Nurse ☐ Physician ☐

Signature of patient:_____

Date reviewed by physician with patient:_____

Physician Signature:_____

Annual Review of History

Date reviewed:_____ Physician Signature:_____

Date reviewed:_____Physician Signature:_____

Date reviewed:_____Physician Signature:_____

Date reviewed:_____Physician Signature:_____

Today's Date:_____ Primary Care Physician:_____

Patient's Name: Patient Name_____ Date of Birth:_____

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## Medical Information (HIPAA) Permission

Patient Name: DOB:

Situations may arise when we are unable to reach you personally. We would like to know your wishes about giving medical information about you to others.

Please list below those who may receive medical information regarding such things as your appointments, test results, referral appointments, etc.

**Name:** [] **Relationship:** []

**Name:** [] **Relationship:** []

**Name:** [] **Relationship:** []

May Women First Health Services leave voice messages regarding your *appointments*?
Yes ☐ No ☐

May Women First Health Services leave voice messages regarding *test results*?
Yes ☐ No ☐

# HIPPA Omnibus Notice of Privacy Practices

**Revised 2013**
**Effective as of April 14, 2013**

**Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.**

**Acknowledgment Form**

Sign_____

Printed Name_____

Date_____ Witnessed_____

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# LAB WORK

Please notify us of any special instructions that you may have for your **LAB WORK**. As a general rule, most lab work is sent to Allegiance Hospital. If you or your insurance company require your lab work to be sent to any other location, it is necessary to inform us **PRIOR** to labs being sent out.

We are not responsible for labs being sent to the wrong location, If not specified at the time of service.

Patient Name: Patient Name

Patient Signature: Date: