Patient Intake Forms

Name_____Age_____Today's Date_____/_____/_____

Reason for visit: _____

Current Medications (include over the counter) Vitamins, Supplements/Herbal preparations

Medical History:

Allergies to Medications		☐ No Known Drug Allergies
Medical problems		
Surgeries		
Hospitalizations		
Date of Last Menstrual Period	First day: ____/____/____	Or age at menopause? _____ years
Pregnancies and Outcomes	Vaginal birth(s) _____ C-Section(s)_____ Miscarriage(s)_____ Abortion(s)_____	
Current Contraceptive (if applicable)		

Screening and Preventive Health Care:

Most Recent	Never had	Date	Place	Result
Pap smear				
Mammography				
Cholesterol/ Lipid Panel				
DEXA/ Bone Density Scan				
Colonoscopy or flex sig.				
Vaccination against HPV				

Family History:

	Alive (Y / N)	Current age or age at death	Health problems or cause of death
Mother			
Father			

Is there any family history of **breast, uterine, ovarian, or colon cancer**? No Yes

If yes, in **whom** at what **age**? _____what type _____

Social History: Amount / How long?

Tobacco use No Yes amount per day_____ for how long _____mo/years

Prior smoker No Yes amount per day_____ for how long _____year quit_____

Alcohol use No Rare 1-5 per week 5-10 per week over 10 per week

Street drug use No Yes _____

Please describe your diet:

- ☐ Special Needs (Lactose/Gluten Intolerant)
- ☐ Vegetarian
- ☐ Low Carb Diet
- ☐ Healthy Balanced
- ☐ Strict Vegan
- ☐ High in refined sugars and processed foods

How many dairy servings do you eat/drink daily? _____ Do you take a calcium supplement? No Yes

Do you exercise regularly? **No** **Yes** **How many hours per week?** **1-3 hours** **4-6 hours** **over 6 hours**

- ☐ Running/ Jogging
- ☐ Weight Training
- ☐ Swimming
- ☐ Hiking/Walking
- ☐ Gym(aerobics/cardio)
- ☐ Skiing
- ☐ Biking
- ☐ Yoga/Pilates
- ☐ Other_____

Review of Systems:

Do you have any of the following signs or symptoms? If yes, please explain.

Unexplained weight loss or gain	No	Yes
Fevers, chills, sweats	No	Yes
Chronic fatigue	No	Yes
Vision changes	No	Yes
Severe or recurring headaches	No	Yes
Chest pain	No	Yes
Shortness of breath	No	Yes
Heart palpitations	No	Yes
Swelling of the ankles	No	Yes
Wheezing / coughing	No	Yes
Coughing up blood	No	Yes
Vomiting up blood	No	Yes
Frequent nausea or vomiting	No	Yes
Frequent abdominal pain	No	Yes
Frequent constipation	No	Yes
Frequent diarrhea	No	Yes
Blood in stool or black tarry stool	No	Yes
Frequent urination	No	Yes
A frequent strong sense of urgency to urinate	No	Yes
Waking up more than once per night to urinate	No	Yes
Burning with urination	No	Yes
Losing urine with coughing, laughing, sneezing	No	Yes
Blood in urine	No	Yes
Pain with intercourse	No	Yes
Abnormal vaginal bleeding	No	Yes
Muscle weakness	No	Yes
Breast problems	No	Yes
Dizziness	No	Yes
Numbness	No	Yes
Depression or mental health problems	No	Yes
Thyroid problems	No	Yes
Blood sugar problems	No	Yes
Easy bruising / bleeding	No	Yes

Date of Birth: _____/_____/_____SSN:_____ Email Address:_____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Numbers: Primary:_____ Secondary_____

Relationship Status: ☐ Married ☐ Partnered ☐ Single

(included, Divorced, Widowed and Separated)

Occupation: _____ Employer's Name: _____

Employer's location: _____ Employer's phone number: _____

Primary Care Physician: _____Referred by: _____

Emergency Contact: _____Phone _____

Pharmacy: _____Location:_____Phone:_____

Insurance Information (All information must be filled out completely to bill insurance company.)

Insurance Company Name: _____

Insurance Company Address: _____City _____State ____Zip Code_____

Policy Holder Name: _____ DOB___/___/_____ Relationship to Patient_____

Policy Holder Member ID#_____ Group #_____

Policy Holder Employer Name: _____Phone _____

Is there a secondary insurance? No Yes

If yes, name of insurance company_____
Policy Holder Name: _____DOB____/____/_____
Relationship to Patient_____Policy Holder ID#_____Group #_____

How did you hear about our practice?

