New Patient – GYN – Medical History Form

Name:	Date:

Thank you for choosing Sunflower Ob-Gyn as your health care provider today! To better serve you and provide you with quality care, we ask that you complete the following questions regarding your past medical history. It is not our intention to offend any person by the content of these questions. You may choose to leave any question unanswered but please understand your responses to these questions will help us develop the appropriate plan of care.

Medical History

What is the reason for your visit today?	
Do you have any specific concerns or questions?	
Who is your primary care provider or family physician?	
Are you currently seeing any other specialists? ☐ YES ☐ NO If yes, who are you seeing?	
For what diagnosis?	

In the past at any time, have you ever had, or do you have now:	NO	YES	Date of diagnosis:	Date of treatment:
Skin Cancer				
Breast Lumps or Breast Cancer				
Other Cancers--please specify				
Cardiac Disease				
Hypertension (high blood pressure)				
Hepatitis (or Jaundice)				
Diabetes				
Asthma				
Blood transfusion (if so, what for?)				
Hypothyroidism				
Hyperthyroidism				
Epilepsy				
Physical Disabilities				
Blood Disease (sickle cell, clots, etc..)				
Tuberculosis				
High Cholesterol				
Kidney Disease				

Hospitalizations and Surgical History

Have you had any hospitalizations, procedures or surgeries? If so, please list below:

Reason for Hosp./Surgery	Dates of Occurrence	Name of Hospital

Check the box beside the symptoms you are currently experiencing:

Eyes	Ears	Cardiovascular	Respiratory
☐ Dry eyes ☐ Itching ☐ Water eyes	☐ Hearing problems ☐ Ear pain ☐ Sinus problems ☐ Sore throat	☐ Chest pain ☐ Shortness of breath ☐ Palpitations ☐ High blood pressure ☐ Swelling	☐ Coughing ☐ Wheezing ☐ Difficulty breathing ☐ Coughing up blood
Gastrointestinal	**Genitourinary**	**Breasts**	**Musculoskeletal**
☐ Abdominal pain ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Heartburn ☐ Constipation ☐ Painful bowel movements ☐ Blood in stool	☐ Pelvic Pain ☐ Abnormal bleeding ☐ No menstrual cycle ☐ Heavy menstrual cycle ☐ Vaginal odor ☐ Vaginal discharge ☐ Vaginal irritation ☐ Frequent urination ☐ Painful urination	☐ Breast Pain ☐ Breast lump ☐ Breast skin changes ☐ Nipple discharge	☐ Joint pain ☐ Joint swelling ☐ Back pain ☐ Muscle aches ☐ Scoliosis
Skin	**Neurological**	**Psychiatric**	**Endocrine**
☐ Bruising ☐ Rash ☐ Jaundice	☐ Chronic headaches ☐ Numbness ☐ Memory problems ☐ Seizures	☐ Depression ☐ Anxiety ☐ Bipolar disorder ☐ PTSD	☐ Diabetes ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Heat intolerance ☐ Cold intolerance
Blood disorders	**Allergies/Immunity**	**Constitutional**	**Any others? Please list.**
☐ Lymphadenopathy ☐ Bleeding problems	☐ Hay fever ☐ Frequent infections	☐ Fever ☐ Chills ☐ Night sweats ☐ Fatigue	☐ _____ ☐ _____ ☐ _____ ☐ _____

Gynecologic History

How old were you when you started menstruating?	
When was the first day of your last menstrual period?	
Are your menstrual cycles regular?	☐ YES ☐ NO Every_____days?
Have you been sexually active?	☐ YES ☐ NO
Have you had more than two sexual partners in your lifetime?	☐ YES ☐ NO
Have you ever been treated for a sexually transmitted infection?	☐ YES ☐ NO If yes, please circle what type: chlamydia, gonorrhea, trichomonas, herpes, HIV/AIDS, syphilis, hepatits(A,B,C), HPV, other.
If yes, approximately when were you diagnosed and treated?	
Are you using any form of birth control?	☐ YES ☐ NO If yes, please circle which type: birth control pills, IUD, implant, patch, injection, vaginal ring, other.
If no, have you had a tubal ligation or other form of sterilization?	☐ YES ☐ NO
If yes, please list:	
If no, has your partner had a vasectomy?	☐ YES ☐ NO
When was your most recent pap smear taken?	
What doctor's office was this done at?	
Have you ever had an abnormal pap smear?	☐ YES ☐ NO
Have you ever had a mammogram?	☐ YES ☐ NO
If yes, list year of most recent mammogram?	

