PATIENT INFORMATION: TODAY'S DATE:_______

LAST NAME:______________________ FIRST NAME:_____________________ MIDDLE INITIAL:____

ADDRESS:____

____

HOME PHONE:____-____-______ WORK PHONE:_____-_____-______CELL PHONE:_____-_____-______

DATE OF BIRTH:_______________________________ SOCIAL SECURITY NUMBER:_____-___-_____

EMAIL ADDRESS:____

EMPLOYER:_______________________________________ ____FULL TIME________PART TIME_______

EMPLOYER ADDRESS: ____

____

SPOUSE: ____DATE OF BIRTH:________________________

SOCIAL SECURITY NUMBER_______-____-______

PRIMARY INSURANCE INFORMATION:

SUBSCRIBER'S NAME:____

ADDRESS:____

CITY:___________________________________STATE:_______ ZIP:__________

INSURANCE CARRIER:____

GROUP NUMBER:____________________________________ID NUMBER:________________________

SUBSCRIBER'S RELATION TO PATIENT: _________SELF __________SPOUSE

SUBSCRIBER'S EMPLOYER: ____

EMPLOYER'S WORK PHONE:____

SOCIAL SECURITY #: __________________________________ DATE OF BIRTH: _____________________

EMERGENCY CONTACT:

NAME:____PHONE: ____________________________

RELATIONSHIP TO PATIENT:____

I, ______________________________, give permission for you to discuss my medical condition with my family members specified below.

Spouse/Partner: ______________________________________.

Name

Parent(s):____.

Name(s)

Children:____.

Name(s)

____.

____.

Other parties (Please specify:__________________________________.

____.

Name(s)

I do not want my medical condition discussed with anyone other than myself. _____Yes_____, No____.

I give permission for you to leave a message on my answering machine at home. Yes_____, No______.

I give permission to leave a message on my answering machine at work. Yes______, No________.

Signature: ____.

Print Name: ____.

MERCY CLINIC WOMEN'S HEALTH

Today's Date:____________________

Name________________________________Age__________Date of Birth________________

Home Phone (____)______________________Work Phone(____)______________________

Referred by____

Pharmacy Name and Number____

Primary Care Doctor __________________________ Date of last visit? ____________________

INITIAL WOMENS HEALTH QUESTIONNAIRE

Reason for Today's Visit:

____

GYNECOLOGIC HISTORY:

Date of first day of your last period? ________________Age of first period? ________________

How often are your periods? _____________________How long do they last? ______________

Are you currently sexually active? ☐ No ☐ Yes

If so what form of contraception are you using (including tubal sterilization or vasectomy in your partner)? ____

Are your partners: ☐ Men ☐ Women ☐ Both

How many sexual partners have you had in the last year? _____________________________

Have you ever had a Hysterectomy? ☐ No ☐ Yes If so, were your ovaries removed? ☐ No ☐ Yes

Do you have any questions regarding sexual relations? ☐ No ☐ Yes

Date of last PAP smear? ____________________ ☐ Normal ☐ Abnormal

Have you ever had an abnormal PAP smear? ☐ No ☐ Yes Date_______________________

Have you ever had a sexually transmitted disease? ☐ No ☐ Yes

☐ Herpes ☐ Gonorrhea ☐ Chlamydia ☐ HTV ☐ Genital Warts ☐ Syphilis

☐ Pelvic Inflammatory Disease ☐ Other______________________________

Date of last mammogram ____________________ ☐ Normal ☐ Abnormal

Date of last Bone Density ____________________ Date of last Colonoscopy _________________

OB HISTORY:

How many times have you been pregnant? ____________________

Number of vaginal deliveries? ____________ Number of Caesarean sections? _____

Reason for Cesarean section?____

Number of living children?_______________ Number of adopted children?_____

Number of miscarriages? _______________ Number of abortions? ______

Number of pregnancies in your tubes?________ Number of stillbirths?______

Largest baby weight?____________________

Any problems with your pregnancies or deliveries?______________________________________

