Mid-Kansas Women's Center, PA

Patient Information

Last Name _____ First Name _____ MI _____ Preferred or Nickname _____ Maiden Name _____

DOB _____ Sex _____

SSN _____ Marital Status _____

Primary Language _____ Race _____ Ethnicity _____

Preferred Provider at MKWC _____

Preferred Pharmacy and Address _____

Primary Care Physician _____

Address _____ Apt _____

City _____ State KS Zip _____

Email Address _____

Primary Phone # _____

Cell Phone # _____

Work Phone # _____

Emergency Contact Name _____

Relationship _____

Phone # _____

Responsible Party

Full Name _____ Relationship to Patient _____ DOB _____ Phone # _____ Work Phone # _____

Insurance

Primary Insurance _____ Policy Holder's Name _____ Relationship to Insured _____ Policy holders DOB _____

Policy Holder's SSN _____ Policy Number _____ Group Number _____

Secondary Insurance _____ Policy Holder's Name _____ Relationship to Insured _____ Policy holders DOB _____

Policy Holder's SSN _____ Policy Number _____ Group Number _____

RELEASE OF INFORMATION

May we give out any medical/financial information to anyone other than yourself, your treating physician, or insurance company?

Yes _____ No _____ If Yes, to whom:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

E-PRESCRIBE AND PHARMACY BENEFITS MANAGEMENT PROGRAM (PBM)

ePrescribing allows physicians to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Benefits are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs who provide medication history and maintain formularies, or lists of drugs covered by a particular drug benefit plan. Having this information allows your provider to help you find the most beneficial and cost-effective treatments while improving your overall care.

By signing this consent form at the bottom of the page, you are agreeing that Mid-Kansas Woman's Health can request and use your prescription medication history from other health care providers and/or third party benefit payers for treatment purposes.

PRIVACY INFORMATION

I hereby acknowledge that I have received a copy of this clinic's Notice of Privacy Practices.

I understand my signature requests that payment be made to the provider and authorizes release of medical information necessary to pay the claim. A photocopy of the authorization and assignment shall be considered as valid as the original. If item 12of CMS-1500 claim form is completed, my signature authorizes release of the information to the insurer or agency shown above in Medicare/Other Insurance Company assigned cases. Co-pay must be paid at time of service. Please let us know if you need more information.

Patient Name (Print): _____

Signature of Patient: _____ Date: _____

Mid-Kansas Women's Center, PA
www.mkwc.net
9300 E. 29th St. N., Ste. 201
Wichita, KS 67226
Tel: 316-685-1277
Fax: 316-685-2135

Patient History Form

Today's Date: _____ Name: _____ DOB: _____

Reason for Visit: _____ Pharmacy:_____

Primary Care Physician: _____ Referring Physican: _____

Personal History

Please circle any that may apply.

Abnormal Pap Smears
Anemia
Arthritis
Asthma
Blood Clot
Blood Transfusion
Breast Lump
Cancer:
- Breast
- Cervical
- Colon
- Ovarian
- Skin
- Uterine

Chronic Pelvic Pain
Chronic Urinary Infection
Chronic Vaginal Infection

Colonic & Rectal Disorders
Crohn's Disease
Diabetes
Elevated Cholesterol
Endometriosis
Endometrial Hyperplasia
Fibrocystic Breast
Fibromyalgia
Habitual Aborter
- (>3 Miscarriages)

Heartburn/Reflux
Heart Disease:
- Angina
- Congestive heart failure
- Coronary artery disease
- MVP

Heavy Bleeding

Hepatitis (Type _A, _B, _C)
Hiatal Hernia
High Blood Pressure
HIV/Aids
IBS
Infertility
Irregular Periods
Kidney Stones
Migraines
Osteopenia/Osteoporosis
Ovarian Cyst
Pelvic Inflammatory Disease
Seizure Disorder
Psychiatric Disorder:
- Bipolar Disorder
- Depression
- Obsessive/Compulsive
- Schizophrenia

Sexually Transmitted Disease:
- Chlamydia
- Genital Warts
- Gonorrhea
- Herpes
- Trichomonas

