PATIENT INFORMATION

TODAY'S DATE _____ PREFERRED PHARMACY_____LOCATION_____

PATIENT'S NAME _____ DATE OF BIRTH _____ SS# _____

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

RACE ☐ AFRICAN-AMERICAN ☐ ASIAN ☐ CAUCASIAN ☐ NATIVE HAWAIIAN
☐ AMERICAN INDIAN ☐ HISPANIC ☐ OTHER _____

ETHNICITY_____ PREFERRED LANGUAGE_____

ADDRESS _____ CITY _____ STATE _____ ZIP_____

HOME PHONE _____ CELL PHONE _____ WORK PHONE_____

PRIMARY PHONE _____ EMAIL_____

PREFERRED CONTACT FOR APPOINTMENT REMINDERS **PLEASE CIRCLE ONE** CELL HOME TEXT EMAIL PATIENT PORTAL

SPOUSE'S NAME _____ DATE OF BIRTH _____ SS# _____
(OR RESPONSIBLE PARTY)

FAMILY DOCTOR _____ PREVIOUS OB/GYN SEEN _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

DO YOU HAVE A LIVING WILL? _____ DO YOU HAVE A DURABLE POWER OF ATTORNEY? _____

EMPLOYER INFORMATION

PLEASE CIRCLE ONE

PATIENT'S EMPLOYER _____ FULL TIME PART TIME UNEMPLOYED RETIRED

SPOUSE'S EMPLOYER _____ FULL TIME PART TIME UNEMPLOYED RETIRED
(OR RESPONSIBLE PARTY)

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT _____ RELATIONSHIP TO PATIENT _____

PHONE NUMBER _____

I hereby authorize The Center for Women, Inc. to apply for benefits on my behalf for services rendered by them or by their order. I request payment from my insurance company to be made directly to The Center for Women, Inc. I certify that the information reported with regard to my insurance coverage is correct. If my insurance does not cover the cost of any services, I agree to be fully responsible for them. If I default on any payment, I will be responsible for collection costs including but not limited to collection agency fees, court costs, and reasonable attorney fees incurred to collect this debt. I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of the original.

I have read, fully understand and agree to the above

SIGNATURE _____ DATE _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule give individuals the right to request a restriction on uses and disclosures of their protected heath information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. I acknowledge that I have received The Center for Women's Rights and Responsibilities policy and have been offered a copy of the entire HIPAA privacy notice. This notice is also available at all times in The Center for Women's waiting room and I may request an additional copy of it at any time by contacting the Office Manager at 330-702-1281.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home Telephone
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call back number only
- ☐ Work Telephone
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call back number only
- ☐ Written Communication
  - ☐ OK to mail to my home address
  - ☐ OK to mail to my work address
- ☐ Other _____

YOU MAY DISCUSS MY HEALTH INFORMATION WITH:

NAME	RELATIONSHIP	PHONE

_____ _____
Patient Signature Date

_____ _____
Printed Name Date of Birth

THE CENTER OF WOMEN

PATIENT ADVOCACY PROGRAM

The doctor and patient are desirous of entering into and/or maintaining a positive physician/patient relationship that focuses on quality patient care and open lines of communication. The parties to this agreement shall agree to pursue a good faith effort to resolve any problems that may arise between them. As a part of entering into the physician/patient relationship, the patient agrees to submit in writing to the MaternOhio Mediation Program, any dispute, controversy or disagreement arising out of or relating to the physician/patient relationship and the agreement to provide medical services.

1. After the matter has been presented in writing to the MaternOhio Mediation Program, the parties shall use negotiation in an attempt to reach a voluntary resolution of their differences.

2. If the dispute, controversy or disagreement is not resolved in a reasonable time, then the matter shall be submitted to mediation in accordance with the MaternOhio Mediation Program Rules of Procedure.

   Mediation is a process in which a neutral third party helps the doctor and the patient discuss the issues that have arisen between them with the ultimate goal of resolving any problems. Either party is entitled to seek legal respresentation at any time, but MaternOhio wishes to provide the patient with the opportunity to settle any problems that may have arisen without the need to incur additional costs and fees.

