



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.



2951 Doctors Park Drive  
Medford, OR 97504  
Roguemenshealth.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:** \_\_\_\_\_



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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.

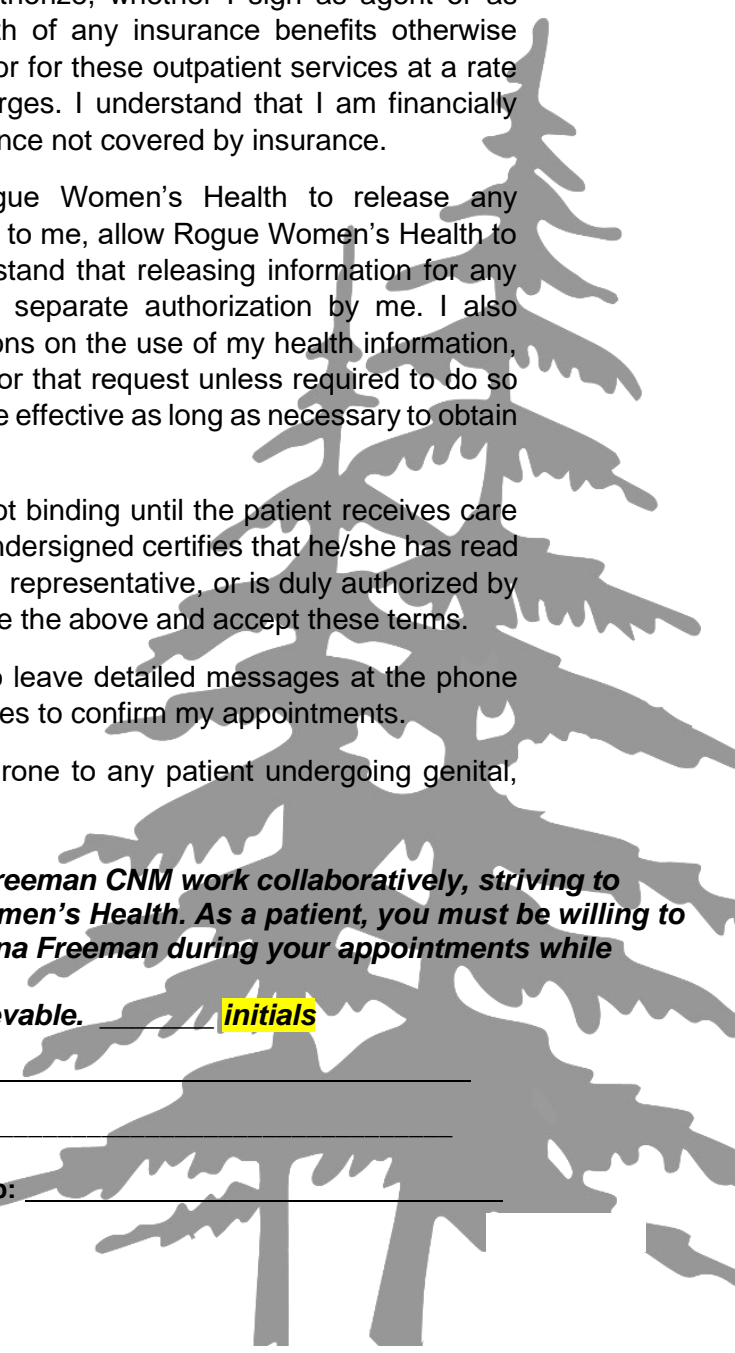
***Dr. Mills, Sarah Pedrojetti FNP, and Breyanna Freeman CNM work collaboratively, striving to provide the best OB/GYN services at Rogue Women's Health. As a patient, you must be willing to see both Dr. Mills, Sarah Pedrojetti, and Breyanna Freeman during your appointments while understanding that accommodating 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:** \_\_\_\_\_





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Medford, OR 97504

**PATIENT ACKNOWLEDGEMENT OF  
PRIVACY PRACTICES (HIPAA)**

By my signature below, I hereby acknowledge that I have received a 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:** \_\_\_\_\_

