Account #: _____ **Southern Oklahoma Women's Health**

Date: _____

Last Name: _____ First Name: _____ M.I. _____

Mailing Address: _____

City & State: _____ Zip: _____ Age: _____

Date of Birth: _____ Phone: ( ) _____ Cell: ( ) _____

Social Security Number: _____ Marital Status: **S M W D Sep** (Circle One)

Email: _____ Pharmacy: _____

Race: □ Asian □ Black/African American □ Native Hawaiian/Pacific Islander □ Other □-American-Indian/Alaskan-Indian □ White/Caucasian □ Refuse to Give Info

Ethnicity: □ Hispanic or Latino □ Non-Hispanic or Latino □ Refuse to Give Info

Preferred Language: □ English □ Spanish □ French □ Japanese □ Other

Employer: _____ Occupation: _____

Business Phone: ( ) _____

Spouse's Name: _____ Spouse's Phone: ( ) _____

Spouse's Date of Birth: _____ Spouse's SSN: _____

Emergency Contact: _____

Phone: ( ) _____ Relationship: _____

INSURANCE INFORMATION

'LEASE FURNISH ALL INSURANCE AND MEDICAID CARDS/INFORMATION TO THE FRONT DESK. MEDICAID CARDS MUST REPRESENTED \T EACH VISIT.

Number of Insurance Plans: _____ *(If more than one, please notify front office)*

Name of Insurance Company: _____

Address: _____ City/State/Zip: _____

Name of Insured: _____ Insured's SSN: _____

'olicy #: _____ Group Name or #: _____

hereby authorize Southern Oklahoma Women's Health to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand hat I am responsible for any amount not covered by insurance. _____ **INITIAL**

NOTICE OF PRIVACY PRACTICES

Southern Oklahoma Women's Health has Privacy Practices in place. The notice describes how medical information about you may be used and disclosed, and how you can get access to this information. By signing this, you acknowledge receipt of Southern Oklahoma Women's Health's Notice of Privacy Practices.

Signature: _____ Date: _____

EFERRED BY:

Please Circle One) Physician Family/Friend Facebook/Instagram Website

f a physician or friend referred you to us, please give us their name so that we may thank them.

_____

IF PATIENT IS A MINOR, PLEASE COMPLETE THIS SECTION

Responsible Party Name: _____ Phone: ( ) _____

Address: _____ City/State/Zip: _____

Employer: _____ Employer's Phone: ( ) _____

Acct #: _____ **Name:** _____ **Date:** _____

Date of Last Pap Smear: _____ Date of Last Colon Screen: _____ Date of Last Mammo: _____

Have you ever had an abnormal pap smear: YES NO If YES, WHEN: _____

Social History:

Alcohol: YES NO Amount Used: _____

Tobacco: YES NO Amount Used: _____ Age Start: _____Age Stop: _____

Exercise: YES NO

Wear a seatbelt while traveling: YES NO

Please mark the following you have been diagnosed with by a physician:

□ Anemia	□ Depression	□ Hepatitis C	□ Urinary Incontinence	□ Blood clot/DVT/PE
□ Anxiety	□ Diabetes Type I	□ Herniated disc	□ Urinary Retention	□ TB
□ Arthritis	□ Diabetes Type II	□ High Cholesterol	□ Reflux	□ Dental problems
□ Asthma	□ Disorder of thyroid	□ High Blood Pressure	□ Rheumatic fever	□ Migraines
□ ADD	□ Gastric ulcer	□ HIV/AIDS	□ Scoliosis	□ STD
□ Bladder stone	□ Genital herpes	□ Kidney stones	□ Seizures	□ Pacemaker
□ Blood in urine	□ Genital warts	□ Sleep apnea	□ Heart Palpitations	

□ OTHER Diagnosis: _____

Menstrual History:

Age starting period: _____ Duration: _____ days Heavy □ Medium □ Light □ Last Period Date: _____

Pelvic pain with periods: YES NO Clots with periods: YES NO

Currently taking birth control: YES NO

Use hormone replacement: YES NO Menopausal: YES NO

Birth History:

How many pregnancies in total? _____ How many vaginal deliveries? _____

How many living children do you have? _____ How many cesarean sections? _____

Surgeries: Please list

Surgery	WHY?	DATE

Medications: Please list all medications you are currently taking

_____

_____

_____

_____

Medication Allergy: YES NO

LIST MED: _____

Reaction: RASH Anaphylaxis Itching

OR Other : _____

Family History:

LIST THE FAMILY MEMBER & AGE DIAGNOSED BELOW

Family History of Breast Cancer:	YES	NO	_____
Family History of Ovarian Cancer:	YES	NO	_____
Family History of Colon Cancer:	YES	NO	_____
Family History of Lung Cancer:	YES	NO	_____
Family History of Skin Cancer:	YES	NO	_____
Family History of Diabetes:	YES	NO	_____
Family History of Kidney Disease:	YES	NO	_____
Family History of Pancreatic Cancer:	YES	NO	_____
Family History of Uterine Cancer:	YES	NO	_____
Family History of Esophageal Cancer:	YES	NO	_____
Family History of Prostate (MET) Cancer	YES	NO	_____

Account #: _____

Financial Agreement:

Payment Policy: Payment is expected at the time services are rendered. We accept cash, check, VISA, or MasterCard. Arrangements must be made for the payment of any balance greater than $200.