Stroke
Thyroid Disorder:
- Goiter
- Graves
- Hyperthyroidism
- Hypothyroidism

Urinary Loss of Control
Uterine Fibroids
Varicose Veins
Other:_____

Surgeries/Procedures

Age or Year

_____Adenoids
_____Appendectomy/Appendix
_____Breast Augmentation
_____Breast Reduction
_____Cataracts
_____Cardiac Surgery (_____)
_____Cesarean Section
_____Cervical Procedures:
- _____Colonoscopy
- _____Cone Biopsy
- _____Cryo
- _____Laser
- _____Leep

_____Cytoscopy
_____Other: _____

Age or Year

_____D&C
_____Endometrial Ablation
_____Gallbladder Removal
_____Hip Replacement R or L
_____Hysteroscopy
_____Hysterectomy (Abd / Vag / Laparoscopic / Robotic)
_____Knee Replacement R or L
_____Laparoscopy
_____Laparotomy
_____Mastectomy R / L / B
_____Ovaries Removed R / L / B
_____Tonsillectomy
_____Tubal Ligation
_____Wisdom Tooth Extraction

(over)

Obstetrical History

Please fill out for each pregnancy even if it was a miscarriage or abortion.
If you have had a tubal ligation, hysterectomy, or are over the age of 50, only date and type of delivery are necessary.

Preg #	Type	Date mm/dd/yy	Gestational Age	WT of Baby	Sex	Hospital	Doctor	Complications
	Abortion C-Section Miscarriage Vaginal Delivery		Term / Preterm		M / F			
	Abortion C-Section Miscarriage Vaginal Delivery		Term / Preterm		M / F			
	Abortion C-Section Miscarriage Vaginal Delivery		Term / Preterm		M / F			
	Abortion C-Section Miscarriage Vaginal Delivery		Term / Preterm		M / F			
	Abortion C-Section Miscarriage Vaginal Delivery		Term / Preterm		M / F			
	Abortion C-Section Miscarriage Vaginal Delivery		Term / Preterm		M / F			

Family Medical History

Please check if anyone in your immediate family has been diagnosed or treated for the following:

Family Medical History	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Arthritis								
Blood Clot								
Breast Cancer								
Cervical Cancer								
Colon Cancer								
Ovarian Cancer								
Skin Cancer								
Uterine Cancer								
Other Cancer_____________								
Diabetes								
Heart Disease								
Hepatitis								
High Cholesterol								
Hypertension								
Kidney Disease								
Osteoporosis								
Pulmonary Disease								
Stroke								
Thyroid Disorder								

Social History

Marital Status: Married____ Divorced____ Legally Separated____ Single____ Widowed____

How often per week do you exercise? Daily____ Times per week____ Occasionally____ Rarely____ Never____

Tobacco Use (current or previous): No____ Yes____ Amount_____ Years used____ Year quit_____

Alcohol Use (current or previous): No____ Yes____ Amount_____ Type_____ Years used____ Year quit_____

Illicit Drug Use (current or previous): No____ Yes____ Amount_____ Type_____ Years used____ Year quit_____

Sexual Preference: Heterosexual (Straight)____ Homosexual (Gay)____ Bisexual____

Current Gender Identity: Male____ Female____ Transgendered Male____ Transgendered Female____ Non-Binary____

History of Physical Abuse____ History of Sexual Abuse____

Menstrual History

Age at first period: _____

First day of last period: _____

Do you have monthly periods? Yes or No

Do you have cramping? Yes or No

How many days is your typical period? _____

Length of time between periods: _____

Bleeding between periods? Yes or No

Bleeding after intercourse? Yes or No

Do you use more than 2 pads per hour? Yes or No

Types of birth control currently used? _____

Health Maintenance

Date of last pap smear: _____ Results: _____Normal Abnormal

Date of last mammogram: _____ Results: _____Normal Abnormal

Breast Biopsy: Yes or No Results: _____

Date of last Bone Density: _____ Results: _____Normal Abnormal

Date of last Colonoscopy:_____ Results: _____Normal Abnormal

Vaccine History

(Check which apply)

Hepatitis A: Yes or No

Hepatitis B: Yes or No

Zostavax: Yes or No

Gardisil (HPV) : Yes or No

Tetanus (within the last 5 years) : Yes or No

Varicella (Chicken Pox) : Yes or No

Pneumovax: Yes or No

Flu Vaccine: Yes or No

(over)

