

# The Women's HEALTH GROUP, P.C.



Welcome to The Women's Health Group! We understand you have many options for healthcare providers. We are happy that you chose us! Visiting a new doctor can be an unnerving experience. We are here for you and hope to make your visit as pleasant as possible.

In order to get to know you better and eliminate some of your waiting time, we are enclosing your new patient paperwork in this packet. **Please complete all the forms and bring them with you to your appointment. Please have your current insurance card and a photo I.D. with you (a driver's license or state-issued identification card will be sufficient).** The enclosed checklist should help you remember everything for your appointment.

It is our policy to collect all co-payments, co-insurance, and deductibles at the time of service. If you are unable to make such payments at the time of your appointment, please call our billing department at 303-280-2229, option 3 to make financial arrangements prior to your visit. We now offer **Simple Solutions**, an easy way to make automatic payments on your account through your credit card. You will find the paperwork for **Simple Solutions** enrollment in this packet.

Our physicians make every effort to maintain a time-efficient schedule however occasionally a patient will have more questions than expected and will require extra time. And you know babies- they come when they are ready, so your physician may get called out to a delivery. If the doctor is called away during your appointment time, we will do everything we can to accommodate your schedule. You may be able to see another physician if time permits. Please understand this is a people-business and schedule changes and interruptions are sometimes unavoidable.

The patient portal, accessed through our website, [www.whg-pc.com](http://www.whg-pc.com), has options to request an appointment, and once you are established with us, request prescription refills and pay your bill. Our website also offers educational material, pictures and biographies of our physicians, as well as many useful links. You can also find us on Facebook at [www.facebook.com/thewomenshealthgroup](http://www.facebook.com/thewomenshealthgroup). We have Facebook discussion topics planned for the upcoming months, so tune in! You can also stay informed about product recalls and office news through our Facebook page.

If you ever have a concern, a question, or a compliment, please feel free to contact our office. You can call us at our main phone number, 303-280-2229 or send an email to: [info@whg-pc.com](mailto:info@whg-pc.com). Our Patient Experience Coordinator will research your request and respond to you promptly.

Thank you for choosing The Women's Health Group! We look forward to seeing you soon!

Sincerely,

**The Physicians and Staff at The Women's Health Group**

**THE WOMEN'S HEALTH GROUP, P.C.**  
**PATIENT REGISTRATION**

**PATIENT INFORMATION**

Legal Name \_\_\_\_\_

Street Address \_\_\_\_\_  
Last First Middle Initial Apt/Unit #

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ SS # \_\_\_\_\_ Marital Status // S // M // D // Other

Race \_\_\_\_\_ Ethnicity - Hispanic // Non-Hispanic // Decline

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_ Email Address \_\_\_\_\_

**Preferred Pharmacy** \_\_\_\_\_ Address \_\_\_\_\_

Spouse/Responsible Party: Name \_\_\_\_\_ SS# \_\_\_\_\_

Work Phone \_\_\_\_\_ Employer/Occupation \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance** \_\_\_\_\_ Type (HMO, PPO, etc) \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_ Insured's Birth Date \_\_\_\_\_

Claims Address \_\_\_\_\_

Membership Services Phone \_\_\_\_\_ **Effective Date** \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ Type (HMO, PPO, etc) \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_ Insured's Birth Date \_\_\_\_\_

Claims Address \_\_\_\_\_

Membership Services Phone \_\_\_\_\_ **Effective Date** \_\_\_\_\_

**ADDITIONAL INFORMATION**

Emergency Contact \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Home Phone \_\_\_\_\_ Work phone \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone number \_\_\_\_\_

**Whom may we thank for referring you?** \_\_\_\_\_

**MEDICAL INFORMATION AUTHORIZATION:** I authorize release of any medical information necessary to process my claims.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**ASSIGNMENT OF BENEFITS AND AGREEMENT FOR PAYMENT:** I authorize medical benefits to the named provider. I understand that I am financially responsible for charges not covered by this authorization. I agree to pay all noncovered fees incurred within 30 days or my account may incur interest at the rate of 18% ANNUAL PERCENTAGE RATE. I further agree to pay all costs including actual attorney fees incurred for collection of my account.

