OB/GYN New Patient Information

# Medical History Form

Patient Name: _____
Date of Birth: _____ Today's date _____
What is the reason for your visit today? _____
Local Pharmacy Name and Address: _____
_____
What is the highest level of education you have achieved: _____

**Gynecologic/Obstetric History**

When was the first day of your last menstrual period? _____
How often do you get your period? _____ At what age did your periods begin? _____
How many days does your average period last? _____
Is your menstrual flow: ☐ Light ☐ Moderate ☐ Heavy
Do you have painful periods? ☐ Yes ☐ No If yes, is it: ☐ Mild ☐ Moderate ☐ Severe
Do you have sex with: ☐ Men ☐ Women ☐ Both
Are you currently sexually active? ☐ Yes ☐ No
Are you trying to get pregnant? ☐ Yes ☐ No
Are you currently using Contraception? ☐ Yes ☐ No

☐ Patch ☐ Non-hormone IUD (Para Gard) ☐ Tubal ligation ☐ Male vasectomy
☐ Condoms ☐ Hormone IUD (Mirena) ☐ Vaginal ring ☐ Implant
☐ Depo injection ☐ Pill _____ ☐ Other _____

Please list the dates of your most recent vaccine/test (month/year):
Bone Density Scan _____ PAP Test _____ HPV Vaccine _____
Colonoscopy _____ Mammogram _____

Have you ever been diagnosed with any of the following conditions? Check all that apply:

☐ Abnormal pap smear ☐ Gonorrhea ☐ Chlamydia ☐ HIV
☐ Fibroids ☐ Trichomoniasis ☐ Genital herpes ☐ Infertility
☐ Endometriosis ☐ Genital warts ☐ Syphilis ☐ Hepatitis
☐ Ovarian cyst ☐ Pelvic inflammatory disease (PID) ☐ Other gynecologic problems

| Number of Pregnancies | Date of Pregnancy | Outcome (Vaginal delivery, C-section, Miscarriage, Ectopic, Abortion) | Complications (Yes or No) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
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| | | | |

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## General Medical History

Have you ever been diagnosed with any of the following conditions? Check all that apply:

| | | | |
|---|---|---|---|
| ☐ High blood pressure | ☐ Diabetes | ☐ Peptic Ulcer | ☐ Arthritis |
| ☐ Heart disease | ☐ COPD/Emphysema | ☐ Bipolar Disorder | ☐ Anemia |
| ☐ High cholesterol | ☐ Reflux | ☐ Blood clotting problems | ☐ Asthma |
| ☐ Gallstones | ☐ Kidney stones | ☐ Lupus | ☐ Depression |
| ☐ Seizure disorder/epilepsy | ☐ Migraine headache | ☐ Bladder infection | ☐ Cancer |
| ☐ Anxiety | ☐ Kidney infection | ☐ Hyperthyroid/Hypothyroid | |
| ☐ Urinary or stool incontinence | | ☐ Genetic problems or birth defects | |
| ☐ Other _____ | | ☐ Other _____ | |

Have you ever used any of the following substances?

| | | | |
|---|---|---|---|
| Tobacco | ☐ No | ☐ Yes, previously | ☐ Yes, currently (#packs/day _____) |
| Alcohol | ☐ No | ☐ Yes, previously | ☐ Yes, currently (#drinks/day _____) |
| Street drugs | ☐ No | ☐ Yes, previously | ☐ Yes, currently (#drinks/day _____) |

## Surgical History

Please indicate your surgical history (month/year):

| Surgery | Month/Year | Other Surgery (please indicate) | Month/Year |
|---|---|---|---|
| Tubal ligation | | | |
| D&C | | | |
| Hysterectomy | | | |

## Family History

Please mark all that apply.

| | Mother | Father | Maternal GM | Maternal GF | Paternal GM | Paternal GF | Child | Other |
|---|---|---|---|---|---|---|---|---|
| Diabetes | | | | | | | | |
| High blood pressure | | | | | | | | |
| Heart disease | | | | | | | | |
| Breast cancer | | | | | | | | |
| Ovarian cancer | | | | | | | | |
| Uterine cancer | | | | | | | | |
| Cervical cancer | | | | | | | | |
| Colon Cancer | | | | | | | | |
| Mental retardation or birth defects | | | | | | | | |
| Other: | | | | | | | | |
| Other: | | | | | | | | |

# OB/GYN New Patient Information

| List your current medications Including over the counter medications: | |
|---|---|
| | |
| | |
| | |
| | |

| List your medication or contact allergies below (e.g., latex, nickel): | |
|---|---|
| | |
| | |
| | |

Are you currently experiencing any of the following problems?

