Woman to Woman Gynecology

A-All Women Care 7908 W. Sahara Ave. Las Vegas, NV 89117 (702) 531-5400

PATIENT INFORMATION
Información Del Paciente

Today's Date: _____
Fecha

Name: (Last, First): _____
Nombre

Date of Birth:_____/_____/_____ Age:_____ Social Security #----------_____
Fecha de Nacimiento *Edad* *Seguro Social*

Address: _____Apt#:_____
Dirección

City:_____State:_____ Zip Code:_____
Cuidad *Estado* *Código Postal*

Home Phone#:_____ Cell Phone#:_____
Teléfono de casa *Teléfono de celular*

Email Address:_____
Correo Electrónico

Employer:_____ Occupation:_____
Empleador *Trabajo*

Work Phone#:_____
Teléfono de trabajo

Marital Status (Circle one): Single Married Divorced Separated Widowed
Estado Civil *Soltera* *Casada* *Divorciada* *Separada* *Viuda*

Race: □ White □ Asian □Pacific Islander □ Black or African American

□ Native American Indian Other:_____

Ethnicity: □Hispanic or Latino □Not Hispanic or Latino Specify: _____

EMERGENCY CONTACT INFROMATION
En Caso de Emergencia Notifique

Emergency Contact: _____
Contacto de Emergencia

Phone: _____ Relationship:_____
Teléfono *Relación*

Nearest Friend or Relative Not living with you: _____
La Persona o Amistad que no Vive con Usted

Phone:_____ Relationship:_____
Teléfono *Relación*

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INSURANCE INFORMATION

Información de Seguranza

Primary Insurance:_____ Policy#:_____
Seguro Primario *Number de Póliza*

Claims Address:_____ City: _____
Dirección de Reclamar *Cuidad*

State:_____ Zip Code: _____ Phone#: _____
Estado *Código Postal* *Teléfono*

Policy Holder:_____ Insured D.O.B ____/_____/_____
Tenedor de una Póliza *Fecha de Nacimiento*

Relationship to Patient: _____ Social Security of Insured: _____
Relación *Seguro Social del Asegurado*

Employer: _____ Occupation: _____
Empleador *Trabajo*

Date:

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Last name:_____ First name:_____ Date of birth:_____

Last Menstrual Period:_____ Was it normal? Yes No If No, please describe:_____

Are you menopausal or postmenopausal? Yes No I experience no more periods due to:_____

_____

Why are you here today?

- O Routine Annual Visit with **NO** problems
- O Are you having any gynecologic problems you want to discuss with the doctor?_____

_____

_____

_____

_____

Are you **CURRENTLY** experiencing any of the following (please circle those that apply):

Neurological: dizziness, numbness in arms or legs, trouble walking, other: _____

Eyes: double vision, spots before eyes, vision changes, other: _____

ENT/Mouth: ear aches, ringing in ears, sinus problems, sore throat, mouth sores, other: _____

Cardiovascular: swelling of the legs, chest pain, blood clots in legs or lungs, other: _____

Respiratory: spitting up blood, shortness of breath, coughing, other: _____

Gastrointestinal: diarrhea, constipation, nausea or vomiting, bowel trouble, blood in stool, black stools, incontinence of stool, other: _____

Genitourinary: blood in urine, painful urination, frequent urination, painful intercourse, vaginal: discharge, odor, or itching, urine incontinence, other: _____

Musculoskeletal: muscle pain, joint pain, muscle weakness, joint weakness, other: _____

Constitutional: weight loss, weight gain, fatigue, fever, changes in appetite, difficulty sleeping, other: _____

Endocrine: hot flashes, abnormal thirst, other: _____

Hematologic/Lymphatic: enlarged lymph nodes, continuous bleeding, bruising easily, other: _____

Psychiatric: thoughts of suicide, frequent crying, depression, anxiety, other: _____

MEDICATION INFORMATION

Please list the **PHARMACY** you would like us to use if you needed a prescription. Name and cross streets or phone number.

_____

Do you have any **ALLERGIES** to medications, latex, or iodine? If so, please list them and your reactions:

_____

_____

_____

_____

List any **MEDICATIONS** (prescription and over the counter), **Vitamins, or supplements** you are taking and the dosage.

Name Dose

_____

_____

_____

_____

Do you smoke tobacco (select applicable choice)?