Signed \_\_\_\_\_ Date \_\_\_\_\_

# THE WOMENS HEALTH GROUP, PC

## Patient Questionnaire

**Patient Name** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Reason for visit** \_\_\_\_\_ **DATE** \_\_\_\_\_

Last Annual exam: Date \_\_\_\_\_

Last Colonoscopy: Date \_\_\_\_\_ Result \_\_\_\_\_

Last Diabetes Screen: Date \_\_\_\_\_ Result \_\_\_\_\_

Last Cholesterol Screen: Date \_\_\_\_\_ Result \_\_\_\_\_

Last Mammogram: Date \_\_\_\_\_ Result \_\_\_\_\_

Last Osteoporosis Screen: Date \_\_\_\_\_ Result \_\_\_\_\_

Last Pap Screen: Date \_\_\_\_\_ Result \_\_\_\_\_

Last Thyroid Screen: Date \_\_\_\_\_ Result \_\_\_\_\_

### **PAST GYNECOLOGICAL HISTORY**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Birth control<br>Type _____ | <input type="checkbox"/> Ectopic Pregnancy | <input type="checkbox"/> No Periods        |
| <input type="checkbox"/> Cervical Dysplasia          | <input type="checkbox"/> Endometriosis     | <input type="checkbox"/> Abnormal Bleeding |
| <input type="checkbox"/> Fluid in fallopian tubes    | <input type="checkbox"/> Fibroids          | <input type="checkbox"/> Painful Periods   |
| <input type="checkbox"/> Vaginal Dysplasia           | <input type="checkbox"/> Herpes            | <input type="checkbox"/> Pelvic Pain       |
| <input type="checkbox"/> Vulvar Dysplasia            | <input type="checkbox"/> Infertility       | <input type="checkbox"/> Pelvic Infection  |
| Other _____  | <input type="checkbox"/> Menopause         | <input type="checkbox"/> Pelvic Mass       |
|  |  | <input type="checkbox"/> Pelvic Prolapse   |

### **PAST MEDICAL HISTORY**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Abnormal Mammogram         | <input type="checkbox"/> Elevated Prolactin             | <input type="checkbox"/> Anemia                    |
| <input type="checkbox"/> Breast Cyst                | <input type="checkbox"/> Hyperthyroid                   | <input type="checkbox"/> Blood Transfusion in past |
| <input type="checkbox"/> Fibrocystic Breast Disease | <input type="checkbox"/> Hypothyroid                    | <input type="checkbox"/> Coagulation Disorder      |
| <input type="checkbox"/> Breast Discharge           | <input type="checkbox"/> Metabolic Syndrome             | <input type="checkbox"/> Varicose Veins            |
| <input type="checkbox"/> Breast Mass                | <input type="checkbox"/> Obesity                        | <input type="checkbox"/> Blood clot in leg/lung    |
| <input type="checkbox"/> Breast Pain                | <input type="checkbox"/> Polycystic Ovarian<br>Syndrome | <input type="checkbox"/> Von Willebrand's Disease  |
| <input type="checkbox"/> Cancer<br>Type _____       | <input type="checkbox"/> Lupus                          | <input type="checkbox"/> Chronic Back Pain         |
| <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Anal Fissures                  | <input type="checkbox"/> Fibromyalgia              |
| <input type="checkbox"/> High Cholesterol           | <input type="checkbox"/> Constipation                   | <input type="checkbox"/> Osteopenia                |
| <input type="checkbox"/> Heart Palpitations         | <input type="checkbox"/> Reflux Disease/Heartburn       | <input type="checkbox"/> Osteoporosis              |
| <input type="checkbox"/> Mitral Valve Prolapse      | <input type="checkbox"/> Hemorrhoids                    | <input type="checkbox"/> Headaches/Migraines       |
| <input type="checkbox"/> Diabetes Type _____        | <input type="checkbox"/> Irritable Bowel Syndrome       |  |

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Seizure Disorder   | <input type="checkbox"/> Seasonal Allergies             | <input type="checkbox"/> Interstitial Cystitis      |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Bladder urgency            |
| <input type="checkbox"/> Anxiety Disorder   | <input type="checkbox"/> COPD/Obstructive<br>Bronchitis | <input type="checkbox"/> Protein/Blood in Urine     |
| <input type="checkbox"/> Bipolar Disorder   | <input type="checkbox"/> Chronic Sinusitis              | <input type="checkbox"/> Kidney/Bladder Infections  |
| <input type="checkbox"/> Depression         |   | <input type="checkbox"/> Incontinence/Loss of urine |
| <input type="checkbox"/> Other _____        |   | <input type="checkbox"/> Kidney Stones              |