   These Mediation Rules of Procedure provide in part that:

   - The patient is not required to reach a resolution in mediation.
   - The mediator (or comediators) will be a neutral third party who is trained in mediation.
   - All mediation sessions are considered confidential as defined in Ohio Revised Code 2317.023.
   - MaternOhio will pay the costs of the mediation.
   - The date, time and place of any mediation session shall be scheduled by the mediator in consultation with the parties.
   - The use of mediation does not preclude either party from pursuing any other remedies that may be available to them.
   - Any agreements reached by the parties shall be in writing and signed by both parties.
   - Parties considering negotiation or mediation should remember that any decisions may affect their legal rights. Mediation is not a substitute for legal advice. Parties should consult with their legal counsel for any questions regarding legal rights.

It is the goal of MaternOhio Management, Inc. that all physicians and patients engage in a cooperative approach to ensure quality healthcare and that any conflicts that may arise between them will be resolved in the same cooperative style through mediation.

Patient Signature _____ Date _____

Witness _____ Date _____

THE CENTER FOR WOMEN, INC.
4139 BOARDMAN-CANFIELD ROAD • CANFIELD, OH 44406
PHONE (330) 702-1281 • FAX (330) 702-1287

NEW PATIENT FORM

PATIENT NAME: _____ DOB: _____ AGE: _____ DATE: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

REASON FOR VISIT: _____

PAST MEDICAL HISTORY: Check if YOU have ever had or been diagnosed with any of the following:

☐ Alcoholism	☐ Fibroids	☐ Kidney Stones
☐ Anemia	☐ Gallbladder Disease	☐ Mental Illness
☐ Anxiety	☐ Gonorrhea	☐ Other STDs
☐ Bleeding/Clotting Disorders	☐ Heart Attack	☐ Ovarian Cysts
☐ Blood Transfusion	☐ Heart Disease	☐ Pelvic Pain
☐ Breast Disease	☐ Heart Murmur	☐ Polycystic Ovaries
☐ Cancer - Type?	☐ Hepatitis	☐ Pulmonary Embolus
☐ Cervical Dysplasia	☐ Herpes	☐ Reflux
☐ Chlamydia	☐ High Blood Pressure	☐ Stroke
☐ Deep Vein Thrombosis	☐ High Cholesterol	☐ Suicide Attempt
☐ Depression	☐ HPV	☐ Syphilis
☐ Diabetes	☐ Infertility	☐ Thyroid Disease
☐ Endometriosis	☐ Irritable Bowel Syndrome	☐ Trichomonas
☐ Epilepsy/Seizures	☐ Kidney Disease	☐ Ulcer
	☐ Other	

HEALTH MAINTENANCE

Last Colonoscopy	Year	☐ Normal	☐ Abnormal
Last Cologard	Year	☐ Normal	☐ Abnormal
Last Mammogram	Year	☐ Normal	☐ Abnormal
Previous Abnormal Mammograms	☐ No	☐ Yes - When?	☐ Where?
Last Pap Smear	Year	☐ Normal	☐ Abnormal
Previous Abnormal Pap Smears	☐ No	☐ Yes - When?	☐ Treatment?
Last Bone Density Test	Year	☐ Normal	☐ Abnormal

SURGICAL HISTORY: Please check any that you have had and list date.

Date	Date	Date
☐ Appendix	☐ Hysterectomy	☐ Laparoscopy
☐ Breast	☐ Ovaries Removed	☐ Ovary
☐ Heart	☐ Left	☐ Tubal Ligation
☐ Cervix	☐ Right	☐ Tubal Reversal
☐ Gallbladder	☐ Both	☐ Vaginal Repair
☐ D&C	Reason	☐ Tonsils
☐ Cesarean Section	Type:	☐ Other
	☐ Abdominal	
	☐ Vaginal	
	☐ Laparoscopic	

GYNECOLOGICAL HISTORY: Fill in all blanks and check all that are appropriate.