Obstetric History

How many times have you been pregnant?	
How many living children do you have?	

Please list the number of each of the following pregnancies that you have experienced:

Vaginal Deliveries	
Cesarean Sections	
Premature Births (before 37 weeks gestation)	
Miscarriages	
Elective Abortions	
Tubal or Ectopic Pregnancies	
Do you have any history of gestational diabetes or pre-eclampsia?	☐ YES ☐ NO
Have you ever experienced complications during pregnancy or childbirth? If yes, what happened?	☐ YES ☐ NO

Have you ever struggled with mental illness?	☐ YES ☐ NO
If yes, what were you diagnosed with?	
If yes, what year(s) were you diagnosed?	
Is this something you are actively struggling with?	
Are you currently seeing a psychiatrist, therapist, or counselor?	

Family History

Has anyone in your family been diagnosed with or have a history of:	NO	YES	Who in your family was diagnosed? *(If this is an extended family member - i.e. aunt, uncle, grandparent – is this on your mother's or father's side?)*
Breast Cancer			
Cervical Cancer			
Ovarian Cancer			
Uterine Cancer			
Colon Cancer			
Diabetes			
Hypertension (High Blood Pressure)			
High Cholesterol			
Heart Disease			
Any other Cancers or Illnesses? *(Please specify which type.)*			

Personal History

How many people live in your household?	
What is your marital status?	☐ Single ☐ Married ☐ Living with Partner ☐ Widowed ☐ Divorced
Who do you prefer to have sex with?	☐ Men ☐ Women ☐ Men &Women
Highest Education Completed:	☐ High School ☐ GED ☐ Associates ☐ Bachelor's ☐ Master's ☐ PhD
Are you currently employed?	☐ YES ☐ NO
If yes, what is your current occupation?	
Have you traveled outside of the US in the past 6 months?	☐ YES ☐ NO
If yes, where did you travel?	
Do you currently smoke cigarettes?	☐ YES ☐ NO
If yes, approximately how many packs per day?	
For how many years?	
Have you ever smoked cigarettes in the past?	☐ YES ☐ NO
If yes, how long ago did you quit smoking?	
Do you use any other form of tobacco? (i.e. smokeless tobacco, e-ciggarettes, lozenges, patches, etc)	☐ YES ☐ NO
Do you drink alcohol?	☐ YES ☐ NO
If yes, how often?	
How much?	

Are you currently addicted to any street drugs or prescription opioids?	☐ YES ☐ NO
If yes, what kind?	
Have you previously used any illegal drugs?	☐ YES ☐ NO
If yes, what kind?	
How long have you been clean?	

Medications

Did you receive a flu shot this flu season?	☐ YES ☐ NO
If yes, list approximate date of flu shot:	
Have you received any other immunizations in the past 12 months?	☐ YES ☐ NO
If yes, list type and approximate date:	
Have you had the COVID-19 vaccine?	☐ YES ☐ NO
If yes, which manufacturer?	☐ Moderna ☐ J&J ☐ Pfizer
Dates you Received COVID- 19 vaccines:	1st: _____ 2nd:_____ Booster: _____
Are you currently taking any prescription medications?	☐ YES ☐ NO
If so, please list current medications with dosages and how many times per day:	_____ _____ _____ _____ _____ _____
Are you currently taking any supplements or vitamins?	☐ YES ☐ NO
If so, please list current supplements/vitamins with amounts and times taken per day:	_____ _____ _____ _____
Do you have any allergies to medications or food?	☐ YES ☐ NO
If yes, please list allergen and type of reaction that you experienced:	_____ _____ _____ _____
Do you have any allergy to latex or latex-containing products?	☐ YES ☐ NO
Preferred Pharmacy Name:	City:

Patient Demographics Form - Sunflower OB/GYN at WILLIAM NEWTON HOSPITAL

Welcome to Sunflower OB/GYN at William Newton Hospital. We appreciate the opportunity to take care of you. **Please fill out each section carefully, do NOT leave any sections blank, write N/A where applicable.** Thank you.