### **PAST GYNECOLOGICAL SURGERY**

- |  |  |                      |
|--|--|----------------------|
| <input type="checkbox"/> Cesarean Section      | Number _____                             | Reason _____         |
| <input type="checkbox"/> Ectopic Pregnancy     | Side _____                               | Treatment _____      |
| <input type="checkbox"/> Hysteroscopy          | Date _____                               | Diagnosis _____      |
| <input type="checkbox"/> Hysterectomy          | Date _____                               | Diagnosis/Type _____ |
|  | <input type="checkbox"/> Ovaries Removed | Reason _____         |
| <input type="checkbox"/> Laparoscopy           | Date _____                               | Diagnosis _____      |
| <input type="checkbox"/> Prolapse/Incontinence | Date _____                               | Type _____           |
| <input type="checkbox"/> Sterilization         | Date _____                               | Type _____           |

**PAST SURGERIES**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Abdominal Surgery     | <input type="checkbox"/> Hand Surgery       | <input type="checkbox"/> Chest Surgery    |
| <input type="checkbox"/> Ankle Surgery         | <input type="checkbox"/> Hemorrhoid Surgery | <input type="checkbox"/> Thyroid Removed  |
| <input type="checkbox"/> Appendix              | <input type="checkbox"/> Hernia Repair      | <input type="checkbox"/> TMJ Surgery      |
| <input type="checkbox"/> Bariatric - LapBand   | <input type="checkbox"/> Knee Surgery       | <input type="checkbox"/> Tonsils/Adenoids |
| <input type="checkbox"/> Bariatric – Roux-en-Y | <input type="checkbox"/> Lasik              | <input type="checkbox"/> Hip Replacement  |
| <input type="checkbox"/> Bronchoscopy          | <input type="checkbox"/> Spine Surgery      | <input type="checkbox"/> Knee Replacement |
| <input type="checkbox"/> Cataract Surgery      | <input type="checkbox"/> Neck Surgery       | <input type="checkbox"/> Other_____       |
|  | <input type="checkbox"/> Plastic Surgery    | _____                                     |
| <input type="checkbox"/> Gall Bladder Removed  | <input type="checkbox"/> Shoulder Surgery   |   |
| <input type="checkbox"/> Colonoscopy           | <input type="checkbox"/> Sinus Surgery      |   |
| <input type="checkbox"/> Brain Surgery         | <input type="checkbox"/> Skin Biopsy        |   |
| <input type="checkbox"/> Bladder Scope         | <input type="checkbox"/> Skin Tag Removal   |   |
| <input type="checkbox"/> Foot Surgery          | <input type="checkbox"/> Spleen Removed     |   |

**MEDICATIONS**

TYPE	DOSE	DATE STARTED

**ALLERGIES** \_\_\_\_\_

**FAMILY HISTORY**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Breast Cancer_____   | <input type="checkbox"/> Heart Disease_____                  | <input type="checkbox"/> Sickle Cell Disease/Trait      |
| <input type="checkbox"/> Colon Cancer_____    | <input type="checkbox"/> Thyroid Disease_____                | <input type="checkbox"/> Lupus                          |
| <input type="checkbox"/> Kidney Cancer_____   | <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper | <input type="checkbox"/> Blood Clots/Coagulation<br>D/O |
| <input type="checkbox"/> Ovarian Cancer_____  | <input type="checkbox"/> Osteoporosis                        | <input type="checkbox"/> Von Willebrand’s Disease       |
| <input type="checkbox"/> Prostate Cancer_____ | <input type="checkbox"/> Problems w. Anesthesia              | [<br>]Other_____  |
| <input type="checkbox"/> Uterine Cancer_____  |  | _____   |



**THE WOMEN'S HEALTH GROUP, PC**  
**SYMPTOM REVIEW**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

***PLEASE NOTE ANY SYMPTOMS YOU HAVE RECENTLY HAD THAT YOU FEEL ARE ASSOCIATED WITH YOUR VISIT TODAY. IT IS NORMAL NOT TO HAVE MOST OF THESE SYMPTOMS.***