- O Current every day smoker
- O Current some day smoker
- O Former smoker Date Quit:_____
- O Never smoker

Do you use any smokeless tobacco, if so how often? _____

Do you drink alcohol ever, if so how often and how many drinks average? _____

Do you use any street drugs, if so please list names and last time used?_____

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PREVENTIVE CARE

When was your last?	Date	Was it normal?		If No, explain:
Pap smear	_____	Yes	No	_____
Mammogram	_____	Yes	No	_____
DEXA Scan	_____	Yes	No	_____
Colonoscopy	_____	Yes	No	_____

Have you had the following (mark all that apply and dates):

- O Gardasil vaccine (ages 9-26 for the prevention of cervical cancer and genital warts:_____
- O Flu vaccine: _____
- O Pneumococcal vaccine_____

PREGNANCY HISTORY

How many times have you been pregnant? _____
How many children do you have? _____
How many vaginal deliveries?_____
How many C-Section deliveries?_____

How many ectopic/tubal pregnancies?_____
How many miscarriages?_____
How many abortions?_____

Describe any problems you had during the prior pregnancies, **include details**:

- O Rh Negative
- O Severe bleeding requiring transfusions
- O Diabetes
- O High Blood Pressure
- O Clots in the lungs or legs (DVT)
- O Infections
- O Congenital anomalies
- O Any other problems or difficulties:_____ _____

CONTRACEPTIVE HISTORY

Are you using any contraception **currently**, if so which one? _____
Have you used any of these below?

- O Birth control pills (include names)
- O Nuvaring
- O Ortho-Evra Patch
- O IUD Mirena/Skyla/Paragard
- O Implanon
- O Depo-Provera shot
- O Diaphragm
- O Tubal Ligation

Describe any **problems** you had while taking them:_____

Please mark if **you currently have or have previously had** any of the following while taking hormonal contraception:

- O Smoker
- O Migraine Headaches
- O High Blood Pressure
- O Breast Cancer
- O Liver Problems
- O Varicose Veins
- O Gallbladder Problems
- O Blood clots of the legs or lungs
- O Family member with blood clots of the legs or lungs

SEXUAL HEALTH HISTORY

Difficulties with intercourse
Pain with intercourse
Dryness with intercourse
Inability to have an orgasm
Decreased desire for intercourse
Bleeding with intercourse

BREAST HISTORY

- O Fibrocystic changes
- O Blocked Milk Ducts
- O Cysts
- O Fibroadenomas
- O Intraductal Papillomas
- O Mastitis
- O Nipple discharge
- O Biopsy
- O Breast cancer

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GYNECOLOGIC HISTORY (Please mark those that apply to you, including dates where possible)

- O Pelvic Infections: Chlamydia, gonorrhea, mycoplasma, ureaplasma
- O Vaginal Infections: yeast, bacterial vaginosis, beta strep
- O Abnormal Pap smear
- O HPV Infection
- O Genital Warts
- O Dysplasia
- O Mollascum contagiosum
- O Trichomonads
- O Heavy or Painful periods
- O Endometriosis
- O Pelvic scarring (adhesions)
- O Uterine fibroids
- O Ovarian cysts
- O Inflamed blocked fallopian tubes (Salpingitis)
- O Uterine Cervical Ovarian Cancer
- O Ovarian Cancer
- O Fallopian Tube Cancer
- O Cervical Cancer
- O Urgency (the sensation to urinate all the time)
- O Frequency: the need to urinate frequently
- O Loss of urine with sneezing, coughing, or laughing
- O Needing to wear diapers or pads to prevent being wet
- O Uterine or vaginal anomalies: double uterus, double vagina, double cervix
- O Nocturia: waking up at night to use the bathroom more than once per night

Prolapse of pelvic organs:

- O Uterine prolapse
- O Cystocele (prolapse of the bladder)
- O Rectocele (prolapse of the rectum)
- O Enterocele (prolapse of the bowel)

HORMONAL HEALTH HISTORY

When was menopause for you (year and age)?_____

Hormonal Changes (select those that apply to you):

- O Hot flashes
- O Night and day sweats
- O Weight gain
- O Poor Bone Health
  - O Loss of height
  - O Osteopenia
- O Memory loss
- O Dry skin
- O Mood changes
- O Osteoporosis
- O Fractures
- O Lack of sexual desire
- O Vaginal dryness
- O Vitamin D status

FAMILY HISTORY

Has anyone in your family ever had the following, please list relation and their age of diagnosis if known.

- O Breast Cancer_____
- O Colon Cancer_____
- O Ovarian Cancer_____
- O Endometrial Cancer_____
- O Cervical Cancer_____
- O Diabetes_____
- O Other (please describe):_____
- O High blood pressure_____
- O Stroke_____
- O Heart disease_____
- O Thyroid disorder_____
- O Addiction_____
- O Seizures/Epilepsy_____

SOCIAL HISTORY

Please mark appropriate sexual orientation:

Heterosexual Bisexual Lesbian

Please select current relationship status:

Single Married Long term monogamous relationship

Separated Divorced Widowed

Please list current occupation: _____

Highest education level (circle one):

Some high school: _____ yrs. Some College :_____yrs. Master's Degree

Graduated High School Associates Degree PhD

GED Bachelor's Degree Technical/Trade school

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GENERAL HEALTH HISTORY Do you have any of the following?