Name:					
Address:	City:	State:	Zip:		
Race: (circle one)	☐ White ☐ African American ☐ American Indian ☐ Hispanic ☐ Asian Other:_____ ☐ Decline to answer				
Preferred Language (circle one): ☐ English ☐ Spanish Other:_____					
Marital Status: (Circle one)	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other				
Social Security #:	Date of Birth:				
Phone Number:	☐ Cell ☐ Home ☐ Other:				
I agree to allow Sunflower OB/GYN at WNH to send me automated appointment text reminder texts to the number I have provided (Initial) :_____					
Alternate Phone Number:	☐ Cell ☐ Home ☐ Other:				
Employer:	WNMH Employee? Y ☐ N ☐	Work Phone:			
Email Address:					
Primary Care Physician:	**Date of Last visit:**				
Preferred Pharmacy:	City:				
Emergency Contact Name **(Must be filled out)**: Phone Number:	Relationship:				
Guarantor Information: (If not patient, this person is financially responsible for the account)					
Name:					
Address:	City:	State:	ZIP:		
Social Security #:	Date of Birth:				
Phone Number:	(Circle One): ☐ Cell ☐ Home ☐ Other				
Employer:	Work Phone:				
Insurance Information: You **MUST** attach a copy of your insurance card and ID.					

Primary Insurance:	Secondary Insurance:
Policy Number:	Policy Number:
Group #:	Group #:
Subscriber Name:	Subscriber Name:
Relationship To Patient:	Relationship To Patient:
Subscriber Date of Birth:	Subscriber Date of Birth:
☐ Check if NO insurance	

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for services rendered. I understand that I may be asked to fill this form out yearly, or more as needed. I authorize the release of any information requires for the submission of claims to my insurance company(s).

Name:	Signature:
Date:	Relation to Patient:

Consent to Communicate

HIPAA Privacy Acknowledgement

SUNFLOWER OB-GYN at William Newton Hospital

Printed Name: _____ Date of Birth: _____

This form allows you to name a person (such as your spouse, partner, other family member or friend) to communicate on your behalf with Sunflower OB/GYN at William Newton Hospital. This is NOT for access to your medical records. This form, when signed, allows Sunflower OB/GYN at William Newton Hospital to communicate with the authorized person(s) regarding your personal information concerning insurance, benefits, payments, treatment or other healthcare information regarding your care.

I hereby give my consent for Sunflower OB/GYN at William Newton Hospital to communicate personal information on my behalf to the authorized person(s) named below. This authorization allows Sunflower OB/GYN at William Newton Hospital to speak with the authorized individual(s) regarding the following: treatment, insurance claims, copays, or other aspects of care. I understand that this is limited to verbal and telephone conversations and does not permit or authorize the release of any written health information to any of the individuals named. I understand that it is my responsibility to let Sunflower OB/GYN at William Newton Hospital know of any changes or to revoke this authorization. I may revoke this authorization at any time in writing to Sunflower OB/GYN at William Newton Hospital. This authorization remains in effect for an unlimited amount of time unless revoked or updated. Any updated signed communication forms will supersede and replace all prior communication forms.

Person(s) authorized to speak with Sunflower OB/GYN at William Newton Hospital:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

NOTICE OF PRIVACY PRACTICES AND CODE OF CONDUCT - PATIENT ACKNOWLEDGEMENT

I hereby acknowledge that I have read and/or received a copy of Sunflower OB/GYN at William Newton Hospital NOTICE OF PRIVACY PRACTICES and CODE OF CONDUCT.

Signature: _____ Date: _____

Relationship of representative (if applicable): _____

Patient Financial Policy

SUNFLOWER OB-GYN at William Newton Hospital

Thank you for choosing Sunflower OB/GYN at William Newton Hospital as your healthcare provider. This policy is being provided to you in order to have a clear understanding of our Patient Financial Policy and is important for our professional relationship. It is your responsibility to provide Sunflower OB/GYN at William Newton Hospital with current insurance information. We may ask for your insurance card, so please have it available each time you come to the clinic. If current information is not obtained at the time of service, it will become your responsibility to pay until current information is provided to the clinic. If you fail to provide this information and timely filing expires, you will be responsible for the outstanding balance.

INSURANCE FILING: Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file the claim for you. However, we will not become involved in disputes between you and your insurance company. If a problem occurs with your claim, you will be asked to contact your insurance company to help resolve the problem. This includes, but is not limited to, questions regarding your deductible, co-insurance and non-covered charges. Sunflower OB/GYN at William Newton Hospital will provide information as needed to assist you with your dispute. Please contact us at 620-222-6261 should you need any documents or information. We want to help you understand your healthcare billing.

CO-PAYMENTS: If your insurance policy calls for a co-pay for office visits, you will be required to pay it at the time of your service.

