



LEGAL NAME _____
Last _____ *First* _____ *MI* _____

Mailing Address _____
Street _____ *Apt No.* _____ *City* _____ *State* _____ *Zip* _____

Telephone Home: () _____ **Work :** () _____ **Cell:** () _____

Date of Birth: _____ **Age:** _____ **SSN:** _____

Marital Status: M D S W **Student?** Yes or No **School:** _____

Employer: _____ **Title:** _____

SPOUSE OR PARENT/GUARDIAN INFORMATION

LEGAL NAME _____
Last _____ *First* _____ *MI* _____

Mailing Address _____
Street _____ *Apt No.* _____ *City* _____ *State* _____ *Zip* _____

Telephone Home: () _____ **Work :** () _____ **Cell:** () _____

Date of Birth: _____ **Age:** _____ **SSN:** _____

Employer: _____ **Title:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Company Name _____ **Effective Date:** _____

Mailing Address _____
Street _____ *City* _____ *State* _____ *Zip* _____

Telephone: _____ **ID #:** _____ **Group #:** _____

Subscriber _____
Last _____ *First* _____ *MI* _____

Date of Birth: _____ **SSN:** _____

Employer: _____ **Relationship to Subscriber** _____

SECONDARY INSURANCE

Company Name _____ **Effective Date:** _____

Mailing Address _____
Street _____ *City* _____ *State* _____ *Zip* _____

Telephone: _____ **ID #:** _____ **Group #:** _____

Subscriber _____
Last _____ *First* _____ *MI* _____

Date of Birth: _____ **SSN:** _____

Employer: _____ **Relationship to Subscriber** _____

Referred by: _____ **Primary Care Physician:** _____

I hereby authorize payment of surgical and/or medical benefits if any, otherwise payable to me, directly to Colorado Obstetrics & Women's Health for services rendered. I understand that I am responsible for all Medical Bills incurred and all collection expenses that may become necessary to collect those bills. By my signature, I understand and agree to the terms set forth therein.

Patient Signature: _____ **Date:** _____

I hereby authorize the release of pertinent medical information in the possession of the physician to my insurance agency listed above for the processing of and insurance claims.

Patient Signature: _____ **Date:** _____

FOR EXISTING PATIENTS: In lieu of filling out a new patient information sheet, please verify your address and insurance information is the same as shown above. I have reviewed the above information and I hereby certify, by signing and dating this document, that the above information is true and accurate.

Patient Signature: _____ **Date:** _____



Patient Consent Form & Acknowledgment of Notice of Privacy Practices

I understand I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand by signing this consent, I authorize Colorado Obstetrics & Women's Health to use and disclose my protected health information to carry out:

- Treatment (including direct and/or indirect treatment by other healthcare providers).
- Obtaining payment from third party payers, for example my insurance carrier.
- Day to day healthcare operations of the practice of Colorado Obstetrics & Women's Health.

I have been informed of and given the opportunity to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of the notice and I may contact the office at any time to obtain the most current copy of the Notice of Privacy Practices

I understand I have the rights to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to the requested restriction. However, if you do agree, you are bound to comply with the restriction.

I understand I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the revocation is not affected.

Printed Name: _____

Signature: _____ **Date:** _____



This is an agreement between Colorado Obstetrics & Women's Health and the responsible party.

Please read this document **CAREFULLY** and initial each section.

Late Policy (Physician):

All efforts are made to keep the physicians schedule on time; therefore, if you are more than 15 minutes late, every effort will be made to fit you into the schedule. There is no guarantee that you will be seen immediately. If your physician's schedule is full, you will be asked to reschedule your appointment.

When the physician is called out for an emergency or a delivery of a baby, every effort is made to give you enough notice so that the appointment can be rescheduled. However, there may be times when you are present in the office and the appointment will need to be rescheduled. Every effort is made to accommodate your schedule when rescheduling your appointment. We appreciate your understanding.

Initials

Late Policy (Ultrasound):

All efforts are made to keep our sonographers schedule on time; therefore, we ask that you please arrive 15 minutes early for your appointment. If you are more than 15 minutes late, you will be asked to reschedule your appointment.