- |                         |  |   |   |
|-------------------------|--|---|---|
| <b>CONSTITUTIONAL</b>   | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Weight Loss          | <input type="checkbox"/> Weight Gain        |
|                         | <input type="checkbox"/> Other _____         |   |   |
| <b>EYES</b>             | <input type="checkbox"/> Glasses/Contacts    | <input type="checkbox"/> Other _____          |   |
| <b>HEAD/NECK</b>        | <input type="checkbox"/> Sinus Congestion    | <input type="checkbox"/> Dentures             | <input type="checkbox"/> Decreased Hearing  |
|                         | <input type="checkbox"/> Other _____         |   |   |
| <b>BREAST</b>           | <input type="checkbox"/> Lumps               | <input type="checkbox"/> Tenderness           | <input type="checkbox"/> Nipple Discharge   |
|                         | <input type="checkbox"/> Other _____         |   |   |
| <b>CARDIOVASCULAR</b>   | <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Fainting           |
|                         | <input type="checkbox"/> Other _____         |   |   |
| <b>RESPIRATORY</b>      | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Wheezing             | <input type="checkbox"/> Cough              |
|                         | <input type="checkbox"/> Other _____         |   |   |
| <b>GASTROINTESTINAL</b> | <input type="checkbox"/> Nausea              | <input type="checkbox"/> Vomiting             | <input type="checkbox"/> Diarrhea           |
|                         | <input type="checkbox"/> Constipation        | <input type="checkbox"/> Blood in Stools      | <input type="checkbox"/> Other _____        |
| <b>GENITOURINARY</b>    | <input type="checkbox"/> Urgency             | <input type="checkbox"/> Frequency            | <input type="checkbox"/> Dysuria            |
|                         | <input type="checkbox"/> Incontinence        | <input type="checkbox"/> Decreased Libido     | <input type="checkbox"/> Other _____        |
| <b>SKIN</b>             | <input type="checkbox"/> Rash                | <input type="checkbox"/> Changes in Moles     | <input type="checkbox"/> Changes in Lesions |
|                         | <input type="checkbox"/> Other _____         |   |   |
| <b>NEUROLOGICAL</b>     | <input type="checkbox"/> Muscular Weakness   | <input type="checkbox"/> Incoordination       | <input type="checkbox"/> Tingling/Numbness  |
|                         | <input type="checkbox"/> Other _____         |   |   |
| <b>MUSCULOSKELETAL</b>  | <input type="checkbox"/> Joint Pain          | <input type="checkbox"/> Muscle Pain          | Other _____                                 |
| <b>ENDOCRINE</b>        | <input type="checkbox"/> Frequent Urination  | <input type="checkbox"/> Constant Drinking    | <input type="checkbox"/> Cold Intolerance   |
|                         | <input type="checkbox"/> Heat Intolerance    | <input type="checkbox"/> Other _____          |   |
| <b>PSYCHIATRIC</b>      | <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Depression           | <input type="checkbox"/> Difficult Sleeping |
|                         | <input type="checkbox"/> Other _____         |   |   |
| <b>HEME-LYMPH</b>       | <input type="checkbox"/> Easy Bleeding       | <input type="checkbox"/> Easy Bruising        | <input type="checkbox"/> Lymph Node Pain    |
| <b>ALLERGIC-IMMUNE</b>  | <input type="checkbox"/> Sinus Symptoms      | <input type="checkbox"/> Frequent Illness     | <input type="checkbox"/> Other _____        |

**MENSTRUAL HISTORY**

Menses began \_\_\_\_\_ y/o    Cycle Interval \_\_\_\_\_ days    Duration \_\_\_\_\_ days

light     medium     heavy    Last period \_\_\_\_\_

Birth Control Method \_\_\_\_\_     Home Pregnancy Test     Positive     Negative

Peri-menopause     Menopause Age began \_\_\_\_\_

**THE WOMENS HEALTH GROUP, PC**  
**New OB Patient Questionnaire**

Name: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

When was your last menstrual period (1<sup>st</sup> day)? \_\_\_\_\_

Are your cycles  Regular  Irregular

Were you on birth control when you became pregnant?  Yes  No

How did you find out you were pregnant?