☐ Insurance website ☐ Google (or other search engine) internet search

☐ Referral from: _____ (please provide name of person)

☐ Other_____

Boulder Gynecology Policies on Preventive Screening Tests

In this women's health practice, we follow evidence-based guidelines for periodic screening tests. Such guidelines are published by authoritative organizations such as the American Congress of Obstetrics and Gynecology, the American Society for Colposcopy and Cervical Pathology, the US Preventive Services Task Force, the American Cancer Society, and the Centers for Disease Control and Prevention. They were developed by expert consensus after reviewing the published medical literature. The purpose of the guidelines is to strike a balance between overuse of medical tests where they are not of value and could potentially result in harm, and inadequate screening where early, treatable diseases are missed.

The recommended screening tests in women's health are as follows:

Pap smear screening: Initial Pap test is at the age of 21. For low risk women, the Pap is then repeated every three years, but it may be done more frequently for higher risk women. After the age of 30, Pap screening can be extended to every three years as long as there have been no recent abnormal Pap results. HPV testing after age 30 can also add to the sensitivity of cervical screening. Women who choose to have co-testing of HPV with their Pap can safely extend the screening interval to every 5 years, provided both tests are normal. After age 65, Pap smear screening can be discontinued among women who have had three or more consecutive negative Pap results and no abnormal results in the preceding 10 years.

Sexually transmitted infection screening: Because infections with *Chlamydia* and *gonorrhea* can go without symptoms and can lead to devastating consequences such as pelvic inflammatory disease, infertility, and chronic pelvic pain, it is recommended that sexually active women younger than the age of 26 be screened for these bacterial STIs annually.

Mammography: There has been some recent controversy about mammogram screening. The American Cancer Society recommends that women over the age of 40 have annual mammograms. The US Preventive Services Task Force has recently advocated that mammogram screening start at the age of 50 instead of 40, and that it can occur every two years rather than every year. Because taking menopausal hormones mildly increases the risk of breast cancer, we feel it is important for any woman on hormones to have an annual mammogram.

As your health care provider, Dr. Lepine is in a partnership with you to maximize your health. If you choose not to abide by these guidelines, then our practice is not a good fit for you and you should seek care elsewhere.

I agree to follow the evidenced-based guideline and undergo the preventive health screenings as prescribed above.

_____ _____

Patient signature Printed name

_____/_____/_____

Date

Boulder Gynecology & Minimally Invasive Surgery
Financial Policies

Please read, initial, and sign at the bottom, indicating your understanding of the following information. If you have questions, please do not hesitate to ask. It is important that you understand these specific policies of our office and that you understand how your insurance company will handle your claims.

_____ **It is your responsibility to provide the office with current and correct insurance information.** Failure to do so could result in your insurance company rejecting your claims for failing to obtain authorization or timely filing. In the event that this should happen, you will be responsible for the incurred charges.

_____ **It is your responsibility to verify your coverage and adhere to the restrictions of your plan.** We participate in most major insurance companies. However, insurance companies frequently specify the time frame in which patients can be seen and the coverage varied widely group to payor. If appointments are made that are not covered by your insurance plan, you will be responsible for payment.

_____ **Non-covered services**. You agree to pay for services rendered that are subsequently determined to be "not covered" and applied to patient liability by your insurance company.

_____ **It is your responsibility to know if you have a deductible, if your deductible has been met, or if you have co-insurance.** We do not always have that information. You are responsible for all charges that are not paid by your insurance company, including those applied to your deductible or co-insurance.

_____ **You will need to pay in full at the time of services if you are self-pay**. We offer a 30% discount on office charges provided they are not submitted for insurance reimbursement by you.

_____ **If you have a co-pay, you are expected to pay this when you check in for your visits.** Most insurance companies assign a co-payment to the patient and it is our responsibility to collect this at the time of service. We take checks and credit cards—Visa, Master Card, and Discover. We do not accept cash. Be prepared to pay your co-pay when you check in for each appointment.

_____ **You will be charged $50 if you fail to show up for your appointment of if you cancel your appointment with less than 24 hours' notice.** Exceptions may be made for inclement weather or emergencies. The correct number to call when cancelling an appointment is (720)382-2621.

