Women's Care Center of Columbus, Inc.

Dear New Patient,

Welcome to the Women's Care Center of Columbus, Inc. We look forward to seeing you at your scheduled appointment. Please help us serve you better by completing and returning the following forms:

1. Patient Information Form-----Complete all areas, sign and date both the release authorization and the HIPAA Privacy statement at the bottom of the page.

2 Patient History Form----------Complete both pages.

3 Tuberculosis Questionnaire--Answer questions, sign and date at the bottom.

4 Financial Policy----------Read, sign and date the bottom.

To allow time to create your medical chart and have it ready for your visit, **it is necessary for you to return the enclosed forms within the next couple of days.**

At the time of your appointment please bring your photo ID showing your current address, or a photo ID with a utility bill showing your current address. Please also bring your insurance card and copay with you to your appointment, or pay in full at the time of your appointment.

We look forward to seeing you.

Sincerely,

Physicians and staff of
Women's Care Center of Columbus, Inc.

WOMEN'S CARE CENTER OF COLUMBUS, INC.

PATIENT INFORMATION

PATIENT

NAME	MARITAL STATUS	BIRTH DATE	SOCIAL SECURITY NUMBER (REQUIRED)
STREET ADDRESS	HOME PHONE		CELL PHONE
CITY/STATE/ZIP	EMAIL		
EMPLOYER	WORK PHONE		OCCUPATION
PHARMACY	EMERGENCY CONTACT & PHONE NUMBER		
PHARMACY PHONE NUMBER	FAMILY PHYSICIAN		
HOW WOULD YOU LIKE YOUR APPOINTMENT CONFIRMED? CHOOSE ONE: ___ TEXT ___ EMAIL ___CALL (CELL OR HOME?)	MAY WE LEAVE TEST RESULTS OR INFORMATION ON YOUR VOICE MAIL? __ YES __ NO MAY WE LEAVE INFORMATION WITH OTHERS ANSWERING YOUR PHONE? __ YES __ NO		

SPOUSE OR PARENT/GUARDIAN

NAME	BIRTH DATE	SOCIAL SECURITY NUMBER
STREET ADDRESS	EMPLOYER	
CITY/STATE/ZIP	WORK PHONE	OCCUPATION

INSURANCE

PRIMARY INSURANCE COMPANY NAME		
POLICYHOLDER NAME	BIRTH DATE	SOCIAL SECURITY NUMBER
POLICY ID NUMBER	GROUP NUMBER	RELATIONSHIP TO PATIENT

SECONDARY INSURANCE COMPANY NAME		
POLICYHOLDER NAME	BIRTH DATE	SOCIAL SECURITY NUMBER
POLICY ID NUMBER	GROUP NUMBER	RELATIONSHIP TO PATIENT

I authorize the release of any medical information necessary to process any claim and collect payment for the services rendered. I authorize Women's Care Center of Columbus, Inc. to apply for benefits on my behalf for covered services by my physician or her order. I request payment from my insurance company be made directly to Women's Care Center of Columbus, Inc.. I authorize Women's Care Center of Columbus, Inc. to release information to collection agencies or attorneys if necessary to recover payment for services rendered. I understand I am responsible for all charges rendered by Women's Care Center of Columbus, Inc. to me or my dependent regardless of coverage including collection and attorney fees if rendered. I permit a copy of this authorization to be used in place of the original.

Signature of Patient or Guardian_____ Date_____

I understand I may have a copy of the Women's Care Center of Columbus, Inc. Notice of Privacy Practices at any time upon request

Signature of Patient or Guardian_____ Date_____

Women's Care Center of Columbus, Inc.

History Form

☐ Jean Atwood, M.D. ☐ Britta Buchenroth, M.D.

☐ Susan Doyle, M.D. ☐ Delois Teqgue, M.D.

☐ Nicole Zochowski, M.D. ☐ Rebecca Schmitt, CNP

Name: _____ Date Completed: _____

Date of Birth: _____ Age: _____ Race: _____

Allergies: _____

Reason for visit today: _____

	Amt/Day	# Years Used
Tobacco:		
Alcohol:		
Caffeine:		

MENSTRUAL HISTORY

Last Menstrual Period: _____

Age of Onset: _____ Interval: every _____ days Duration: _____ days

Age of Menopause: _____ ☐ Natural or ☐ Surgical

Current Contraception: _____

OBSTETRICAL HISTORY (include miscarriages)

Date of Delivery	Duration of Gestation	Length of Labor	Type of Delivery	Anesth	Place of Delivery	Birth Weight	Name	Complications

MEDICATIONS

Medication	Dose	How Often Taken

Past Medical History Continued

	Patient	Family	Comments
Varicosities:			
Thyroid Dysfunctions:			
Major Accidents:			
History of Blood Transfusions:			
Respiratory Problems:			
Breast Disease:			
Arthritis:			
Tuberculosis:			
Uterine Anamolies:			
Infertility:			
In Utero DES Exposure:			
Street Drugs:			
History of Sexually Transmitted Diseases:			
History of Herpes:			
Cancer or Tumors:			
Other:			

Hospitalization/Surgery

Month/Year	Illness/Operation

History of Abnormal Pap Smear: _____

Last Pap Smear: _____

Last Mammogram: _____

Date Completed: _____

TUBERCULOSIS (TB) QUESTIONAIRE

Must be completed and returned to our office before you are seen

Patients Name_____

Date_____ SS#_____

Yes or No

1. Have you ever had been diagnosed with TB? _____
   (this question is asking if you have actually had tuberculosis-it is not asking if you have ever had a TB test)
   If yes-we need medical records verifying your non-TB status, including chest x-ray
2. Have you lived with anyone in the last two years who has been diagnosed with TB? _____
3. Have you had a persistent cough and fever for more than 2 weeks? _____
4. Have you had a persistent cough and night sweats for more than 2 weeks? _____
5. Have you had a persistent cough and loss of appetite for more than 2 weeks? _____
6. Have you been coughing up or spitting up bloody sputum (saliva)? _____

Signature of patient (or person completing this form) Date

WOMENS CARE CENTEROF COLUMBUS, INC.
1375 CHERRY WAY DRIVE SUITE 110 GAHANNA, OHIO 43230

WOMENS CARE CENTER OF COLUMBUS, INC.
PATIENT FINANCIAL POLICY ACKNOWLEDGEMENT

We are committed to providing you with the best possible medical care; if you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

- Our physicians participate with a variety of insurance plans. ***It is your responsibility to :***
    * Verify physicians participation with your insurance company.
    * Bring your insurance card at every visit. ***WITHOUT YOUR INSURANCE INFORMATION, YOU WILL NEED TO EITHER PAY FOR YOUR VISIT IN FULL AT THE TIME OF THE APPOINTMENT, OR RESCHEDULE.***
    * Be prepared to pay your coinsurance and/or deductible at each visit. Payment can be made by cash, check or credit card.
    * For medical care ***not covered*** under your insurance, ***payment in full is due at the time of visit.***
    * Pay any cost incurred if sent to collection agency/attorney.
- If you have insurance that we do not participate in, payment in full is expected at the time of service. You will receive direct payment from the insurance company.
- If the patient is a minor (18 or younger), the parent or guardian must sign below. The parent, guardian, or unaccompanied minor is responsible for any payment due at time of service, and bringing the most current insurance card.
- If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company.

Womens Care Center of Columbus, Inc. firmly believes that a good physician/patient relationship is based on understanding and good communication. ***Please sign below stating that you have read and agree to this financial policy.***

_____ _____

Signature of Patient or Responsible Party Date

_____

Print Name