Home pregnancy test  Missed period  Doctor Visit

Was your last period normal?  Yes  No

Did it occur at the expected time?  Yes  No

What pregnancy symptoms are you having? \_\_\_\_\_

Did you have any of the following medical problems in a previous pregnancy? (Mark all that apply):

	Yes	No
Preeclampsia	<input type="checkbox"/>	<input type="checkbox"/>
Gestational Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Preterm labor	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Blood clot	<input type="checkbox"/>	<input type="checkbox"/>

Other (please list) \_\_\_\_\_

Please list anything you may have taken or used since your last period, including prescription or over the counter drugs, vitamins, supplements, herbals medications, or recreational drugs (e.g. alcohol, speed or cocaine): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

1. Will you be 35 or older when you deliver?  Yes  No

Do you, the baby's father, or any family members have any of the following?

	Yes	No	If yes, who?
2. Thalassemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Neural Tube defect	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Down syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Tay Sachs	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Canavan's Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Sickle cell disease or trait	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Cystic fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Huntington's chorea	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Mental retardation / autism	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. Any other genetic disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
15. Birth defect not listed above	<input type="checkbox"/>	<input type="checkbox"/>	_____
16. Recurrent pregnancy losses	<input type="checkbox"/>	<input type="checkbox"/>	_____
17. Jewish or Black ancestry	<input type="checkbox"/>	<input type="checkbox"/>	_____

1. Do you live with someone with tuberculosis or have you been exposed to tuberculosis?  
 Yes  No
2. Do you have a history of genital herpes?  Yes  No
3. Have you had a viral illness or rash since your last period?  Yes  No
4. Have you ever had chickenpox or the vaccination?  Yes  No
5. Have you been exposed to radiation or chemicals?  Yes  No
6. Do you have any religious objections to any form of medical treatment (i.e. blood transfusion)?  
 Yes  No If so, what: \_\_\_\_\_
7. Do you feel safe in your home (i.e. domestic violence in the home)?  Yes  No

The Women's Health Group, P.C.  
9195 Grant Street, Suite 410  
Thornton, CO 80229

300 Exempla Circle, Suite 470  
Lafayette, CO 80026

## *SIMPLE SOLUTIONS*

I, \_\_\_\_\_ authorize The Women's Health Group, P.C. to charge my credit card for payments due including my co-pays, co-insurance, deductible, non-covered charges and charges billed but not paid by my insurance company within 90 days. *The Women's Health Group, P.C. will submit my claims to the insurance company as a courtesy, but timely payment to my account is my responsibility.* By enrolling in *Simple Solutions*, the "Patient Responsibility Amount" shown on my Explanation of Benefits (EOB), will be transferred to my credit card as listed below.

**Automatic payment will be transferred to my credit card:**

- Upon the physician's receipt of insurance EOB (preferred)
- Per payment plan arrangements with Billing Account Manager
- End of the month
- Each visit

**Options:**

- Use my credit card automatically
- I prefer a courtesy call (phone) \_\_\_\_\_ or (email) \_\_\_\_\_ to alert me to the billing date.

**If no response is received by the office within five business days, my credit card will be charged automatically.**

I assign my insurance benefits to The Women's Health Group, P.C. I authorize The Women's Health Group, P.C. to maintain my credit card information on file for *SIMPLE SOLUTIONS* purposes only.

\_\_\_\_\_  
Cardholder signature

\_\_\_\_\_  
Date

**This form is valid for one year from date of signature or upon my notification to The Women's Health Group IN WRITING prior to the next billing cycle.**

Patient Name \_\_\_\_\_ Phone: \_\_\_\_\_

Cardholder Name (Please Print) \_\_\_\_\_

Cardholder Address (Please Print) \_\_\_\_\_

City, State, Zip (Please Print) \_\_\_\_\_

Circle one:    Visa    MasterCard    Discover

Credit Card Number \_\_\_\_\_ Exp: \_\_\_\_\_ Security Code \_\_\_\_\_

For office use only:  
Account Number \_\_\_\_\_

**PRIVACY NOTICE ACKNOWLEDGEMENT**

I received a copy of The Women's Health Group, P.C.'s Notice of Privacy Practices.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\*\*A copy of the Privacy Practices can be found on our website on the Forms page. Signing this acknowledgement confirms you are aware of our Privacy Policy. If you would like a paper copy of our policy, please ask the receptionist.

## APPOINTMENT CHECKLIST

- Forms (filled out completely)
- Insurance card
- Photo I.D. (Driver's license or other state issued identification card)
- Co-payment (cash, check, credit card)
- Simple Solutions paperwork

\*\*\*\*\*

### QUESTIONS I WANT TO REMEMBER TO ASK THE DOCTOR:

---

---

---