Last menstrual period: _____ ☐ Not applicable due to: ☐ Menopause ☐ Hysterectomy ☐ Ablation ☐ Mirena/Lilette IUD ☐ DepoProvera ☐ Other

HPV Vaccine/Gardasil Completed: ☐ Yes ☐ No

Flow: ☐ Light ☐ Medium ☐ Heavy Clots: ☐ Yes ☐ No Severe Cramps: ☐ Yes ☐ No # of days you bleed: _____

# of days between periods: _____ (i.e. 28,30)

Breakthrough bleeding: ☐ Yes ☐ No Bleeding after Intercourse: ☐ Yes ☐ No Current Sexual Partner: ☐ Male ☐ Female

Age of first menstrual cycle: _____ Age of first intercourse: _____

Number of **NEW** sexual partners since last visit: _____ Lifetime number of sexual partners: _____

Are you currently sexually active? ☐ Yes ☐ No

Type of contraception currently used: ☐ Pills ☐ Condoms ☐ IUD ☐ NuvaRing ☐ Tubal Ligation ☐ Other _____ ☐ DepoProvera ☐ Vasectomy

Do you want STD testing? ☐ Yes ☐ No

OBSTETRICAL HISTORY:

# of Pregnancies: _____ Full Term: _____ Abortions: _____ Miscarriages: _____ Living: _____ Multiple: _____

SOCIAL HISTORY: Fill in all blanks and check all that are appropriate.

Alcohol Use:	☐ Never	☐ Current	☐ Former	Amount _____
Recreational Drug Use:	☐ Never	☐ Current	☐ Former	Amount _____
Tobacco Use:	☐ Never	☐ Current	☐ Former	Amount _____
Vape Use:	☐ Never	☐ Current	☐ Former	Amount _____

Domestic Violence: Emotional: ☐ Current ☐ Past Physical: ☐ Current ☐ Past Sexual: ☐ Current ☐ Past

Do you have a living will? ☐ Yes ☐ No

CURRENT MEDICATIONS: Please list all medications - even over-the-counter, vitamins, herbals, etc. with dosages and who prescribed

MEDICATION NAME	DOSAGE	PRESCRIBING DOCTOR

ALLERGIES TO MEDICATIONS: Please list your reaction to the medications (Write "None" if no known drug allergies)

FAMILY HISTORY Please check if any of your family members have had the following & list who had it.

Relation	Relation	Relation
☐ Breast Cancer	☐ Heart Disease	☐ Pulmonary Embolus
☐ Colon Cancer	☐ High Blood Pressure	☐ Stroke
☐ DVT	☐ Osteoporosis	☐ Birth Defects
☐ Diabetes	☐ Ovarian Cancer	☐ Mental Retardation
☐ Uterine Cancer	☐ Prostate Cancer	☐ Other

REVIEW OF SYSTEMS Please check if you are **CURRENTLY** experiencing any of these symptoms.

CONSTITUTIONAL	GASTROINTESTINAL	INTEGUMENTARY
☐ Unexplained Weight Loss	☐ Heartburn	☐ Rash
☐ Unexplained Weight Gain	☐ Nausea	☐ Skin Lesions
☐ Fever	☐ Vomiting	**NEUROLOGIC**
☐ Excessive Thirst	☐ Abdominal Pain	☐ Seizures
☐ Excessive Urination	☐ Bloating	☐ Dizziness
HEENT	☐ Diarrhea	☐ Syncope (Fainting / Passing out)
☐ Headaches	☐ Constipation	**ENDOCRINE**
☐ Problems with teeth/gums	☐ Bloody Stool	☐ Cold Intolerance
BREAST	**GENITOURINARY**	☐ Heat Intolerance
☐ Breast Lumps	☐ Pain with Intercourse	☐ Excessive Hair Growth
☐ Breast Pain	☐ Spotting with or after Intercourse	
☐ Breast Discharge	☐ Abnormal Vaginal Discharge	
☐ Changes in Skin	☐ Vaginal Dryness	
CARDIOVASCULAR	☐ Urinary Frequency	
☐ Chest Pain	☐ Urinary Urgency	
☐ Heart Palpitations	☐ Urinary Retention	
RESPIRATORY	☐ Painful Urination	
☐ Wheezing	☐ Blood in Urine	
☐ Shortness of Breath	☐ Incontinence	
☐ Cough		

Patient's Signature _____

Doctor's Signature _____