Medicaid/SoonerCare Patients: Medicaid/SoonerCare patients will not be seen unless a current Medicaid/SoonerCare card is presented at each visit and eligibility has been verified. Any patient without a current card will be re-scheduled. Medicaid/SoonerCare gynecology patients will also be required to obtain and present a referral from their PCP. If the patient does not obtain a referral the appointment will be cancelled.

Medicare Patients: We accept Medicare assignment, therefore, we will gladly file your Medicare and secondary insurance claims. However, you will be responsible for your deductible, coinsurance, and any charges not covered by Medicare.

Returned Checks and Non-Payment of Account: All returned check will be subject to a collection fee. Returned checks not paid within 30 days of receipt will be turned over to the District Attorney's office. Receipt of two (2) returned checks in any 12-month period will result in our inability to accept future payments by check from you. Payments at that time will need to be in cash, money order, or credit card.

Accounts that are delinquent for greater than 90 days will be turned over to our collection department for handling. Once your account has been turned to the collection department, it must be paid in full before another appointment can be scheduled.

Insurance: Please remember, your insurance is a contract between you and the insurance company. As a service to you, we will be happy to file your insurance. However, the ultimate responsibility for all charges is yours. It is also your responsibility to make sure your insurance is active and current the day you are seen in the office.

Completion of Insurance/Employer Forms: There will be a completion fee for each form requested to be filled out for your insurance company or employer. Payment must accompany forms at the time of the request. Please allow at least 3 business days for completion of such forms.

Prescription Policy:

Southern Oklahoma Women's Health diagnoses and treats gynecological and obstetrical conditions. On occasion, we may prescribe medications for you to help relieve pain. These medications, when used properly, can help patients feel better and lead more productive lives. These medications can also be misused, causing harm to patient, unborn fetuses and others. For this reason, the State of Oklahoma and the Federal Drug Enforcement Administration regulate the use of medications. Southern Oklahoma Women's Health follows those laws.

Our policy:

1. Written prescriptions will NOT be replaced if lost, stolen or misplaced.
2. Prescriptions are to be taken as directed. DO NOT change the frequency of the dose unless otherwise directed by a Southern Oklahoma Women's Health professional. If a change does occur this will be documented in your chart.
3. By law, controlled substances cannot be refilled over the phone.
4. Refills for prescriptions listed below may be refilled every three months. As a result, if you were not seen in the hospital or office in the past three months, prescriptions cannot be refilled.
    a. Sleep aids such as: Ambien, Lunesta
    b. Anti-inflammatories such as: Celebrex, Bextra
    c. Narcotics such as: Lortab, Vicodin, Hydrocodone
    d. Muscle Relaxers such as: Soma, Flexeril, Robaxin
5. If your prescription bottle indicates that you have refills remaining, contact your pharmacy directly. If there are no refills left, you will need to contact our office and schedule an appointment.
6. Refills will NOT be authorized at night, on weekends, or holidays. Be sure to plan ahead to make sure you have enough pills.
7. Before your visit to Southern Oklahoma Women's Health, please check your supply of medication. If you need a refill, please ask during your appointment.
8. Refills requests for hormone replacement medications and birth control pills can only be refilled if you have a routine gynecology appointment scheduled.
9. Refill requests for prescriptions not prescribed by Southern Oklahoma Women's Health will not be authorized.
10. Prescription requests made prior to 12 noon will be available at your pharmacy after 5pm that day. Requests made after 12 noon will be available at your pharmacy after 10am the following morning.

Signature: _____ **Date:** _____

Southern Oklahoma Women's Health Covid-19 Consent

I _____, understand that I am opting for an elective treatment/procedure/surgery that is not urgent and may not be medically necessary.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that Dr. Henry Ramirez and all the staff at Southern Oklahoma Women's Health are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure/surgery.

I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for Dr. Henry Ramirez and all the staff at Southern Oklahoma Women's Health to proceed with the same.

Initial _____

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure/surgery can lead to a higher chance of complication and death.

Initial _____

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital.

Initial _____

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself.

Initial _____

I have been given the option to defer my treatment/procedure/surgery to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure/surgery.

Patient Signature: _____ Date: _____

Provider Signature: _____