Neurological:
- O Migraine headaches
- O Seizures/Epilepsy
- O Numbness
- O Other:_____
- O None

Eyes:
- O Glaucoma
- O Macular degeneration
- O Cataracts
- O Other: _____
- O None

ENT/Mouth:
- O Other:_____
- O None

Cardiovascular:
- O High blood pressure
- O Stroke
- O Heart disease
- O Varicosities
- O Blood clots of the legs or lungs (Deep Vein Thrombosis)
- O Circulatory problems (describe): _____
- O Other: _____
- O None

Respiratory:
- O Asthma
- O Chronic Lung Disease
- O Tuberculosis
- O Seasonal allergies
- O Other: _____
- O None

Genitourinary:
- O Kidney disease
- O Urine retention
- O Urine Incontinence
- O Kidney stones
- O Bladder cancer
- O Kidney cancer
- O Other: _____
- O None

Gastrointestinal:
- O Ulcerative colitis
- O Crohn's disease
- O Gastritis
- O Esophagitis
- O Bowel incontinence
- O Ulcers
- O GERD
- O Colonic polyps
- O Stomach cancer
- O Bowel Cancer
- O H. Pylori infection
- O Hepatitis Infection
- O Other: _____
- O None

Musculoskeletal:
- O Fractures
- O Hernia (location): _____
- O Osteoporosis
- O Osteopenia
- O Arthritis
- O Other: _____
- O None

Endocrine:
- O Diabetes
- O Thyroid disorder
- O Thyroid cancer
- O Multiple Endocrine Neoplasia
- O Other: _____
- O None

Hematologic/Lymphatic/Autoimmune:
- O Lupus
- O Leukemia
- O Hodgkin's Lymphoma
- O Sjogren's
- O Other:_____
- O None

Integumentary (Skin):
- O Basal cell carcinoma
- O Melanoma
- O Psoriasis
- O Other:_____
- O None

Psychiatric:
- O Addiction (please provide information):_____
  _____
  _____
- O Mental Illness (please provide information): _____
  _____
  _____
- O Anxiety
- O Depression
- O None

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SURGICAL HISTORY Please list all surgeries and the date of the procedure under appropriate body system.

Neurological (The brain, spinal cord, or nervous system)
- O None
- O Other_____

Eye surgery
- O Cataract removal
- O Other:_____

ENT/Mouth:
- O None
- O Tonsillectomy
- O Adenoidectomy
- O Thyroidectomy
- O Parathyroidectomy
- O Other: _____

Cardiovascular:
- O None
- O Angioplasty
- O Cardiac bypass surgery
- O Stent placement
- O Radiofrequency ablation (For abnormal heart rhythm)
- O Heart transplant
- O Other: _____

Respiratory:
- O None
- O Thoracotomy
- O Lobectomy
- O Lung transplant
- O Other: _____

Musculoskeletal:
- O None
- O Knee replacement
- O Hip replacement
- O Other: _____
- O None

Breast:
- O None
- O Mastectomy for cancer
- O Lumpectomy
- O Breast implants
- O Other: _____

Gastrointestinal:
- O Cholecystectomy (Removal of gallbladder)
- O Appendectomy (Removal of appendix)
- O Pancreatectomy (Pancreatic surgery)
- O Colectomy (Removal of part of colon)
- O Hemorrhoidectomy
- O Hernia repair
- O Other:_____

Genitourinary:
- O None
- O Hysterectomy (Removal of uterus and cervix)
- O Salpingo -Oophorectomy (Removal of ovaries/tubes)
- O Cystectomy (Removal of ovarian cyst)
- O Myomectomy (Removal of fibroids)
- O Laparoscopy (Looking inside the abdomen)
- O Tubal Ligation (Tie tubes for contraception)
- O Pelvic prolapse (Repair of vaginal hernia)
- O Mesh for prolapse
- O Cystocele repair (Repair of bladder prolapse)
- O Rectocele repair (Repair of rectum prolapse in vagina)
- O Enterocele repair
- O Nephrectomy
- O Lithotripsy
- O Cystoscopy
- O Other: _____

Hematologic/Lymphatic:
- O None
- O Lymph node resection
- O Other:_____

Endocrine:
- O None
- O Thyroid surgery
- O Other:_____

I have answered all the questions truthfully and I have not withheld any information that might affect my medical care.

Patient Name (Please print):_____

Signature of Patient:_____ Date:_____

Physician's Signature:_____ Date:_____

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2022 Office Policies

Insurance Policies and Payments:

Our goal is to provide you with the best possible care. We want to be efficient, effective and diligent in our interactions with you. We cannot practice good medicine or business without timely payments.

