PROVIDENCE
Medical Group
OB-Gyn Health Center

PMG OB-GYN HEALTH CENTER
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Welcome to Providence Medical Group/OB-GYN Health Center!

We are happy that you have chosen us for your medical care and we look forward to the opportunity to work with you as partners to meet your health care needs.

We would like to take this opportunity to explain our financial policies to you to ensure that you receive the benefits entitled to you with your insurance coverage and understand the financial responsibility you will have.

If you have insurance coverage, the PMG/OB-Gyn Health Center will be happy to bill your insurance company for you. Our office staff will verify coverage and benefit information prior to your visit; however, it is your responsibility to know what your insurance will cover, and how benefits will be paid.
Co-payments are due at the time of your appointment. Please be prepared to make this payment when you arrive for your visit.

For our patients without insurance coverage (private pay), a $100.00 pre-payment is due at the time of your appointment. Please contact our business office prior to your appointment to make arrangements for a payment plan if needed.

As different insurance plans have substantially different benefits, we encourage you to educate yourself on how and what your insurance plan will cover and what portion of your bill you, as the patient, are responsible to pay.

If your appointment is for an annual preventive health exam, not all insurance plans cover these types of services. Additionally, if you have a Managed Care plan you may be required to have preauthorization or a referral prior to seeing one of our providers.

Please feel free to contact Providence Medical Group/OB-Gyn Health Center business office with any questions you may have about billing or payment arrangements.

Some important Pap test information as you prepare for your annual exam.

For women without risk factors, our clinic follows the guidelines established by the American College for Colposcopy and Cervical Pathology.

Women aged 20 years and younger should not have a Pap test.

Women age 21 thru 29 should have a Pap test every three Years.

Women age 30 thru 64 should have a combination Pap with HPV test every five years.

Women age 65 and older do not need Pap smears unless they have a history of abnormal Pap tests.

Although you may not be due for a pap test, you do need an annual gynecologic exam.

Certain risk factors may influence the decision to do more frequent pap tests:
Intercourse before age 16, more than 5 lifetime partners, infrequent pap tests, abnormal pap tests, a history of sexually transmitted infection, HPV, HIV, certain cancers, immunosupression or exposure to DES.
If you have had a hysterectomy, speak to your provider about the need for continuing pap tests.

What is a Pap test? What is the difference between a Pap test and an HPV DNA test?
A Pap test is the standard way to see if there are any cell changes that you should be concerned about. The Pap test looks at a sample of cells from the cervix under a microscope to see if there are any abnormal cells. It is a very good test for finding not only cervical cancer cells but also cells that might become cancer cells. Usually health care providers do the Pap test as part of a pelvic exam. An HPV DNA test checks directly for high-risk HPV viruses. For both the Pap test and HPV DNA test, a small soft brush is used to collect cervical cells that are sent to a laboratory.

What is HPV?
HPV is short for human papillomavirus. An HPV infection is usually harmless and temporary: most people with HPV will never know they are infected because the virus usually goes away on its own. There are many types of this common virus, and only a few “high-risk” types can lead to cervical cancer. These high-risk HPV types are spread through sexual contact. There are also “low-risk” types of HPV that can cause genital or anal warts (and very rarely, oral warts), but do not cause cancer. HPV infection is very common in younger women. In most women under the age of 30, the virus will go away before it causes any significant cell changes or symptoms. If high-risk HPV types do not go away on their own, they may progress to abnormal precancerous cells. If these abnormal cells are not found and treated, they may become cancer over time. Most cell changes return to normal by themselves or simply die without progressing to cancerous lesions.

Is the HPV DNA test covered by insurance?
The screening HPV DNA test is usually covered by insurance. Please check with your own insurance company to see if the HPV DNA screening test is a covered expense for you once every three years. The CPT code for the screening HPV DNA test is 87621.

OBGYN Confidential Health

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Referring MD/PCP: _____

Occupation: _____ Marital/Relationship Status: _____ How long? _____

How did you hear about us? ☐Website/Internet ☐Yellow Pages ☐Postcard/Mailer

☐Friend/Family Member (Name) _____ ☐ Other _____

Reason for visit (problems to be addressed): _____

_____

Cycle History: Last period date: _____☐Regular ☐Irregular ☐No Periods ☐ Menopause

# of days between periods _____ Length of period_____ Problems/Pain_____

Quantity of flow: ☐ Light ☐Moderate ☐Heavy ☐Spotting between periods_____

Pap History: Last Pap date: _____ Results: _____HPV Test Date: _____ Results:_____

History of abnormal Pap, Treatment:_____

Pregnancy History: Total number of pregnancies: _____ deliveries: _____ pre-term births: _____

Miscarriages: _____ abortions: _____ c-sections: _____ ectopic pregnancies: _____RH factor:____

Number of living children: _____ adopted: _____stepchildren: ____Wt of largest baby:_____

Sexual History: currently sexually active: _____ age at first intercourse: _____

Number of current partners: ____ Sex with: ☐men ☐women ☐both Total number of partners: _____

History of STDs or possible exposure to STDs/HIV: _____

Contraception: _____ ☐none needed ☐trying for pregnancy

Previous methods of contraception_____ Problems with contraception_____

Infertility Concerns _____

History of ☐Emotional Abuse ☐Physical Abuse ☐Sexual Abuse

*******If you are an established Providence Health System patient, please simply update the following information. If you are new to Providence, please complete the following information********

Current Medications: Prescriptions, Over-the-counter medications, supplements and vitamins:

_____

_____

_____

Refills needed_____

Tobacco use and history: _____Alcohol Use: _____Recreational Drug Use: _____

Name: _____ **Date of Birth:** _____

Allergies (medication, latex or severe food allergies): _____

Medical History: Have you ever been **diagnosed with or treated for** problems related to: (explain)

