

Corridor OB GYN
Patient Health History

Office Use Only:

Ht. _____ Wt. _____
 BP _____ Pulse _____
 Gardasil Y or N Dexa _____
 Pap _____ Labs _____
 Mam _____ Colo _____

Today's Date _____ Preferred Pharmacy _____
 Name _____
 Date of Birth _____ Age _____ Partner's Name _____
 Reason for Visit _____
 Employer _____ Referred By _____

CURRENT BIRTH CONTROL Pills Condoms IUD Tubal Ligation Vasectomy Nexplanon
 Depo Other _____

RELATIONSHIP STATUS:
 Single
 Married
 Divorced
 Widowed
 Domestic - Partnership

MENSTRUAL HISTORY: 1st Day of Last Period _____ Postmenopausal
 # of days between periods _____ Length of period _____ Hysterectomy

PREGNANCY HISTORY

# of pregnancies	# of full term births	# of premature births	# of miscarriages	# of induced abortions	# of living children

BELOW DETAILS NOT NEEDED IF NO FUTURE PREGNANCIES ARE PLANNED

Born M/D/Y	# of wks pregnant	Hrs in labor	Birth weight	Baby's sex	Type of Delivery	Pain medication	Complications	Baby's Name

CURRENT MEDICATIONS (Prescription & over the counter, i.e. vitamins, etc.)

MEDICATION ALLERGIES or NONE

GYN HISTORY

Birth Control Method _____
 Are you satisfied with your birth control? Yes No
Date of last pap smear _____
 Have you ever had an abnormal pap? Yes No
 When? _____
 Have you ever had a colposcopy or LEEP? Yes No
 Have you ever had an STD or PID? Yes No
 Which STD? _____ When? _____
 Are you sexually active? Yes No
 If YES, with Men Women Both Men & Women
 Do you have pain with intercourse? Yes No
 Do you have any urinary problems? Yes No
 Do you have any breast problems? Yes No
 Do you have problems with vaginal discharge? Yes No
Have you had:
 A mammogram? Yes No When? _____
 A bone density scan? Yes No When? _____
 A colonoscopy? Yes No When? _____
 Your cholesterol checked? Yes No When? _____

PERSONAL MEDICAL HISTORY

No known medical history
 High blood pressure
 High cholesterol
 Heart disease or murmur
 Blood clot/Pulm. Embolus
 Stroke
 Diabetes (what type?) _____
 Thyroid problems
 Cancer (what type?) _____
 Depression/Anxiety
 Osteoporosis
 Asthma
 Migraine
 Other _____ [Grab

SUBSTANCE USE

Alcohol Y N
 Amt _____/week
 Tobacco
 Current every day
 Current some days
 Never
 Former
 Quit Date: _____
 Street Drugs Y N

EXERCISE

No
 Yes _____ days/week

VACCINES

HPV Tetanus
 Flu MMR

FAMILY MEDICAL HISTORY

Please indicate which Relative (M, F, S, B, GMA, GPA, etc.)
 No known medical history _____
 High blood pressure _____
 Heart disease or murmur _____
 Blood clot/Pulm. Embolus _____
 Stroke _____
 Diabetes _____
 Cancer (what type?) _____
 Other _____

SURGICAL HISTORY

Month/Year	Surgery	Complications



Account # _____

Patient Acknowledgement and Consent

Welcome to Corridor OB GYN of Iowa! We are committed to providing you with the best possible health care. The following information is provided to ensure you are aware and understand our policies.

Patient Liability We encourage you to become familiar with your health insurance plan. Each carrier has specific guidelines regarding coverage and benefits. It is **your** responsibility to understand the guidelines set by your insurance carrier. If you have benefit or coverage questions, please contact your insurance company directly. As a courtesy to our patients, we verify benefits for certain procedures. **A quote of benefits is not a guarantee of benefits or payment.** Your claim will process according to your plan. If a discrepancy exists between the benefits quoted and final payment of the claim, the terms of your insurance plan will override. We recommend you also contact your insurance carrier to check benefits.