As a result, **all payments are due at the time of service.**

Our office is NOT contracted with most insurance and does not accept insurance fee schedules.

Our fee schedules are based on 120-150% of Medicare rates**.**

_ _____ ***Patient Initials***

Labs and Testing:

We are not contracted with Insurances for Office Visits or Procedures done in office. We **are able** to use insurances toward labs or testing done in office. If we send out your specimen (s) to a lab for processing though your insurance we are not responsible for any bills you receive from the lab.

If you do not have insurance, or would prefer not to use your insurance, you are responsible for paying the lab fee in our office. You are also responsible for calling the lab within 24 hours for Pap smear collections for the discounted price.

We are not responsible for any bills you have received from the lab.

_ _____ ***Patient Initials***

Communications with Patient:

By supplying my telephone number, I understand that I may receive calls or text message reminders from our office. Phone calls may be made in regard to office visits, test results, or medications. We will not discuss any information over the phone until we have confirmed we are speaking directly to you. If you are unable to answer the phone, we will leave a general message that does not disclose any Personal Health Information.

Text Messages are for appointment reminders. Receiving them is completely optional. You may opt out of them at any time.

_ _____ ***Patient Initials***

Balances on Accounts:

Your balance will be due at your follow up visit, unless, there are special circumstances, such as, payment arrangements scheduled in collaboration with the office manager.

_ _____ ***Patient Initials***

Credit Card Payments

A 3.99% fee will be applied when services are paid by credit and debit. There are no fees when paying with cash.

_ _____ ***Patient Initials***

Cardholder Policy:

It is our policy that the cardholder be present at the time of the appointment. Any charges that are refuted if the cardholder is not present will become the patient's responsibility.

_____ ***Patient Initials***

Contested Credit & Debit Card Policy

After our services are provided should the patient or cardholder contest the charges and we fight the claim for those contested charges and win the patient will be responsible for a fee of $250. If this $250 fee is not paid it will be sent to collections.

_____ **Patient Initials**

Prescription refills:

No prescriptions will be refilled unless the account is paid in full or is up-to-date with the payment schedules. All prescriptions must first be approved by Dr. Anna Contomitros.
We are unable to fill prescriptions for Birth Control over 3 months unless an Annual Exam has been completed.

_____ ***Patient Initials***

Acknowledgement of the Notice of Privacy Practices

I hereby acknowledge that I have reviewed the "Notice of Privacy Practices" from Woman to Woman Gynecology. 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 Woman to Woman Gynecology use and disclose my personal health information, both with and without my authorization. I further understand that I many contact Woman to Woman Gynecology if I have any questions regarding the contents of this notice, or to file a complaint.

_____ ***Patient Initials***

No "Insurance Assignment" For Abortion Services

Any and all abortion services provided by Dr. Contomitros in office, or at the Hospital, are paid for by Cash, Debit, or Credit Card only.

Woman to Woman Gynecology does NOT bill insurances for any abortion services.

Woman to Woman Gynecology does NOT accept insurance assignments for abortion services.

_____ ***Patient Initials***

Missed Appointment Policy

Should you cancel your appointment in less than 24- 48 hours, or not show up for your appointment without giving us a courtesy call, there will be a $50.00 charge applied to your account for the missed appointment date. This amount is payable prior to the provision of any other future services.

We contact via SMS/Email/Phone call in advance with a reminder of their visit time.

Attestation by patient:

I am aware of the policies and I understand that I will be charged for late cancellations of appointment or for not showing up for my scheduled services.

_ _____ ***Patient Initials***

Collaboration between Patients and Office Providers:

We desire to help you at all times. Getting better, feeling well and being satisfied requires our mutual collaboration. So, we absolutely need your help in taking care of you! Failure to follow up with our instructions to do testing, to get your mammograms, biopsies, consultations, failure to show up for your appointments, repeatedly canceling your appointment, all will be considered as an indication that our collaboration in your best interest is not working. We will dismiss patients from our practice that are not civil to our staff and who are inconsistent with their health commitments or their payments to our practice.

We have zero tolerance for obscenities or any form of verbal or physical violence. We do not allow weapons in our office. We do not allow unauthorized photos of our staff and doctor.

Name_____**Date**_____

Signature _____**Date:** _____

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Release of Records:

If anyone were to call on your behalf, we are unable to disclose any information about you, your office visit, or your test results unless they are listed below. You do have the option of marking "No one".

I, _____, give Anna Contomitros, M.D. of A-All Women Care and Woman to Woman Gynecology, the authorization to release and discuss any information about myself and the following people.

○ No one

○ _____ _____
Name Relationship

○ _____ _____
Name Relationship

○ _____ _____
Name Relationship

○ _____ _____
Name Relationship

○ _____ _____
Name Relationship

I understand that is my full responsibility to notify the office of any changes.

Signature:_____ Date:_____