Initials

Missed Appointments:

As a courtesy, we try to call you 1-2 business' days prior to your appointment. If a patient is unable to attend a scheduled appointment, a 24 hour advance notification is required. Patients may leave a cancellation message with the answering service during the weekend or holiday hours. Otherwise, cancellations should be made during regular business hours. In case of extraordinary circumstances that arise within 24 hours of appointment, which prevent the keeping of an appointment, the patient is expected to call and inform the practice that she will be missing her appointment. Abusive missed appointments more than 3 (three) times will result in a \$25.00 cancellation fee as of May 1, 2007. Continued abusive missed appointments may result in dismissal from the practice.

Initials

Payment Policy:

Our office will file the claims to your insurance carrier after your visit. After the claim has processed, the balance will be adjusted according to your contract. If there is a balance due, as determined by your insurance, you will be responsible to pay that balance upon notification. If the balance is not paid within 90 days, your account will be forwarded to a collection agency. As of July 1, 2007, Colorado Obstetrics & Women's Health will no longer be accepting checks as a viable method of payment. Payments may be made by cash, Visa, MasterCard, Discover, or American Express only. Payments made with a check prior to July 1, 2007 will be subject to a \$25.00 fee for any checks returned by the bank. This fee is due when billed, or at the patient's next appointment, whichever comes first. If payment is not made prior to the appointment, you will be rescheduled.

Initials

Annual/Well Woman Exams:

Many insurance plans including Medicare and Medicaid do not cover routine preventive health services (that is physical examinations and other screening examinations). You need to be familiar with your particular plan's covered and non-covered services. Our physicians believe that yearly physical examinations are essential in providing you the best health care possible, regardless of your insurance benefits. Please understand that we will not code a preventive health visit as anything else in order to have your insurance pay. This is considered insurance fraud.

Initials

Referrals:

When your insurance plan requires a referral or authorization from your primary care physician, it is your responsibility to request and verify the initial referral has been received. Otherwise, your appointment may be rescheduled. You will be responsible for the payment of the office visit and any additional tests if the referral is not properly obtained.

Initials

Diagnostic Testing:

Please be aware that fees for diagnostic testing are in addition to the fees for the office visit.

Initials

I have read and I understand the above information.

Printed Name: _____

Signature: _____ **Date:** _____



Patient Name _____ **DOB:** _____

An authorization for release of medical records authorizes our office to discuss and disclose medical information to designated individuals. You may permit individuals, other than yourself, access to this information. You may also deny other individuals from receiving this information.

Please check one of the two boxes listed below.

- I would prefer that information not be given to anyone other than myself.

Patient Signature: _____ **Date:** _____

OR

I hereby authorize the release of information regarding my treatment at this office, including information regarding my illness, test results, and bills to the individuals listed below. I will hold Colorado Obstetrics & Women's Health harmless, for complying with this "Authorization for Release of Medical Information". I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law. I understand that disclosure of information to a party other than the one(s) listed below is forbidden without additional authorization on my part.

Name: _____

Relationship to Patient: _____

Patient Signature: _____ **Date:** _____

Name: _____

Relationship to Patient: _____

Patient Signature: _____ **Date:** _____

Name: _____

Relationship to Patient: _____

Patient Signature: _____ **Date:** _____

Name: _____

Relationship to Patient: _____

Patient Signature: _____ **Date:** _____



Dear Patient,

Your appointment today may require the collection of one or more specimens. All specimens will be sent to an outside laboratory for analysis. We will try to ensure that the specimen(s) are sent to a laboratory that is contracted through your insurance company. There will be outside fees associated with these procedures. Any laboratory fees will be billed to your respected insurance plan. You may receive a bill for those services provided by the laboratory.

Specimens that are collected and sent out for analysis include:

- Pap Smears
- Biopsies
- Tissue Samples
- Genital Culture(s)
- Urine Samples
- Blood Samples

If there is a particular laboratory you would like your specimens forwarded to, please inform us below:

I wish for my specimens to be sent to: _____

Reason(s) for specimens to be sent to this laboratory: _____

I have read and I understand the above information.

