



**1300 Upper Hembree Road  
 Building 100, Suite D  
 Roswell, GA 30076  
 Phone: 770-670-6170  
 FAX: 770-670-6171  
 www.PWHCares.com**

# NEW PATIENT PACKET

LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ MI: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_  
 \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

**PHONE CONTACTS: Please Check Best Contact Number**

HOME: \_\_\_\_\_  CELL: \_\_\_\_\_  WORK: \_\_\_\_\_

**Employment Status:**

Employed Full Time  Employed Part Time  Student  Retired  Homemaker

Place of Employment/School You Attend: \_\_\_\_\_

Phone # of Place of Employment/School You Attend: \_\_\_\_\_

**Ethnicity:**  Caucasian  African-American  Hispanic  Asian  Other: \_\_\_\_\_

**Marital Status:**  Single  Married  Separated  Divorced  Widowed

**Insurance Information:**

I Do Not Have Health Insurance and Will Self-Pay

Insurance Company's Name: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Policy Holder's DOB: \_\_\_\_\_

**Do you have Secondary/Supplemental Insurance?  NO  YES IF YES:**

Insurance Name \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_

Policy Holder's DOB: \_\_\_\_\_

**Spouse's Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Best Contact Number: \_\_\_\_\_  cell  home  work

**Emergency Contact Person:** \_\_\_\_\_ Phone No: \_\_\_\_\_

(other than spouse)

How they are Related to you:  Spouse  Partner  Sibling  Friend  Other: \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US? :**  Google  North Fulton Hospital  Emory Johns Creek Hospital

Referring Person or Doctor: \_\_\_\_\_  Other (please specify): \_\_\_\_\_



**Prescription Refills- Please allow 48 hours for refills. We will not be able to refill anything not prescribed from our offices.**

- Please leave your name, date of birth and pharmacy name and number when calling for a prescription refill.
- Please check your bottles early and call us before you are out of your medication.
- Please check with your pharmacy at the end of the day. We will only call you if there is a problem filling your request.

**Messages- All calls after 3:00 pm will be returned the next business day.**

- Our providers and clinical staff cannot diagnose your symptoms over the phone. If you require a new prescription for symptoms you are experiencing, please be advised that you will need to schedule an appointment to see one of our providers.
- If you call and leave us a message, there is no need to leave multiple messages throughout the day.
- If you require a call back but it's not an emergency, we will contact you by the end of the day.

**Appointments**

**If you are unable to keep an appointment, please call as soon as possible to reschedule.** If you are more than 15 minutes late for your appointment, we will do our best to fit you into the schedule, but we may need to reschedule you. If you do not cancel 24 Hours in advance of your appointment or do not show for an appointment without 24 Hour Notice, you will be charged \$25 per visit. In consideration of our other patients, please know that If you have three (3) or more No Shows or Cancellations Without Notice, we have the right to deny you further appointments.

**Lab/Test Results**

- Our office will contact you with any **ABNORMAL** lab results and instruct you on appropriate follow up. If you do not hear from us, your results are within normal range and no follow-up is necessary.
- However, If you want to know any test results, please call us, and our medical assistant will return your call within 48 hours.
- Please allow 7-10 business days for most pap and lab results.
- Our labs are processed through **LABCORP. It is your responsibility to inform us if your insurance requires a different laboratory.**

**Obstetrical Administrative Fee**

There is an *optional* \$75 Administrative Services Fee for obstetrical patients to cover all administrative services that are not covered by your insurance. If you choose to not pay this optional fee:

- There is a \$35 fee per form for completion of all forms including disability, FMLA and health assessments.
- There is a \$35 administrative fee for each requested copy of your medical records from our office.

**Patient Refund:**

The following criteria must be met prior to issuing a patient refund. There should be no outstanding insurance claims or balances on any of the patient's accounts. Refunds will be issued once all outstanding insurance claims have been paid and all office charges are current. Refunds will be issued once a month.

**Surgical Procedures:**

The patient will be charged a fee of \$300.00 in the event that a surgical procedure which has been scheduled for the patient is cancelled without 72 business hour notice. Exceptions may be made on a case by case basis.

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**Authorization of Insurance Benefits, Medical Treatment, Patient Responsibility and Information Release**

I hereby give consent for medical treatment and authorize direct payment of surgical/medical benefits to Shelley Dunson-Allen, MD, PC for services rendered by her in person, by her employees/affiliates or under her supervision at Providence Women's Healthcare. Our office will file primary insurance claims for you; however, office visit co-pays, deductibles, and co-insurances are due at the time these services are rendered. In the event that a non-covered service is performed, or non-covered lab work is ordered and performed; insurance coverage is not in effect because we are not participating in your plan; or insurance coverage is not in effect on the date of service; you will be responsible for all the charges related to your medical care. Please remember it is **YOUR** responsibility to contact your insurance company to verify that Dr. Shelley Dunson-Allen, at 1300 Upper Hembree Road, Roswell, GA 30076 is a participating physician with your particular insurance plan.