____

Any problems with postpartum depression?____

____

Mercy Clinic Women's Health
15945 Clayton Rd, Suite 305
Ballwin, MO 63011

MEDICALL ILLNESS PROBLEMS:

Please check any of the following conditions that you have (now or in the past):

□ Asthma
□ Chronic Lung Disease
□ Heart Disease
□ Reflux or Ulcers
□ Crohn's
□ Ulcerative Colitis
□ Breast Disease
□ Liver Disease/Hepatitis
□ Kidney Disease
□ Eating Disorder
□ Thrombosis/Blood Clots
□ Diabetes
□ Thyroid Disease
□ High Blood Pressure
□ Stroke
□ Migraines
□Anemia or Transfusion
□Depression or Anxiety
□ Seizures or Epilepsy
□ Glaucoma
□ Fracture or broken bone
□ High Cholesterol
□ Osteopenia/ Osteoporosis

Other:____

____

SURGERY, HOSPITALIZATIONS OR INJURIES:

Date	Procedure/Reason	Hospital	Complications

MEDICATIONS: (including vitamins, herbal and any over the counter)

1.________________ 4.________________ 7.________________
2.________________ 5.________________ 8.________________
3.________________ 6.________________ 9.________________

Are you ALLERGIC to any medications?______________________________

Please check the IMMUNIZATIONS that are up to date: □ Tetanus □ Pertussis □ Varicella
□ Hepatits A □ Hepatitis B □ Gardasil

FAMILY HISTORY: (Any parents, siblings, grandparents, aunts and uncles have any of the following?)

□ Diabetes
□ Breast cancer
□ Blood clots
□ Uterine cancer
□ Heart Disease
□ Ovarian cancer
□ Mental Illness
□ Cancer (Type):______________________________
□ High blood pressure
□ Colon cancer
□ Osteoporosis
□ Stroke
□ High cholesterol
□ Blood Disorders

Other:____

____

SOCIAL HISTORY:

Do you smoke? □ No □ Yes Packs per day___________ How long?___________

Do you drink alcohol? □ No □ Rarely □ Occasionally □ Often □ Daily

Do you use drugs socially? □ No □ Rarely □ Occasionally □ Often □ Daily

□ Marijuana □ Cocaine □ Crack □ Heroine □ Methamphetamine

□ Other____________________ Last Used______________________

Do you exercise regularly? □ No □ Yes

Are you: □ Single □ Married □ Partnered □ Divorced □ Separated □ Windowed

Current or most recent occupation:____

Have you been physically or mentally abused by your spouse or partner? □ No □ Yes

Have you ever been sexually abused, raped or date raped? □ No □ Yes

If so, do you wish to discuss this? □ No □ Yes

REVIEW OF SYSTEMS:

Please "X" any of the following that you are experiencing:

□ Weight changes	□Palpitations	□ Leaking urine	□ Depression
□ Fever	□ Cough	□ Blood in urine	□ Crying spells
□ Fatigue	□ Coughing up blood	□ Urinary urgency	□ Anxiety
□ Vision changes	□ Wheezing	□ Pain with urination	□ Breast masses
□ Loss of gas	□ Swelling of legs	□ Vaginal dryness	□ Pain in breast
□ Sinus problems	□ Frequent diarrhea	□ Seizures	□ Dry skin
□ Sore throat	□ Nausea/vomiting	□ Headache	□ Hair loss/growth
□ Dental problems	□ Constipation	□ Painful intercourse	□ Hot flushes
□ Shortness of breath	□ Leaking stool	□ Bleeding problems	□ Abnormal thirst
□ Chest pain	□ Bloody stool	□ Sleep problems	

ANY CONCERNS OR QUESTIONS?

____

____

____

Patient:____ Date:__________

(Signature)

FAMILY HISTORY QUESTIONAIRE

Name:______________________________ Date:__________________________

Instructions: Please circle Y to those that apply to YOU and/or YOUR FAMILY (on both your mother and father's side). Behind each statement, please list relationship to you of the diagnosed (example: self, maternal aunt, sister, paternal cousin) and their age at diagnosis.