PATIENT FINANCIAL RESPONSIBILITY: Sunflower OB/GYN at William Newton Hospital expects payment in full within 30 days from your first billing statement. We accept cash, checks, Mastercard, Visa, and Discover.

Please be aware our returned check fee is $30.00.

If you do not have health insurance we expect payment at the time of the service unless other arrangements have been made in advance.

If we anticipate that your insurance company may leave you with a deductible, we may require deposits prior to services being rendered.

PAYMENT OPTIONS: Credit is a form of trust Sunflower OB/GYN at William Newton Hospital has placed in you. Prompt payment is your obligation when you are granted credit, and is vital to the clinic's continued provision of quality health care service to this community. You are responsible for the timely payment of your account. You will receive a monthly statement for services which is due upon receipt. If a payment arrangement is needed, please contact our billing department at 620-222-6261. Timely payments are expected once this agreement is made.

We accept many forms of payment including VISA, MasterCard, American Express, DISCOVER, cash, money orders, or checks.

SELF-PAY PATIENTS: You will be required to pay a deposit on services. Any deposit collected will apply toward your total balance due. If you would like to pay in full at the time of service, a discount may be applicable. Please speak with the staff checking you in if you wish to take advantage of this discount.

WORKER'S COMPENSATION: If your office visit is due to an injury at work that has been reported to and verified by your employer, you may be eligible to have your claim covered by Worker's Compensation insurance. Be sure to inform our receptionist that the injury occurred while on the job. You will need to provide all claim information and complete a form in order for us to file this claim correctly.

ACCIDENTS AND INJURIES: All medical expenses that result from a vehicle accident or public liability are considered the personal responsibility of the patient.

COLLECTIONS PROCESS: If we do not receive your payment in full within sixty (60) days of your first mailed statement, and you have not made arrangements with our office or billing department, your account will be considered delinquent and may be considered for collection action. If your account is placed in collections you will be charged collection fees including but not limited to agency fees, attorney fees and court costs.

FINANCIAL ASSISTANCE: For more information concerning financial assistance programs contact the Billing Office at 620-222-6261.

There is a $25 fee for our office completing sets of FMLA, short or long term disability forms

Please ask if you have any questions regarding our fees, policies or your responsibilities. Please direct questions to our billing office at 620-222-6261.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize my Medicare and/or medical insurance benefits to be paid directly to Sunflower OB/GYN at William Newton Hospital separately from other Facility or professional bills. I understand that I am financially responsible for non-covered services as well as any deductibles, coinsurance, co-pays, or amounts in excess of insurance benefits. If coverage is denied, I give my express consent to appeal to the insurance on my behalf.

Signature for Assignment of Benefits & acknowledgment of Financial Policy:

Signature of patient or responsible party:

_____

Relationship if other than patient:

_____

Date: _____

Patient Financial Policy

SUNFLOWER OB-GYN
at William Newton Hospital

OBSTETRIC FINANCIAL POLICY

Obstetric patients with Insurance coverage

Thank you for choosing Sunflower OB/GYN at William Newton Hospital for your pregnancy and delivery. In an effort to keep your healthcare costs to a minimum, we have adopted the following policies. Your understanding of these policies is important. Please review this document and contact our billing office with any questions you may have. We encourage all patients to become familiar with their medical insurance coverage and pre-certification requirements. Please notify us of any insurance change during your pregnancy. You are required to have a photo ID and insurance card at each visit.

GLOBAL CARE:
Your insurance company describes this as all visits relating to your pregnancy from the initial prenatal visit until 6 weeks after delivery, including your delivery. Global billing means that you are not billed for each visit; rather most services will be billed in a single charge at the time of delivery.
Standard Fee for OB care and Vaginal Delivery: $5275
C-section: $5792

Labs and ultrasounds are not considered to be part of the global fee and are billed separately at the time of service. Depending on your insurance coverage, you may be responsible for a portion of these charges. Ultrasounds fees range from $350-$500, Lab test price varies.

PATIENT PORTION AND OB PAYMENT PLAN:
The billing staff will contact your insurance company to obtain benefits for pregnancy and verify if pre-certification of services is required. You will then be contacted to set up a payment plan for the estimated cost of the OB care.

OB PAYMENT PLAN:
Your insurance will advise us of your portion of the global fee. If you have financial responsibility, we will create a payment plan that divides your total amount due into a monthly payment for you.

You have received and signed this form as part of your initial New OB patient registration packet. This is your copy of the financial Policy for review.