**Patient Financial Responsibility:** The patient is expected to present all insurance cards at each visit. All co-payments, deductibles, and co-insurance are due at time of service. No new services will be rendered if you have an outstanding balance.

**Self-Pay Account:** Self-pay accounts are patients who are covered by insurance plans that our office does not participate with, patients without a correct insurance card on file, or patients that do not have insurance at time of service. It is expected that payment is required at time of service for all services including surgeries.

**Authorization to Release Information**

I hereby authorize Providence Women's Healthcare to release my medical or incidental information that may be necessary for medical care or in processing applications for financial reasons.

\_\_\_\_\_  
Patient or Parent/Guardian Signature (if patient is a minor/under age 16)

\_\_\_\_\_  
Today's Date



At Providence Women's Healthcare we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes personal information we collect from you, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective 10/01/2014 and applies to all protected health information by federal regulations.

Understanding Your Health Record/Information

Each time you contact Providence Women's Healthcare a record of your contact is made. Typically, this contains symptoms, diagnosis, treatment and plan for future care. It also contains a description of the equipment or supplies we provided for you. The information is often referred to as health or medical record and serves as a:

- Basis for planning your care and treatment
• Means of communication among the many health professionals who contribute to your care
• Legal document describing the care you received
• Means by which you or a third party payer can verify that services billed were actually provided
• A tool in which we can assess and continually work to improve the care we render and outcomes we achieve

Understanding what is in your record and how your health information is used to help you to: ensure its accuracy, better understand, who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Your health record is the physical property of Providence Women's Healthcare, but the information it contains belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request
• Inspect a copy of your health record as provided for in CFR 164.524
• Request amendment to your health record as provided in 45 CFR 164.528
• Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
• Request communications of your health information by alternative locations
• Request a restriction on certain uses and disclosures of your health information as provided by 45 CFR 164.522, and revoke authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Providence Women's Healthcare is required to:

- Maintain the privacy of your health information
• Provide you with this notice as to our legal duties and privacy with respect to information we collected and maintain about you
• Abide by the terms of this notice
• Notify you if we are unable to agree to a requested restriction, and accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us with.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in this authorization.

For More Information or to Report a Problem

If you have any questions and/or would like any additional information, you may contact the office manager at Providence Women's Healthcare at (770)670-6170.

If you believe your privacy rights have been violated, you can file a complaint with the privacy officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office of Civil Rights. The address for the OCR is: Office of Civil Rights: U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201

Examples of Disclosure for Treatment, Payment and Health Options

Table with 2 columns: Category (e.g., For treatment, For payment) and Description of disclosure scenarios.

## Initial Patient Information

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

What is the **main** reason for your appointment today? \_\_\_\_\_

Please list your pharmacy **name, address and phone number** where you would like your prescription refills to be called in for you:

### Obstetrical History

Please indicate total number of:

Pregnancies	Full Term Births	Preterm Births	Miscarriages	Abortions	Ectopic/Tubal Pregnancies	Live Births	Living Children

Number of Cesarean sections \_\_\_\_\_ List the date of each delivery: \_\_\_\_\_

Any pregnancies complicated by:

High blood pressure    Hemorrhage    Preterm labor    Gestational Diabetes    Other: \_\_\_\_\_

Were you ever hospitalized before labor?  YES  NO   If yes, why \_\_\_\_\_

### Gynecological History

Please fill out completely

I had my very first period at age \_\_\_\_\_. My most recent period started on \_\_\_\_/\_\_\_\_/\_\_\_\_ (date). My period comes approximately every \_\_\_\_\_ (number) days and stays on for a total of \_\_\_\_\_ days. On average, I use \_\_\_\_\_ (number) of pads/tampons on the heaviest day of my period.

If not menstruating, age when stopped \_\_\_\_\_ Any bleeding or spotting since last period?  YES  NO

Do you have...?	Yes	No	
Painful periods?			If yes, please indicate: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Incapacitating
Any clots?			
Bleeding or spotting between periods?			
Bleeding after intercourse?			
Pain with sexual intercourse?			