HEREDITARY BREAST AND OVARIAN CANCER SYNDROME

	Personal History	Relationship	Age of Diagnosis
Y N	Personal history of breast cancer before age 50	____________	____________
Y N	Personal history of ovarian cancer at ANY age	____________	____________
Y N	Breast cancer in both breasts at any age	____________	____________
	Family History		
Y N	Breast cancer in both breasts in a family member (at any age)	____________	____________
Y N	Both breast & ovarian cancer (at any age)	____________	____________
Y N	Male breast cancer (at any age)	____________	____________
Y N	Two or more breast or ovarian cancers (on one side of family or in an individual)	____________	____________
Y N	Ashkenazi Jews with personal history or family History of breast or ovarian cancer (at any age)	____________	____________

HEREDITARY NONPOLYPOSIS COLORECTAL CANCER SYNDROME

Y N	Personal history of cancer of the uterus before age 50	____________	____________
Y N	Personal history of colon or rectal cancer before age 50	____________	____________
Y N	Personal history of colon or rectal or cancer or Cancer of the uterus after 50 & family member with any of the following cancers:	____________	____________

(PLEASE circle those that apply) Colon, Rectal, Uterine, Stomach, Ovarian, Biliary tract, Small bowel, Pancreas, Kidney (ureter/renal pelvis), Brain, Sebaceous adenoma

---

If you circled YES to one or more statements on the Family History Questionnaire, you may be a candidate for counseling and may be appropriate for a blood test to help determine if you have an inherited risk of cancer.

________ Patient offered risk counseling ☐ Accepted ☐ Decline ☐ Undecided

Name: Date of Birth: MRN#: CSN:

Consent for Provider Services

1. **Annual Consent for Services:** I consent to the services that may be performed by a Sisters of Mercy Health System ("Mercy") physician/provider ("provider") or facility. I understand I can withdraw my consent at any time.

2. **Legal Relationship between Hospital and Provider:** I understand that when I am hospitalized I am under the care and supervision of my attending provider and it is the responsibility of the hospital and nursing staff to carry out his/her instructions. It is the responsibility of my provider or surgeon to obtain my informed consent, when required, for specific medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under instruction of the provider.

3. **Rules and Regulations:** I understand that my visitors and I must obey all rules and regulations. I understand that in the event all rules and regulations are not followed, Mercy may pursue corrective action.

4. **Notice of Privacy:** I acknowledge that I have received a copy of the Notice of Privacy Practices (NPP), which describes when Mercy may use or disclose information for treatment, payment and health care operations. The NPP is considered part of these Conditions of Admission by this reference. I understand that this notice is only provided the first time I receive services from the hospital and is otherwise available upon request.

5. **Personal Valuables:** I understand that as a patient, I am encouraged to leave valuable personal items at home. While Mercy may maintain a safe for small personal items of unusual value, Mercy is not responsible for the loss or damage to these items.

6. **Demographic Information:** I have reviewed the demographic information listed for me and confirm that it is correct. I am aware that I need to inform Mercy of any changes as soon as possible.

7. **Release of Information:** I authorize Mercy to release the minimum necessary medical and/or billing information concerning my care, including copies of my medical records, electronically or on paper, for the purpose of ongoing medical treatment and billing for services provided. I acknowledge that this authorization is valid for one year, or until all accounts are settled.

8. **Financial Agreement:** I agree to accept financial responsibility for all services provided to me by Mercy. I also agree to promptly pay all hospital and provider bills, in accordance with the applicable rates and terms, which can be modified by agreement between the hospital or provider and my health care insurance company. Should an account be referred to an attorney or collection agency for collection, I will pay attorney's fees and collection expenses. I understand that if my account is delinquent, it will incur interest at the legal rate. Mercy will provide a medical screening exam to anyone in need of emergency medical treatment, regardless of ability to pay.

