Thank you for scheduling your appointment with Rogue Women's Health. By following the instructions below, you will help us provide you with the best care and save you time at your appointment.

Things to do before your appointment:

- ✓ Fill out the enclosed information sheets. Answer all questions to the best of your ability.
- ✓ If able to do so – please mail, fax, or drop off completed forms to allow the possibility of having a sooner appointment date if a cancellation occurs.
- ✓ Contact your health plan regarding your benefits.
- ✓ Please check with your Primary Care Provider to be sure a **referral** is sent to us prior to your appointment if one is needed.

The day of your appointment:

- ✓ Arrive **fifteen minutes** before your scheduled appointment.
- ✓ Have your insurance card and photo ID with you.
    - If you do not have your photo ID at your appointment, your appointment may be rescheduled.
- ✓ Have your forms completed and bring with you to your visit.
- ✓ Bring any pertinent medical records with you, such as medication list.
- ✓ If you are private pay, payment is due on the day of service.

If you are unable to keep this appointment, please give our office at least a 24-hour notice. Should you have any questions or need assistance in completing any of the forms, please contact our office. Thank you for selecting us to help you with your healthcare needs.

ROGUE Women's Health

2951 Doctors Park Drive
Medford, OR 97504
Roguewomenshealth.com
Phone: 541-200-2646
Fax: 541-200-2649

Patient Name: _____Preferred Name: _____

Date of Birth: _____Social Security #: _____Sex: _____

Mailing Address: _____

Physical Address if different: _____

Phone: _____ Employer: _____

Spouse or Parent Name: _____ Relationship: _____

Date of Birth: _____Social Security #: _____Sex: _____

Phone: _____Employer: _____

Emergency Contact: _____ Relationship: _____

Phone: _____

Primary Care Provider: _____ Referred by: _____

Preferred Pharmacy Name and Address: _____

Primary Insurance: _____ Secondary Insurance: _____

ID/Policy #: _____ ID/Policy #: _____

Subscriber: _____ Subscriber: _____

Patient/Representative Signature: _____Date: _____

2951 Doctors Park Drive
Medford, OR 97504

Condition and Consent for Services Rendered

FINANCIAL AGREEMENT: I agree, whether I sign as agent or as patient, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account with Rogue Women's Health in accordance with the regular rates and terms. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collections expenses.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize, whether I sign as agent or as patient, direct payment to Rogue Women's Health of any insurance benefits otherwise payable to or on behalf of the patient for the visits or for these outpatient services at a rate not to exceed Rogue Women's Health actual charges. I understand that I am financially responsible for charges, deductibles, and co-insurance not covered by insurance.

RELEASE OF INFORMATION: I authorize Rogue Women's Health to release any information necessary to provide medical treatment to me, allow Rogue Women's Health to bill and be paid for services they provide. I understand that releasing information for any reason other than those listed above requires a separate authorization by me. I also understand that I have the right to request restrictions on the use of my health information, but Rogue Women's Health is not obligated to honor that request unless required to do so by State or Federal regulations. This consent shall be effective as long as necessary to obtain payment.

The Terms and conditions of this agreement are not binding until the patient receives care and treatment from Rogue Women's Health. The undersigned certifies that he/she has read the foregoing, and is the patient, the patient's legal representative, or is duly authorized by the patients as the patient's general agent to execute the above and accept these terms.

I authorize Rogue Women's Health and its staff, to leave detailed messages at the phone numbers provided, as well as send me text messages to confirm my appointments.

Rogue Women's Health provides a medical chaperone to any patient undergoing genital, rectal, breast, or body exams when dressed down.

Dr. Mills and FNP work collaboratively, striving to provide the best OB/GYN services at Roque Women's Health. As a patient, you must be willing to see both Dr. Mills or FNP during your appointments while understanding that accommodating a patient's request to see only one or the other is not achievable. _____ ***initials***

DATE:_____ PRINT NAME: _____

SIGNATURE: _____

(PATIENT/PARENT/CONSERVATOR/GUARDIAN)

If signed by the other than patient, indicate relationship: _____

2951 Doctors Park Drive
Medford, OR 97504

PATIENT ACKNOWLEDGEMENT OF PRIVACY PRACTICES (HIPAA)

By my signature below, I hereby acknowledge that I have received copy of Rogue Women's Health *Notice of Privacy Practices.* Rogue Women's Health is permitted to use or disclose my health information to carry out treatment, payment, or health care operations. Health information means all information relating to health care services provided to me, including information related to services provided to me prior to the date I sign the acknowledgement form.