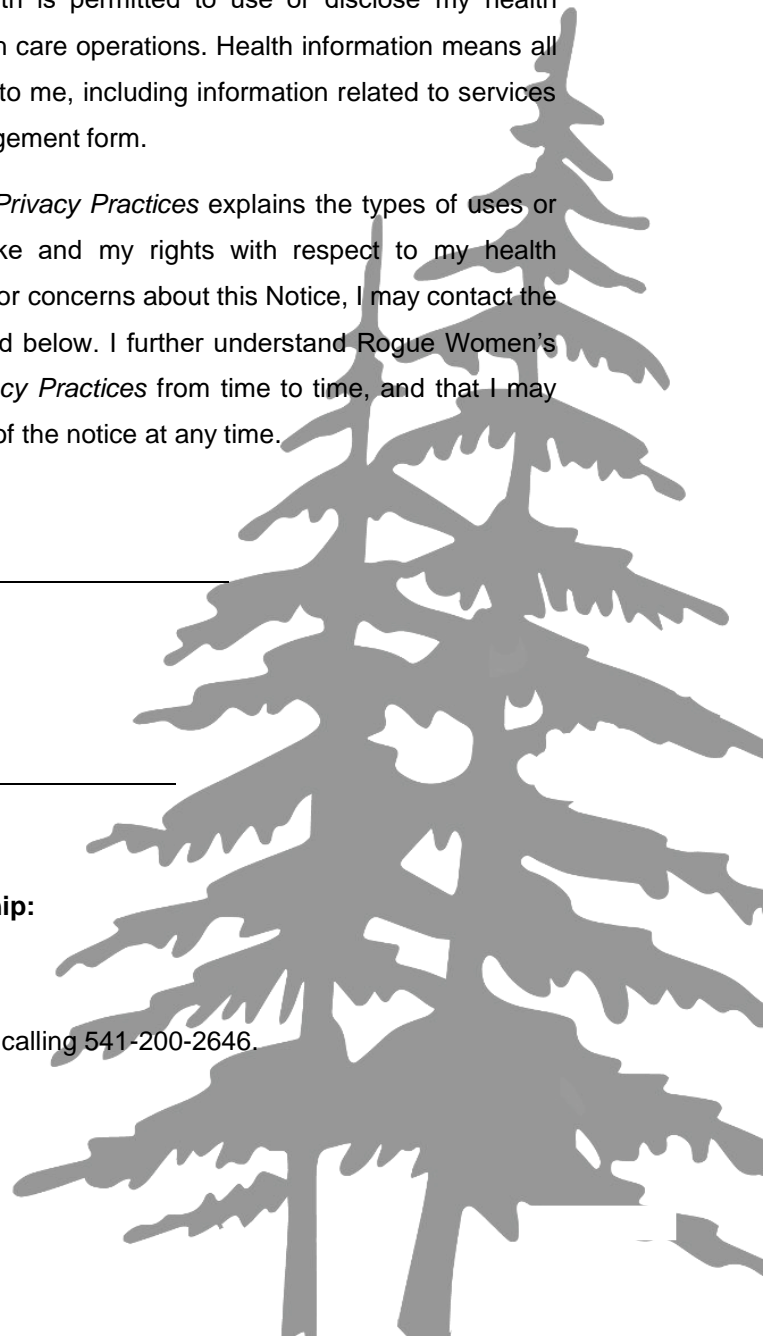
**Signature of Patient:** \_\_\_\_\_

**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: \_\_\_\_\_

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## 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	<u>Male</u>	<u>Female</u>	<u>Male</u>	<u>Female</u>	<u>Male</u>	<u>Female</u>	<u>Male</u>	<u>Female</u>	<u>Male</u>	<u>Female</u>
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**

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

**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

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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	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Thyroid Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Alcoholism	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Ulcers	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Heart Attack	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Mental Illness	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Stroke	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Blood Clots	<input type="checkbox"/> No	<input type="checkbox"/> Yes
			High BP	<input type="checkbox"/> No	<input type="checkbox"/> Yes
			TB	<input type="checkbox"/> No	<input type="checkbox"/> 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)**

<b>General</b> <input type="checkbox"/> Recent fever <input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain <input type="checkbox"/> Night sweats <input type="checkbox"/> Loss of energy <input type="checkbox"/> Trouble sleeping	<b>Breasts</b> <input type="checkbox"/> Discharge from nipples <input type="checkbox"/> Lumps <input type="checkbox"/> Breast pain	<b>Genitourinary</b> <input type="checkbox"/> Burning or urination <input type="checkbox"/> Bloody urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Infections <input type="checkbox"/> Difficulty urination <input type="checkbox"/> Urination at night # times _____ <input type="checkbox"/> Multiple sexual partners
<b>Blood</b> <input type="checkbox"/> Easy bruising <input type="checkbox"/> Transfusions	<b>Cardiovascular</b> <input type="checkbox"/> Chest pain <input type="checkbox"/> Leg swelling <input type="checkbox"/> Heart murmur <input type="checkbox"/> Palpitations <input type="checkbox"/> Varicose veins	<b>Neurological</b> <input type="checkbox"/> Dizziness <input type="checkbox"/> Blackouts <input type="checkbox"/> Headaches <input type="checkbox"/> Depressions <input type="checkbox"/> Anxiety, excessive worry
<b>Digestive</b> <input type="checkbox"/> Poor appetite <input type="checkbox"/> Gas or heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Abdominal pain or cramping <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Rectal bleeding	<b>Pulmonary</b> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Cough <input type="checkbox"/> Cough up blood	Is there anyone that you're afraid of? _____  Source of stress? _____  Do you have an advanced directive for end-of-life? _____





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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 prescricoin 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: \_\_\_\_\_

