WHASN
Women's Health Associates of Southern Nevada

# PATIENT REGISTRATION

Preferred Pharmacy: _____ Location: _____ Pharmacy Phone: _____

Referring Physician: _____ Preferred Provider: _____

## Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

Preferred Name: _____ ☐ Miss ☐ Mrs. ☐ Ms. DOB: _____/_____/_____ SS#: _____-_____-_____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined Primary Language: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner ☐ Widowed

Street Address: _____ Apt./Ste./Unit: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____ Primary #: ☐ Home ☐ Cell ☐ Work

Fax #: _____ Email: _____ Preferred Communication: ☐ Phone ☐ Mail ☐ Email ☐ Text

Employer: _____

## Associated Parties

Spouse's Name: _____ DOB: _____/_____/_____ Phone #: _____

Parent's Name (if minor): _____ DOB: _____/_____/_____ Phone #: _____

Emergency Contact Name: _____ Relationship: _____ Phone #: _____

## Insurance Information

Primary Insurance: _____

Policy Number: _____ Group Number: _____ Effective Date: _____/_____/_____

Name of Insured: _____ Relationship to Insured: _____ SS# of Insured: _____/____/_____

Insured's Date of Birth: _____/_____/_____ Insured's Employer: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____ Effective Date: _____/_____/_____

Name of Insured: _____ Relationship to Insured: _____ SS# of Insured: _____/____/_____

Insured's Date of Birth: _____/_____/_____ Insured's Employer: _____

-More on opposite side-

**PLEASE READ THE FOLLOWING CAREFULLY:**

- You are responsible for knowing if your insurance is contracted with Women's Health Associates of Southern Nevada.
- You are responsible for knowing your coverage and benefits.
- All deductibles, co-payments and applicable charges will be due at the time of service – **NO EXCEPTIONS.**
- All surgery fees MUST be paid in advance of the surgical date – **NO EXCEPTIONS**.
- There is a $25.00 fee per signature for any FMLA/Disability forms completed. Please speak with the Care Center regarding their time frame for completion.
- Should you need to cancel or reschedule an appointment, please call at least 48 hours in advance. Failure to do so could result in a $25.00 fee.
- All checks returned due to insufficient funds will result in a $25.00 NSF fee being placed on the patient account.

**NOTE:** If your insurance requires you to utilize a particular laboratory, you will need to inform the nursing staff every time you are seen. If you are not sure whether your insurance company requires you to use a specific laboratory, please contact them directly for that information. There will be a separate bill from the lab for PAP SMEAR interpretation, cultures, urinalysis and other laboratory services.

**Notice of Assignment of Benefits and Release of Medical Information**

The above information is complete and correct. I hereby guarantee payment of all charges incurred with this office. I hereby assign and direct my insurance company or companies to pay any and all benefits for my medical services directly to this office. I authorize the release of medical information requested by my insurance company or companies to insure payment on this account. I understand that should my insurance company or companies deny any submitted charges for any reason, I am responsible for payment of those charges. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover money due to Women's Health Associates of Southern Nevada.

| _____ | _____ | _____/_____/_____ |
|---|---|---|
| Patient/Legal Guardian Name | Patient/Legal Guardian Signature | Date |

# E-PRESCRIBING PBM CONSENT FORM

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBMs are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions--** Gives the prescriber information about which drugs are covered by the drug benefit plan.

- **Medication history transactions--**Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form you are agreeing that Women's Health Associates of Southern Nevada can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Patient Name (printed): _____ Date of Birth: ____ /____ /____

Signature of Patient (or representative): _____ Date: ____ /____ /_____

Relationship (If other than patient): _____

Consent Denied: _____ Date: ____ /____ /_____

# PATIENT PORTAL

Dear Patient,

We would like to invite you to take advantage of our online Patient Portal. Our secure portal is a helpful resource to:

- Request appointment times
- Pay statement balances and bills
- Request prescription refills
- Fill out forms before your appointment
- Ask non-emergency medical questions
- Request test results

We still welcome your phone calls, but we offer this service to you as a more convenient way to communicate with your care center.

If you would like to sign up for the portal, please visit WHASN.com and click the Patient Portal link.

Thank you,

WHASN

Preferred Email: _____

Patient name: _____
(Please print clearly)

Patient DOB: _____/_____/_____


# ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received from WHASN a copy of the Notice of Privacy Practices of WHASN. I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how WHASN can use and disclose my personal health information both with and without my authorization. I further understand that I may contact WHASN's Privacy Officer, Michael Oliphant if I have any questions regarding the contents of this Notice or to file a complaint.