I understand the Rogue Women's Health *Notice of Privacy Practices* explains the types of uses or disclosures that Rogue Women's Health may make and my rights with respect to my health information. I understand that if I have any questions or concerns about this Notice, I may contact the Practice Administrator at the telephone number listed below. I further understand Rogue Women's Health may change the terms of the *Notice of Privacy Practices* from time to time, and that I may contact the Administrator to obtain a revised version of the notice at any time.

Patient's Printed Name: _____

Patient's DOB: _____

Signature of Patient: _____

Date: _____

If signed by other than patient, indicate relationship:

_____

You may contact our office regarding your privacy by calling 541-200-2646.

Name:_____

Date of birth:_____

Today's date:_____

OBSTETRICAL DATABASE

First day of last menstrual cycle: _____

Partner's name:_____Is this your partner's first baby? _____

Any infertility in the past? Yes__No____If yes, explain:

_____

PAST PREGNANCIES:

	First	Second	Third	Fourth	Fifth
Date					
Live Birth	Yes No	Yes No	Yes No	Yes No	Yes No
Sex Name	Male Female	Male Female	Male Female	Male Female	Male Female
Weight					
Place of birth					
Hrs of active labor					
Any complications during pregnancy, labor or delivery (please describe)					

Are you going to: _____Breast feed?_____Bottle feed?

Is there anything about your prior pregnancy (or pregnancies), labor or deliver experiences you would or would not want repeated? (please explain)

_____

_____

_____

Is there anything else you feel your doctor should know about you, your partner or your family? _____

_____

_____

Have you had any of the following symptoms during this pregnancy that have been a significant problem for you? Yes No If yes, please explain

		Nausea:
		Vomiting:
		Fatigue:
		Abdominal pelvic pain:
		Abnormal vagina discharge:
		Sore breast/pain/lump:
		Depression:
		Urinary problems/burning/pain:
		Exposure to viral illness:
		Exposure to any drugs:
		Prescription drugs:
		Over-the-counter drugs:

Have you had any X-rays of other radiation exposure during this pregnancy? Yes___No _____

If yes, please explain: _____

_____

Name: _____

DOB: _____

Today's Date: _____

GYN History

Last menstrual period_____Last pap smear_____Last mammogram _____

Age at onset of menstruation: _____
Number of days between typical periods: _____

Are your menstrual periods usually regular? Yes No Please explain: _____

_____

What form of contraception have you used in the past? Birth control pills, IUD, Diaphragm,

DepoProvera, Norplant, Rhythm Method, Condoms or Abstinence

Number of pregnancies:_____Number of births: _____
Have you ever been treated for any sexually-transmitted diseases? Chlamydia, Gonorrhea or Herpes? _____

Have you ever had an abnormal pap? If yes, please explain: _____

Irregular periods **Painful periods** **Heavy periods** Tubal ligation _____

Medical Illnesses

- ⌋ **Diabetes**
- ⌋ **Heart Disease**
- ⌋ **High blood pressure**
- ⌋ **High Cholesterol**
- ⌋ **Lung disease**
- ⌋ **Ulcers**
- ⌋ **Neurological Problems**
- ⌋ **Liver disease or hepatitis**
- ⌋ **Arthritis**
- ⌋ **Tuberculosis**
- ⌋ **Cancer _____**
- ⌋ **Blood clots**
- ⌋ **Depression/Anxiety**
- ⌋ **Kidney Disease/stones**
- ⌋ **Acid reflux or hiatal hernia**
- ⌋ **Migraine**
- ⌋ **Environmental allergies**
- ⌋ **Seizures**
- ⌋ **Asthma**
- ⌋ **Osteoporosis**
- ⌋ **Thyroid disorder**
- ⌋ **STD**
- ⌋ **Other _____**

ALL Operations/Hospitalizations (includes tonsillectomy and appendectomy)

Date	Operation/Hospitalization	Complication

Severe Accidents and Injuries

_____

Allergies and Adverse Medication Reactions (please list reaction)