☐Eyes ☐corrective lenses ☐cataracts ☐glaucoma _____

☐Ears ☐nose ☐throat ☐sinus ☐hay fever _____

☐Heart disease ☐hypertension ☐murmurs ☐rheumatic fever _____

☐Lung disease ☐asthma ☐pneumonia _____

☐Stomach ☐intestinal ☐liver disorders ☐GERD ☐hepatitis ☐ulcers _____

☐Kidney ☐bladder disease ☐frequent bladder infections ☐urinary incontinence ☐fecal incontinence

_____

☐Muscle ☐bone disease ☐fractures ☐arthritis _____

☐Skin problems ☐ tattoos ☐piercing_____

☐Brain ☐nerve disease ☐headaches ☐seizures _____

☐Psychiatric problems ☐mental illness ☐postpartum depression ☐eating disorders_____

☐Diabetes ☐thyroid disease ☐Lupus_____

☐Anemia ☐Sickle Cell Anemia ☐ blood clots ☐blood transfusions _____

☐Anesthetic complications _____☐Cancer _____

Gynecology problems: ☐Menstruation ☐breast ☐vagina ☐uterus/ovaries ☐infertility ☐menopause

☐Pap_____

Surgical History: Please list surgeries and/or hospitalizations with dates

_____

_____

Family History: include parents, grandparents, aunts, uncles, siblings & children. Indicate maternal (M) or paternal (P). Please include your family member's age at onset of illness.

Birth defects: _____ Breast cancer: _____

Ovarian cancer: _____ Uterine cancer: _____

Colon/Rectal cancer: _____ Heart disease: _____

Hypertension: _____ Stroke: _____

Diabetes: _____ High Cholesterol: _____

Osteoporosis: _____ Bleeding: _____

Blood clots: _____ Mental retardation: _____

Alzheimer's: _____ Suicide: _____

Mental illness: _____ Alcohol or drug problems: _____

Are you of Ashkenazi Jewish Decent? _____

Name: _____ Date of Birth: _____

*********All patients, new and established, please complete this information*********

Review of systems: Are you **currently** experiencing problems with:

General Well Being: ☐Activity change ☐Appetite change☐ Fever/Chills ☐Fatigue ☐ Weight changes

Endocrine: ☐ Heat/Cold Intolerance ☐Thirst ☐ Hair Loss/Growth ☐Hot flashes ☐ Excessive sweating

HENT: ☐Facial swelling ☐Neck pain/stiffness ☐Ear discharge/pain, hearing loss/tinnitus ☐ Nose bleeds ☐Vision Loss, Discharge or Pain ☐ Nose bleeds/Runny Nose/Congestion/ Post nasal drip, Sneezing ☐Sinus Pressure ☐Dental Problems ☐Drooling ☐Sore mouth or throat ☐Trouble swallowing ☐Voice changes

Eyes: ☐Discharge ☐Itching ☐Pain ☐Redness ☐ Light sensitivity ☐Visual disturbances

Respiratory: ☐Apnea ☐Chest tightness ☐Choking ☐Cough ☐Shortness of Breath ☐Wheeze

Cardiovascular: ☐Chest Pain ☐Swelling of Lower Legs ☐Irregular Heartbeat (palpitations)

Gastrointestinal: ☐ Abdominal Bloating ☐Anal bleeding ☐Blood in stool ☐Constipation ☐Diarrhea ☐Nausea ☐Rectal Pain ☐Vomiting ☐Reflux

Genitourinary: ☐Urinary Problems: Painful, frequent, sense of urgency, difficulty urinating, blood in urine ☐Urinary Incontinence ☐Flank pain ☐Genital sore ☐Pain or Bleeding with Intercourse ☐Vaginal Discharge, Odor, Itching or pain ☐Abnormal Vaginal Bleeding or Spotting ☐Breast Lumps, Pain or Discharge ☐Concerns about sexual life or functioning

Musculoskeletal: ☐Back Pain ☐Joint Pain/swelling ☐Arthritis ☐Difficulty walking

Skin: ☐Color changes ☐Rash ☐Itching ☐Dryness ☐New Moles ☐Sores

Neurological: ☐Dizziness/Vertigo ☐Facial asymmetry ☐Headaches ☐ Numbness ☐Seizures ☐Speech Difficulty ☐Fainting ☐Tremors ☐Weakness

Hematology/Lymphatic: ☐Severe Bruising ☐Easy Bruising ☐Enlarged Lymph Glands

Psychiatric: ☐Agitation/nervous/ anxious ☐Behavior problems ☐Confusion ☐Decrease concentration ☐Mood changes ☐Hallucinations ☐Hyperactive ☐Self injury ☐Insomnia ☐Suicidal ideations

Allergic/Immunological: ☐Seasonal Allergies ☐Persistent Infections

Other _____

Name: _____ Date of Birth: _____

Health Maintenance: Please date immunizations/tests/exams since your last visit:

Immunizations: Flu _____ Tetanus _____ TDAP _____ Pneumonia _____ HPV _____

Meningococcal _____ Rubella _____ MMR _____ Varicella _____ Shingles _____

Hepatitis A_____ B_____

STD Screening _____HIV_____ GC/Chlamydia _____

Mammogram _____ Bone Density _____ Sigmoid/Colonoscopy_____

Cholesterol screen _____ Thyroid _____ Diabetes Screen _____

Eye Exam _____ Dental Exam _____ Skin Exam _____

Other information your provider should be aware of:

_____

_____

Please list in order of importance some concerns you would like to discuss:

1._____

2._____

3._____

Would you like an escort present during your exam? ☐ Yes ☐ No

Do you need paperwork filled out by your provider? ☐ Yes ☐ No

********Please bring these completed forms with you to your appointment*********

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