Have you had...?	Yes	No	If yes, give date	Result
A Pap test (cervical cancer screening)?			/ /	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal: _____
Mammogram?			/ /	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal: _____
Colonoscopy?			/ /	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal: _____
Bone Density Test?			/ /	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal: _____
Cholesterol Check?			/ /	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal: _____

Contraceptive/Sexual History	Yes	No	
Are you sexually active?			How many partners in the last 12 months: _____ Lifetime: _____
			If yes, do you have sex with...? <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both
Have you ever tested positive for STDs?			<input type="checkbox"/> Genital Herpes <input type="checkbox"/> Genital Warts <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Trichomonas <input type="checkbox"/> Cervical Human Papilloma Virus (HPV) on Pap
Type of contraception used:	<input type="checkbox"/> Pills <input type="checkbox"/> Mirena IUD inserted: _____ <input type="checkbox"/> ParaGard IUD inserted: _____ <input type="checkbox"/> Diaphragm <input type="checkbox"/> Condoms <input type="checkbox"/> Rhythm <input type="checkbox"/> Withdraw <input type="checkbox"/> Tubal Ligation <input type="checkbox"/> Vasectomy <input type="checkbox"/> Foam <input type="checkbox"/> Other: _____ <input type="checkbox"/> None		
Are you happy with your current method?			

**Medical History**

Do you presently have any of the following?

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Chills or Fevers     | <input type="checkbox"/> Fainting                  | <input type="checkbox"/> Diarrhea                 | <input type="checkbox"/> Sudden need to urinate                  |
| <input type="checkbox"/> Night sweats         | <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Constipation             | <input type="checkbox"/> Loss of urine with coughing or sneezing |
| <input type="checkbox"/> Recent weight change | <input type="checkbox"/> Hearing aid               | <input type="checkbox"/> Change in bowel habit    | <input type="checkbox"/> Abnormal pain other than period cramps  |
| <input type="checkbox"/> Poor appetite        | <input type="checkbox"/> Breast tenderness         | <input type="checkbox"/> Blood in stool           |  |
| <input type="checkbox"/> Unusual hair growth  | <input type="checkbox"/> Blood or milk from breast | <input type="checkbox"/> Frequent night urination |  |
| <input type="checkbox"/> Marked tiredness     | <input type="checkbox"/> Lump(s) in breast         | <input type="checkbox"/> Painful urination        |  |
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> PMS                       |   |  |
|   | <input type="checkbox"/> Nausea or vomiting        |   |  |

Any unusual vaginal discharge? If yes, Indicate characteristics.

- |                                 |                                 |                                 |                                 |                               |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|-------------------------------|
| <input type="checkbox"/> Watery | <input type="checkbox"/> Clear  | <input type="checkbox"/> Burns  | <input type="checkbox"/> Brown  | <input type="checkbox"/> Odor |
| <input type="checkbox"/> Yellow | <input type="checkbox"/> Bloody | <input type="checkbox"/> Mucous | <input type="checkbox"/> Itches |                               |

Have you ever had any of the following surgeries?

	Year		Year		Year
Appendix		Hernia		Womb/Uterus	
Gallbladder		Hemorrhoids		Vaginal repair	
Kidney Stones		Chest		C-section	
Tonsils		Breast		D&C	
Tumor		Ovary		Cryo/Cautery	
Varicose Veins		Fallopian Tubes		Cosmetic	

List Others:

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Other than surgery have you ever been hospitalized? If yes, why? \_\_\_\_\_

Have you ever been diagnosed with any of the following?	Yes	No	Details
HIV/AIDS			
Blood Clot/Embolism			
Cancer			Type:

Have you ever had a blood transfusion			
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List Allergies (Drugs/Food/Environmental)	Reaction

List Current Medications	Dose/Strength	Frequency

**Social History**

Please provide the following information

Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
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	Yes	No	Details
Do you smoke cigarettes?			How many per day? _____ For how long? _____
Have you ever smoked cigarettes?			When did you quit?
Do you drink alcohol?			How many drinks per day? _____ Per week? _____
Do you use street drugs?			What kind?
Do you get any regular exercise			How often?
Have you been emotionally or physically abused by your partner or someone important to you?			
Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone			

**Family History**

Have your biological grandparents, parents, brothers, sisters or children ever been diagnosed with or treated for?:

	Relationship
Tuberculosis	
Diabetes	
High blood pressure	
Heart Disease	
Breast Cancer	
Ovarian Cancer	

	Relationship	Type
Blood Disease		
Nervous Disorder		
Muscular Disorder		

**Past Medical History**

Have you ever had treatment for any of the following? (If yes, please indicate year respectively)

	Yes	No	Year
German measles			
Poliomyelitis			
Tuberculosis			
Ears			
Eyes			
Headaches			
Hepatitis			
Thyroid problem			
Liver disease			
Gallbladder disease			
Diarrhea			
Kidney Infection			
Kidney Stones			
Varicose veins			

	Yes	No	Year
Pneumonia			
Asthma			
Coughed up blood			
Heart problem			
Shortness of breath			
Anemia			
Bleeding			
Diabetes			
Yellow jaundice			
Chronic constipation			
Blood in stool			
Bladder Infection			
Blood or pus in urine			
Muscle or joint problems			

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