_____

Tobacco Use? ⌋ No ⌋ Yes Pkgs/day_____# years _____ Quit?_____Year Quit? _____

Alcohol Use? ⌋ No ⌋ Yes Drinks/day_____Drinks/week_____ ⌋ Beer ⌋ Wine ⌋ Liquor

Recreational drugs? ⌋ Yes ⌋ No

MEDICATIONS CURRENTLY TAKEN regular or occasionally. Vitamins, birth control pills, sleeping pills, pain pills, laxatives, and aspirin – with dosage

_____

_____

Flu shot	⌋ No	⌋ Yes	When_____	How often do you exercise? _____	
Tetanus	⌋ No	⌋ Yes	When_____	What is your workout? _____	
Pneumonia	⌋ No	⌋ Yes	When_____		
Hepatitis B	⌋ No	⌋ Yes	When_____	Date of last colonoscopy? _____	
Gardasil	⌋ No	⌋ Yes	When_____	Date of last endoscopy? _____	

FAMILY HISTORY

	Age of death	Age if alive	Major health problems & illnesses, OR age and cause of death
Mother			
Father			
Brothers			
Sisters			

Check if any of these illnesses run in the family

Osteoporosis	⌋ No	⌋ Yes	Cancer	⌋ No	⌋ Yes
Diabetes	⌋ No	⌋ Yes	Thyroid Disease	⌋ No	⌋ Yes
Alcoholism	⌋ No	⌋ Yes	Ulcers	⌋ No	⌋ Yes
Heart Attack	⌋ No	⌋ Yes	Mental Illness	⌋ No	⌋ Yes
Stroke	⌋ No	⌋ Yes	Blood Clots	⌋ No	⌋ Yes
			High BP	⌋ No	⌋ Yes
			TB	⌋ No	⌋ Yes

REVIEW OF SYSTEMS: Do you have, or have had in the past month, any of the following? (Place a check mark next to those you have experienced)

General
- ⌋ Recent fever
- ⌋ Weight loss
- ⌋ Weight gain
- ⌋ Night sweats
- ⌋ Loss of energy
- ⌋ Trouble sleeping

Blood
- ⌋ Easy bruising
- ⌋ Transfusions

Digestive
- ⌋ Poor appetite
- ⌋ Gas or heartburn
- ⌋ Nausea
- ⌋ Vomiting
- ⌋ Abdominal pain or cramping
- ⌋ Constipation
- ⌋ Diarrhea
- ⌋ Hemorrhoids
- ⌋ Rectal bleeding

Breasts
- ⌋ Discharge from nipples
- ⌋ Lumps
- ⌋ Breast pain

Cardiovascular
- ⌋ Chest pain
- ⌋ Leg swelling
- ⌋ Heart murmur
- ⌋ Palpitations
- ⌋ Varicose veins

Pulmonary
- ⌋ Shortness of breath
- ⌋ Wheezing
- ⌋ Cough
- ⌋ Cough up blood

Genitourinary
- ⌋ Burning or urination
- ⌋ Bloody urine
- ⌋ Incontinence
- ⌋ Infections
- ⌋ Difficulty urination
- ⌋ Urination at night # times _____
- ⌋ Multiple sexual partners

Neurological
- ⌋ Dizziness
- ⌋ Blackouts
- ⌋ Headaches
- ⌋ Depressions
- ⌋ Anxiety, excessive worry

Is there anyone that you're afraid of? _____

Source of stress? _____

Do you have an advanced directive for end-of-life?
_____

ROGUE Women's Health

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Medford, OR 97504

Authorization to Disclose Medical Information to Another Individual

I authorize the following individual(s):

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

to contact your office on my behalf, either by telephone or in person to discuss my appointments, related medical care and financial issues.

I understand that this above named individual(s) will have full access to **all** information regarding my medical care, including but not limited to medical health, mmental heath and/or drug or prescritoin histories.

I further authorize the individual(s) named above to pick up presccriptions. Once I have completed and signed a Release of Medical Information, medical records may be released to authorized individual(s).

I understand that this authorization will remain in effect until such time that I wish to revoke it, in writing to Rogue Women's Health.

DATE:_____ PRINT NAME:_____

SIGNATURE:_____

(PATIENT/PARENT/CONSERVATOR/GUARDIAN).

If signed by other than the patient, indicate relationship:_____