Insurance Information We require complete and accurate insurance information to bill your insurance. If accurate information is not given to Corridor OB GYN, the patient will be responsible for any balance. In accordance with your insurance contract, payment is required at time of service.

Appointment No-Show/Cancellation When cancelling an appointment, we require advance notice of 24-hours. If the appointment is not cancelled 24-hours in advance or you do not show up for a scheduled appointment, after **three late cancels or no-shows**, you will be charged a \$25.00 no-show/late cancellation fee. This fee is not billable to your insurance, and you will be responsible for the balance due. We reserve the right to discharge patients from Corridor OB GYN for habitual abuse of this policy.

Returned Checks The charge for a returned check is \$25.00. This charge is not billable to your insurance, and you will be responsible for the balance due.

Minors A parent or legal guardian must sign the Patient Acknowledgement and Consent form. The parent or legal guardian that accompanies the minor patient to the clinic will be responsible for any payment as outlined above. It is the responsibility of the parent or legal guardian to forward any bills to other responsible parties.

Self-Pay Patients (No Insurance) Payment is due in full prior to services being rendered. If you are unable to pay at the time of your visit, your appointment will be canceled and rescheduled at a time when payment can be made.

Collections If we have not received a payment on your account after sending 3 statements and no effort is made to make alternative payment arrangements with Corridor OB GYN, your account may be turned over to an outside collection agency. Any standing appointments will be canceled. Fees incurred for sending your balance to collections will be added to your bill. This balance must be paid in full to continue your care with Corridor OB GYN.

I hereby authorize Corridor OB GYN to release necessary medical information to my insurance carrier to process all claims and hereby assign to Corridor OB GYN all payments for medical services rendered. I understand I am responsible for all amounts not covered by insurance. I further understand that copays and coinsurance are due at the time of service.

I have been offered a copy of the Notice of the Privacy Practices of Corridor OB GYN. Corridor OB GYN reserves the right to modify the privacy practices outlined in the Notice of Privacy Practices.

I understand Corridor OB GYN uses electronic prescribing. My prescriptions will be sent, and my medication information may be obtained through Corridor OB GYN electronic prescribing functionality.

I understand Corridor OB GYN will report any vaccines administered throughout my care to IRIS (Immunization Registry Information System).

Patient Signature: _____ Date: _____

(Legal Guardian/Patient Representative - required if patient is minor or adult unable to sign)

Legal Guardian Address: _____



Account # _____

Request for Confidential Communication of Protected Health Information

Patient Information:

Legal Name: _____ Preferred Name: _____ DOB: _____

Mailing Address: _____

City/State/Zip: _____

Race	Ethnicity
<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Other	<input type="checkbox"/> Hispanic/Latino
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Not Hispanic/Latino
<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Declined
<input type="checkbox"/> Native Hawaiian/Pacific Islander	

SSN: _____ Primary Number

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Email: _____

Financially Responsible/Statement Recipient: (if minor, must list parent/guardian)

Name: _____ Relationship to Patient: _____

Mailing Address: _____

City/State/Zip: _____

Emergency Contact (Please select only one option):

- Please use the contact person I provided above as my emergency contact.
- The following person may be contacted in case of an emergency:

Name: _____

Relationship to Patient: _____ Phone: _____

If we are contacted by someone that you know personally (example: parent, spouse, friend), may we release information to them? (Please select only one option.) If minor, must include parent/guardian for financial information.

- No, I prefer no information is released.
- Yes, information can be given to the contact below:

Name: _____

Relationship: _____ Phone: _____

Information to be released to alternate contact (please check any that apply):

- Medical information (including but not limited to information about STDS, pregnancy, and birth control)
- Appointment dates/times
- Financial information about my account
- Other (please specify): _____

I understand this authorization will remain in effect until I revoke or change it. I may do this at any time by contacting Corridor OB GYN in writing.

Patient Signature: _____ Date: _____

Office Use Only:

_____ Employee Initials _____ PBM Consent _____ Photo _____ Changes updated in GW _____ Portal Invite _____ Copay Flag