_____

Patient Name

_____ _____/_____/_____

Patient/Health Care Agent/Guardian/Relative Signature Date

# PATIENT NOTIFICATION OF ADVANCE DIRECTIVE AVAILABILITY

It is the policy of Women's Health Associates of Southern Nevada to inform patients of the availability of an Advance Directive form. Patients are encouraged to make informed decisions about end-of-life care and services. Women's Health Associates of Southern Nevada encourages patients to learn about options for end-of-life care and services. Implement plans to ensure your wishes are honored. You are encouraged to discuss your decisions with family, friends and healthcare providers.

- ☐ Yes, I have an advance health care directive/living will.
- ☐ No, I do not have an advance health directive/living will.
- ☐ I would like additional information on advance health directives.

_____ _____

Patient Name Patient Chart #

_____ _____/_____/_____

Patient/Health Care Agent/Guardian/Relative Signature Date

Name: _____ DOB: _____/_____/_____ PCP: _____ DATE: _____/_____/_____

**PERSONAL/MEDICAL HISTORY**

Anxiety/Depression ☐ Yes ☐ No

Anemia ☐ Yes ☐ No

Asthma/Lung condition ☐ Yes ☐ No

Arthritis ☐ Yes ☐ No

Bleeding disorder ☐ Yes ☐ No

Bowel problems ☐ Yes ☐ No

Cancer: _____

Diabetes ☐ Yes ☐ No

Elevated cholesterol ☐ Yes ☐ No

Endometriosis/PCOS ☐ Yes ☐ No

Heart disease ☐ Yes ☐ No

High blood pressure ☐ Yes ☐ No

Headaches ☐ Yes ☐ No

Kidney disease/stones ☐ Yes ☐ No

Liver disease/Hepatitis ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

Thyroid disorder ☐ Yes ☐ No

Other: _____

**SOCIAL HISTORY**

Married/Single/Divorced/Widowed/Separated

Smoke: ☐ Yes ☐ No Packs per day: _____

Alcohol: ☐ Yes ☐ No How much? _____

Street drugs: _____

Marijuana: ☐ Medical ☐ Recreational

Sexual preference: _____

**ALLERGIES – INCLUDE MEDICATION REACTION**

_____

_____

**GYNECOLOGIC HISTORY**

Last pap smear: _____ ☐ Normal ☐ Abnormal

Last mammo: _____ ☐ Normal ☐ Abnormal

Last colonoscopy: _____ ☐ Normal ☐ Abnormal

Last DEXA (bone) scan: _____ ☐ Normal ☐ Abnormal

Previous treatment for abnormal pap smears?

☐ Colpo ☐ Cryo ☐ LEEP ☐ Conization ☐ N/A

Last menstrual period: _____

Age of first period: _____

Periods occur every _____ days and last _____ days

☐ Heavy ☐ Clots ☐ Pain ☐ Cramping ☐ Irregular bleeding

Average # of pads/tampons used per day: _____

Menopausal: ☐ Yes ☐ No Age began: _____

Hysterectomy: ☐ Yes ☐ No When? _____

Complaints of: ☐ Breast pain ☐ Infertility ☐ Fibroids ☐ Ovarian cysts

☐ Pain w/ intercourse ☐ Vaginal infections ☐ Leaking of urine

Have you ever been diagnosed with any of the following:

Gonorrhea ☐ Yes ☐ No

Chlamydia ☐ Yes ☐ No

Herpes (Genital) ☐ Yes ☐ No

HPV/Genital warts ☐ Yes ☐ No

Hepatitis B or C ☐ Yes ☐ No

HIV ☐ Yes ☐ No

Syphilis ☐ Yes ☐ No

Number of sexual partners (in lifetime): _____

Current birth control method: _____

Previous birth control method(s): _____

_____

**PREGNANCY HISTORY**

Number of Miscarriages: _____ Abortions: _____ Ectopic: _____ Live Births: _____

| Date | Gestational Age | Birth Weight | Gender | C-section or Vaginal | Early Labor | Complications |
|---|---|---|---|---|---|---|
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**SURGICAL HISTORY**

Ablation Date: _____ Laparoscopy Date: _____

Breast surgery Date: _____ Ovaries removed Date: _____

D&C Date: _____ Tubal ligation Date: _____

Hysterectomy Date: _____

☐ Appendectomy ☐ Back surgery ☐ Bowel ☐ Fibroid removal ☐ Gallbladder ☐ Tonsillectomy

Other: _____

**FAMILY HISTORY**

Breast Cancer ☐ Yes ☐ No Family Member: _____

Ovarian Cancer ☐ Yes ☐ No Family Member: _____

Colon Cancer ☐ Yes ☐ No Family Member: _____

Other: _____

_____

**CURRENT MEDICATIONS**

List all medications taken daily

_____ Dose: _____ Frequency: _____

_____ Dose: _____ Frequency: _____

_____ Dose: _____ Frequency: _____

_____ Dose: _____ Frequency: _____

_____ Dose: _____ Frequency: _____