Printed Name: _____

Signature: _____ **Date:** _____



Patient Name: _____ **DOB:** _____

1. Current Medications None

2. Medication Allergy(s) None

**3. Medical History - Family
Problems/Issues**

	Family Member (Whom?)	Type
Anemia/Blood Disorders/HIV/AIDS	<input type="checkbox"/>	_____
Birth Defects/ Inherited Disease	<input type="checkbox"/>	_____
Breast Problems	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	_____
Female/ Sexual Problems	<input type="checkbox"/>	_____
Heart Disease/ MVP	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	_____
Liver Disease/ Hepatitis	<input type="checkbox"/>	_____
Sexual Abuse/ Domestic Violence	<input type="checkbox"/>	_____
Stomach/ Bowel/ Gallbladder	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	_____
Thyroid Problems	<input type="checkbox"/>	_____
Other Medical Problems	<input type="checkbox"/>	_____

**4. Medical History - Personal
Problems/Issues**

	Yes	Type
Abdominal/ Intestinal		
Appendectomy	<input type="checkbox"/>	_____
Bloody Stools	<input type="checkbox"/>	_____
Colon Polyps	<input type="checkbox"/>	_____
Constipation	<input type="checkbox"/>	_____
Diarrhea	<input type="checkbox"/>	_____
Diverticuli	<input type="checkbox"/>	_____
Gallbladder	<input type="checkbox"/>	_____
GERD	<input type="checkbox"/>	_____
Hemorrhoids	<input type="checkbox"/>	_____
Hiatal Hernia	<input type="checkbox"/>	_____
Jaundice	<input type="checkbox"/>	_____
Liver Disease/ Hepatitis	<input type="checkbox"/>	_____
Ulcers	<input type="checkbox"/>	_____
Birth Defects/ Inherited Disease	<input type="checkbox"/>	_____



Patient Name: _____ DOB: _____

Blood/ Heart/ Vessels

- Anemia _____
- Arrhythmias _____
- Blood Clots _____
- Blood Pressure – High/ Low _____
- Blood Transfusion _____
- Chest Pain _____
- Heart Attack _____
- High Cholesterol _____
- HIV/AIDS _____
- Valve Problems/ Murmur _____

Breast Problems

- Fibrocystic Breast _____
- Breast Biopsies _____

Brain/ Nervous System

- Depression _____
- Dizziness _____
- Migraine Headaches _____
- Multiple Sclerosis _____
- Seizures _____
- Shingles _____
- Sleep Problems _____
- Stroke _____

Cancer Type? _____

Female/ Sexual Problems

- Adhesions _____
- Endometriosis _____
- Fibroids _____
- History of Chlamydia _____
- History of Gonorrhea _____
- History of Herpes _____
- History of Syphilis _____
- Infertility _____
- Ovarian Cyst(s) _____
- Pelvic Inflammatory Disease _____
- Poly-cystic Ovary Syndrome _____

Head/ Neck

- Ears/ Hearing _____
- Rheumatic Fever _____
- Seasonal Allergies _____
- Teeth _____
- Throat _____
- Vision _____



Patient Name: _____ **DOB:** _____

Hormones

- Adrenal _____
- Diabetes Type 1 or Type 2 Insulin? _____
- Insulin Resistance _____
- Pituitary Thyroid _____
- Thyroid _____

Respiratory

- Asthma _____
- Emphysema, COPD _____
- Mononucleosis _____
- Pneumonia _____
- Tuberculosis _____

Sexual Abuse/ Domestic Violence

Do you feel safe at home? _____

Skin/ Skeletal/ Muscle

- Arthritis _____
- Bone Fractures/Breaks _____
- Eczema _____
- Excess Hair _____
- Osteoporosis/ Osteopenia _____
- Restless Leg Syndrome _____
- Skin Growth/Moles/Cancer _____

Urinary

- Blood in Urine _____
- Frequent Urinary Infections _____
- Incontinence _____
- Kidney Stones _____