9. **Assignment of Insurance Benefits:** I assign and authorize direct payment to Mercy of all insurance and plan benefits related to services provided by Mercy. By paying Mercy, my insurance company or employer is fulfilling its obligations under my health insurance policy, or my employer is fulfilling its obligations as required by law. I also understand that I am financially responsible for charges not paid according to this assignment.

10. **Independent Contractor/Providers:** I understand that separate bills may be sent for professional services from non-Mercy providers such as radiologists, pathologists, and anesthesiologists, in addition to the Mercy bill.

11. **Medicare Assignment:** I certify that the information given by me in applying for payment from any third party payor, including payment under Title XVIII of the Social Security Act, is correct. I request that payment of authorized benefits be made in my behalf, and I authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my eligibility for coverage under Medicare Part A and Part B, including but not limited to the effective date of such coverage. I also authorize Mercy to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.

12. **Phone Calls:** I authorize Mercy and its collection agencies to contact me, or a representative I appoint, about my account, including using any contact information or cell phone numbers that I have provided or will provide, or that is available to Mercy from third parties. I authorize contact with me by telephone or voice messages and authorize the use of automated dialing technology and pre-recorded messages. I agree such contact will not be "unsolicited" for purposes of local, state or federal law.

13. **Notice to Mercy Co-workers:** As a co-worker employed by an entity owned or controlled by Mercy, I agree to payment of outstanding balances(s) due for medical services rendered to me, or any dependents for whom I am financially responsible, after all applicable insurance payments are received for such services. In the event I do not make reasonable attempts to resolve the outstanding balances, I understand Mercy may initiate payroll deduction, in accordance with Mercy's Co-worker Payroll Deduction Policy.

14. **Patient Self Determination Act:**
    I have an Advance Directive? ___ Yes ___ No

A copy of this form shall have the same force and effect as the original. The undersigned is the patient or is duly authorized to act on behalf of the patient to execute and accept the terms thereof. A copy of the executed form is available upon request.

Date: ______________________ Time:_______Signature: ___________________________

If signed by other than patient, indicate relationship: ____________________________

Witness: ___________________________________

Authorization for Release of Protected Health Information

Patient Identification

Printed Name: ______________________________ Date of Birth: ____________________

Address: ______________________________ SSN: ____________________

______________________________ Telephone: ____________________

Information is to be released by:

____
(Physician or Facility)

____
(Street Address)

____
(City, State and Zip Code)

____
(Telephone Number)

Information is to be sent to:

____
(Individual/ Agency/ Facility)

____
(Street Address)

____
(City, State and Zip Code)

____
(Telephone Number)

Information To Be Released – Covering the Periods of Health Care

From (date) ______________________________ to (date) ______________________________

Please check type of information to be released:

☐ Complete health record	☐ Diagnosis & treatment codes	☐ Discharge summary
☐ Laboratory test results	☐ Complete billing record	☐ X-ray films / images
☐ Other (specify)		

Purpose of Request

☐ Treatment or consultation	☐ At the request of the patient	☐ Billing or claims payment
☐ Other (specify)		

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. ***Check One:*** ☐ **Yes** ☐ **No**

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. ***Check One:*** ☐ **Yes** ☐ **No**

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this Authorization, you have the right to revoke this Authorization by submitting a notice in writing to the Department of HIS or other Department to whom you are authorizing disclosure. Unless revoked, this Authorization will expire on the following date or event ______________________________, or 90 days from date of signature, unless otherwise specified.

Re-release

I understand the information released pursuant to this Authorization may be subject to re-release by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

Your provider will not deny treatment if you do not sign this form. You may inspect or copy your protected health information. **By signing below, you authorize your provider, identified above, to release your protected health information specified above.**

Signature: ______________________________ Date: ____________________

Authority to Sign - if not patient: ______________________________ Witness: ____________________

Identity of Requestor Verified via: ☐ **Photo ID** ☐ **Matching Signature** ☐ **Other, specify** ____________________

ID Verified by: ______________________________