☐ Fever/chills ☐ Chest pain ☐ Abdominal pain ☐ Pelvic pain ☐ Sexual problems
☐ Weight gain ☐ Heart palpitations ☐ Weight loss ☐ Vaginal Discharge ☐ Nausea/vomiting
☐ Diarrhea ☐ Chronic cough ☐ Constipation ☐ Urinary incontinence
☐ Shortness of breath ☐ Stool incontinence ☐ Other _____

OB/GYN New Patient Information

# Financial Policy

Thank you for choosing The Ohio State University Wexner Medical Center for your health care. The location you are being seen is part of Ohio State's Wexner Medical Center. We want to make your visit as easy as possible by providing information that will help you with our billing and payment procedures.

Be sure to bring these items with you to each visit:

- Valid Driver's License or State Issued ID
- Insurance Card(s)
- Payment such as cash, check or credit card
- Test results, x-rays and any other materials, if asked to provide those

We may not be able to see you if you do not bring these items.

If you need to reschedule or cancel an appointment, contact our office at least 24 hours in advance.

Phone numbers are provided below. If you miss an appointment without notice, a rescheduled appointment cannot be guaranteed. Repeated failure to keep your appointment may result in you being dismissed as a patient.

**Payments**

- At the time of your visit, you are responsible to pay any deductible, copayment, coinsurance, or outstanding balance as specified by your insurance company.
- Any medical services not covered by your insurance company must be paid in full at the time of the visit unless you have made arrangements with us before the appointment.
- If you do not have insurance, you will be expected to pay a deposit at the time of service unless other arrangements have been made with us.
- You need to be sure that any needed referrals and authorizations for treatment are provided to us before the visit. Your visit may be rescheduled, or you may have to pay the full amount for the services, if you do not provide the needed referral or authorization.
- Financial aid is available for qualified patients. A check of your credit status may be run to help determine if you qualify. If you feel that you may qualify, please contact the Patient Financial Services Unit. Phone numbers are provided at the end of this document. You may have to wait for your visit to be scheduled until your financial aid has been approved**.**
- Payment can be made with cash, check or credit card. Visa, MasterCard, American Express and Discover are accepted by our offices. There is a $30 fee for any check returned by the bank for any reason. If you have any questions or concerns, please contact the billing customer service phone number provided below.

**Care of Children**

- In the event of a divorce, both parents will be considered equally responsible for payment. It will be up to the parent(s) to resolve divorce decree differences.
- With few exceptions, non-emergent treatment will be denied for any child unless the parent or guardian is present. If you cannot attend an appointment with your child, call the office in advance to see if arrangements can be made. Payment arrangements must be made prior to the appointment.

# OB/GYN New Patient Information

**Insurance Benefits and Forms**

- Ohio State's Wexner Medical Center contracts with many insurance companies. If you have insurance with one of these companies, our billing offices will submit a claim for payment of services for you unless you instruct us not to. All needed insurance information, including special forms, must be completed by you before you leave your appointment.
- If the Ohio State's Wexner Medical Center does not contract with your insurance company, you will be responsible for any balance not paid by your insurance. While our billing offices will file a claim on your behalf to your insurance company, you may be required to pay Ohio State's Wexner Medical Center before receiving services. If payment is received from your insurance company after processing your claim, you will be refunded any extra amount after all charges have been covered.
- If you have questions about your specific insurance coverage, you need to call your insurance company. Their telephone number should be printed on your insurance card.
- Our staff is happy to help with insurance questions relating to how a claim was filed. We will also provide any additional information your insurance company might need to process your claim.