Other Medical Problems _____

5. Hospitalizations/ Surgeries

MONTH/YEAR	ILLNESS/OPERATION	COMPLICATIONS?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



Patient Name: _____ DOB: _____

6. Menstrual History

First Day of LMP: _____ Abnormalities: Cramping/ Pain
 Interval (Days between periods) _____ days Discharge
 Menarche: (Age when periods started) _____ Excessive Bleeding
 Length of Period _____ days PMS

If Menopausal:

When did Menopause start: _____ On HRT's? YES NO

7. Current Contraceptive

BC Pills BC Patch BC Ring Condom Diaphragm Sponge
 IUD Implanon Vasectomy Tubal Ligation Spermicide Other

8. Contraceptive History

BC Pills BC Patch BC Ring Condom
 Diaphragm Sponge IUD Yr? _____ Implanon Yr? _____
 Vasectomy Tubal Ligation Yr? _____ Spermicide Norplant Yr? _____

9. Pregnancy History

of Pregnancies _____ # Induced Abortions _____ # Miscarriages _____
 # of Premature Births _____ # of Multiple Births _____ # of Living Children _____

Name	Birthdate	Gest. Weeks	Hrs in Labor	Birth Wt	M/F	Vag/ CS	Anes.
1.							
Complications?	<i>Hypertension?</i> <input type="checkbox"/>	<i>Pre-Eclampsia?</i> <input type="checkbox"/>	<i>Fetal Abnormalities?</i> <input type="checkbox"/>	<i>Pre-term Labor?</i> <input type="checkbox"/>	<i>Gestational Diabetes?</i> <input type="checkbox"/>		
2.							
Complications?	<i>Hypertension?</i> <input type="checkbox"/>	<i>Pre-Eclampsia?</i> <input type="checkbox"/>	<i>Fetal Abnormalities?</i> <input type="checkbox"/>	<i>Pre-term Labor?</i> <input type="checkbox"/>	<i>Gestational Diabetes?</i> <input type="checkbox"/>		
3.							
Complications?	<i>Hypertension?</i> <input type="checkbox"/>	<i>Pre-Eclampsia?</i> <input type="checkbox"/>	<i>Fetal Abnormalities?</i> <input type="checkbox"/>	<i>Pre-term Labor?</i> <input type="checkbox"/>	<i>Gestational Diabetes?</i> <input type="checkbox"/>		
4.							
Complications?	<i>Hypertension?</i> <input type="checkbox"/>	<i>Pre-Eclampsia?</i> <input type="checkbox"/>	<i>Fetal Abnormalities?</i> <input type="checkbox"/>	<i>Pre-term Labor?</i> <input type="checkbox"/>	<i>Gestational Diabetes?</i> <input type="checkbox"/>		
5.							
Complications?	<i>Hypertension?</i> <input type="checkbox"/>	<i>Pre-Eclampsia?</i> <input type="checkbox"/>	<i>Fetal Abnormalities?</i> <input type="checkbox"/>	<i>Pre-term Labor?</i> <input type="checkbox"/>	<i>Gestational Diabetes?</i> <input type="checkbox"/>		



Patient Name: _____ DOB: _____

10. Lifestyle

What is your marital status? _____

With whom do you live with? _____

What is your occupation? _____

Do you follow a nutritional diet? YES NO _____

Do you have any pets? YES NO Type? _____

Do you use a seatbelt when driving? YES NO _____

Are you sexually active? YES NO Is intercourse painful for you? YES NO

Date of Last Pap _____ Results? _____

History of Abnormal Paps? _____ Treatment: _____

Date of Last Mammogram _____ Results? _____

Do you Perform a Monthly Breast Exam? YES NO

Do you exercise regularly? _____ Type _____ Hrs per Week _____

Do you drink Alcohol? _____ Type _____ How often? _____

Do you drink Caffeine? _____ Type _____ How often? _____

Do you use illegal drugs? _____ Type _____ How often? _____

Current Tobacco Use? YES NO # of Years _____

Cigarettes Per Day _____ Packs Per Day _____

Previous Tobacco Use? YES NO # of Years _____

Cigarettes Per Day _____ Packs Per Day _____