_____ **Late cancellation of surgery**. Surgery scheduling and preparation requires a great deal of time and effort for our staff. If you cancel your surgery within 2 weeks of your scheduled surgery date, you will be assessed a $250.00 charge.

_____ _____

Signature of Patient/Guardian Date

BOULDER GYNECOLOGY AND MINIMALLY INVASIVE SURGERY, P.C.
LISA LEPINE, M.D.
3434 47th Street • Suite 101 • Boulder, CO 80301
Phone (720) 382-2621 Fax (720) 382-2625
bouldergynecology.com

Permission to Disclose Personal Medical Information

Please provide us with the telephone number you would like us to use when contacting you with your medical information such as test results.

Patient Name: _____ Date of Birth: ___/___/_____
(please print)

Primary Phone: _____ Secondary Number: _____

Answering Machine or Voice Mail Messages: (Check one)

___ I prefer no messages be left on an answering machine or on voice mail.

___ I give permission for staff at Boulder Gynecology to leave messages, with discretion, of normal results on an answering machine or voice mail for the numbers listed above.

Disclosure to Other Persons: (Check one)

___ I request that no one be given information but me.

___ I give the staff at Boulder Gynecology permission to disclose health information to the following people:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____

_____ _____
Signature of Patient or Legal Guardian Date

Joint Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Pledge Regarding Medical Information

We understand that your medical information is personal and we are committed to its protection. We create a record of the care and services you receive to ensure that we are providing quality care and to comply with legal requirements. This notice applies to all your health information that we maintain, whether created by our staff or others.
We are required by law to give you this notice of our legal duties and privacy practices, to follow the terms of this Privacy Notice, and to maintain the privacy of your medical information.

How We May Use and Disclose Medical Information about You

For Treatment. We may use your medical information to provide you with medical treatment or services.
For Payment. We may disclose your medical information so that treatment and services you receive may be billed to a third party.
For Heath Care Operations. We may use and disclose your health information to support the daily activities related to health care such as it to monitor and improve our health services. Also, authorized staff may look at portions of your record to perform administrative activities.
Individuals Involved in Your Care or Payment of Your Care. We may release your medical information to a friend or family member who is involved in your medical care or to someone who helped pay for your care.
To Contact You. Your health information may also be used to contact you to provide appointment reminders or test results, to inform you about treatment options or to advise you about other health-related benefits and services.
Miscellaneous. We may disclose your medical information without your prior authorization for several other reasons. Subject to certain requirements, we may give out your medical information without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies, funeral arrangements, Coroner's investigations, organ donation, and emergencies. We also may disclose medical information when required by law in response to a request from law enforcement in specific circumstances, for military or national security purposes, in response to valid judicial or administrative orders, or to avoid a serious mental health threat. Additional specific rules may apply to mental health records.
Other Disclosures. Other uses and disclosures not described above will be made only with your written authorization. You may revoke your authorization at any time unless we have relied on your authorization or your authorization was required as a condition of obtaining health care services.

Your Rights Regarding Medical Information about You

The Right to Inspect and Receive Copies. In most cases, you have the right to inspect and receive a copy of certain health care information including certain medical and billing records. If you request a copy of

the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

Right to a Paper Copy of This Notice. If this notice was sent to you electronically you have a right to a paper copy of this notice.

Right to Request Restrictions. You may request in writing that we do not use of disclose your medical information except when specifically authorized by you, when required by law, or in an emergency. We are not required by law to agree to your request, but we will consider the request. We will inform you of our decision.

Changes to This Notice. We reserve the right to change this notice at any time. Changes will apply to medical information that we already hold, as well as new information after the change occurs. We will provide you with a copy of our current notice at subsequent appointments.

Complaints and Requests. If you believe your privacy has been violated, you may file a complaint with Boulder Gynecology & Minimally Invasive Surgery or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.
All complaints or requests must be submitted in writing to:

Boulder Gynecology & Minimally Invasive Surgery, P.C.
3434 47th Street, Suite 101
Boulder, CO 80301
Phone (720) 382-2621

Office for Civil Rights
U.S. Department of Health and Human Services
999 18th Street, Suite 417
Denver, CO 80202
Voice Phone (303)844-2024
FAX (303)844-2025
TDD (303)844-3439

Signature: _____

Date: _____

Last Revision: 9/2012