**Care as part of Clinical Research Study**

- Many studies involve routine services that would be done even if you were not part of the study. If a service provided is not considered part of the research study, Ohio State's Wexner Medical Center will bill you or your insurance for that service.
- You are responsible to know what services will be billed to you or your insurance and what will be paid for by the study. If you have questions about what services should be paid for by the study, contact your study doctor or coordinator at the number on the study consent form.

**Financial Policy Acknowledgement**

I have read or someone has read the form to me and I received a copy of the above Financial Policy. I agree to follow the policy.

_____

*Printed Patient or Responsible Party Name* *Date*

_____

*Signature for Patient or Responsible Party*

| Ohio State's Wexner Medical Center Phone Numbers | |
|---|---|
| Hospital Billing Inquiries:<br>(614) 293-2100 or (800) 678-8037 | Physician Billing Inquiries:<br>(614) 255-1000 or (888) 886-8446 |
| Appointment or General Information inquiries:<br>(614) 293-5123 or (800) 293-5123 | |

OB/GYN New Patient Information

# Financial Policy

***Please read and sign this form to recognize that we have provided notice and given you a copy of this Patient Identification Policy.***

We strive to provide our patients with excellent quality and patient care services. Our commitment to your wellbeing is something everyone at our organization takes seriously.

As our patient, you will be asked to provide a driver's license (or other legal photo ID) and insurance card(s) at registration. This is to ensure that the information we have is correct, and that your plan is current and one in which we participate. Inaccurate information within your medical record can create patient safety issues for you.

It is our policy that this information must be collected at each time of service. Therefore, it is expected that you will bring this information with you to each appointment. If you fail to bring the proper identification after three instances within a rolling one-year period, the clinic may discharge you from their practice from receiving future services.

We appreciate you as our patient and thank you for your assistance in meeting our patient safety goals at OSU Physicians, Inc. and The Ohio State University Wexner Medical Center.

**This is not a consent. By signing this document, you are only stating that we have provided you with notification and a copy of the policy. If you wish to receive a copy of this form, ask the Registration/Admitting staff member who is helping you.**
**I have been given a copy of the Patient Identification Policy and the reason for the policy is explained above.**

Print Name: _____

Signature: _____

Date: _____

Authorized Agent: _____

Relation to Patient: _____

*Office Use:*

Patent Name: MRN: PIN:

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

# Keeping Your Identity Safe

Keeping your identity safe is important to us. That is why you will be asked to present photo identification at registration. We want to make sure that the name on your record matches who you are.

*Why do I need to present my photo ID?*
We want to make sure we are providing the right care to the right person. We will use your photo ID to match your name with your medical record.

*Do I need to present my photo ID each time I come to OSU Medical Center?*
To ensure that the name in the medical record matches who you are, we will be checking your photo ID each time that you visit any OSU Medical Center facility.

*Why are some areas taking my photo when I register?*
As an extra measure of safety, some areas of the Medical Center will ask to take a photo of you. This photo will be placed in our system so if you need to come back again we can match your photo with your record. This is just another way we are helping to keep your identity safe.

*How can I ensure my identity is safe?*
To help protect yourself, and to make sure that your identity is not being used by someone else to receive care, the Federal Trade Commission suggests the following:

- Closely monitor any "Explanation of Benefits" sent by public or private health insurers. If anything appears wrong, raise questions with the insurer or the provider. Do not assume that there are no problems simply because you may not owe any money.
- Once a year (or more often, if you believe there is cause for concern), request a listing of benefits paid in your name by any health insurers that might have made such payments on your behalf.
- Monitor your credit reports with the nationwide credit reporting companies (Equifax, Experian and TransUnion), to identify reports of medical debts.

For other tips on how you can ensure your identity is safe, visit the Federal Trade Commission's site at www.ftc.gov/idtheft. If you feel that your identity has been compromised contact the Ohio Attorney General's Identity Theft Verification Passport Program at 1-888-MY-ID-4-ME (1-888-694-3463) or get more information regarding Identity Theft at the Ohio Attorney General's website at http://www.ohioattorneygeneral.gov/.

If you have questions about your medical record, please contact the OSU Medical Center privacy officer at 614-293-4477.