Medications

Please include all over the counter medications and prescription medications

Medication	Dose/Strength	# of pills/amount	Times/day

Allergies/Reactions

Medication	Allergies/Reaction

_____ _____

Patients Printed Name Date

_____ _____

Patients Signature Date

Mid-Kansas Women's Center, PA
INFORMED CONSENT

Mid-Kansas Women's Center is committed to providing you with the best possible care and your understanding of our policies and procedures is important to our professional relationship. Please feel free to ask if you have any questions about our fees, our policies or your responsibilities. We request that you carefully review the following information and return this form to us with your signature and today's date.

Insurance:

We will file your insurance claims; however, we will not become involved in disputes between you and your insurance carrier. You are responsible for the timely payment of your account. Your responsibility may include but is not necessarily limited to, deductibles, co-payments, co-insurance, and non-covered charges. Co-payments are due at the time you check in at the front desk and PRIOR to being seen. This requirement is part of the contract you have with your insurance carrier.

Please bring your current insurance card to each appointment. We reserve the right to reschedule appointments if proof of insurance cannot be furnished at the time of the appointment. ***Medicaid, and KanCare patients must notify us of their coverage within the month they first become eligible. We are permitted by those programs to charge you directly for services if your card is presented late.***

Payment Options:

We accept cash, checks or any of the following credit cards for payment: Visa, Master Card and Discover. If your insurance company does not pay the full balance, you will be sent a statement notifying you of any amount due from you. If you cannot pay the balance in full, please contact our billing department to make payment arrangement. Special financing is also offered through CareCredit for those patients who qualify. While we are willing to work with you regarding outstanding balances, it is necessary that you remain in contact with us. Delinquent accounts may be turned to a collection agency.

Payment Requirements for Surgery

When setting up your surgery, we will contact your insurance company to evaluate your estimated out-of-pocket expenses. We require a 50% payment prior to surgery. The remaining balance is due at the time you receive a statement.

Payment Requirements for Obstetrical Care

During your first appointment with our office, you will be scheduled to meet with one of our billing staff. We will contact your insurance company to evaluate your estimated out-of-pocket expenses. Various payment arrangements are available and will be discussed with you in detail. However, please know that our policy is that payments should be made regularly during the course of the pregnancy and payment in full is required prior to your delivery.

Returned checks:

The charge for a returned check is $30.00 payable in cash or money order. This amount will be applied to your account in addition to the insufficient fund amount. You may be placed on a "Cash Only" basis following any returned check.

Appointment times:

Although we endeavor at all times to maintain on time appointments, our doctors are often called to the hospital during the day for deliveries. This may require a delay in your appointment time or you may be given the option of seeing one of our other providers. We appreciate your understanding and patience during these times and request that you allow time in your schedule for possible delays in your appointment time.

Cancellations:

A specified amount of time is reserved for each patient and certain costs are incurred by the practice in preparation for the appointment. If you are unable to keep your appointment, please call our office so your appointment time can be released to someone on our waiting list. Although we appreciate a twenty-four (24) hour notice, we will accept a cancellation up to two hours prior to the appointment. We reserve the right to impose a charge of $35.00 for patients who miss appointments without calling to cancel.

Laboratory:

Mid-Kansas Women's Center utilizes LabCorp for all laboratory testing.

Referrals:

If a referral form is required, it is the patient's responsibility to obtain this form from the primary care physician ***PRIOR*** to any appointment. Failure to obtain a referral form may result in a reduction of benefits or may require that your appointment be rescheduled.

Minors:

The parent(s) or guardian(s) of a minor is responsible for full payment of all services provided to the minor and will receive a billing statement for any balances not covered by insurance. A signed release to treat may be required for unaccompanied minors.

Personal Items:

Personal items are the responsibility of the patient and we encourage you to keep your personal items with you during your office visit(s). **Food and beverages are not permitted in the waiting room or patient treatment areas.**

To insure that proper attention can be focused on our patients, we encourage you to bring no more than one child between the ages of two and six to your appointment. Infants and well behaved older children are welcome.

Financial Responsibility:

I agree to pay Mid-Kansas Women's Center any and all charges for services rendered. I understand that regardless of any assigned insurance benefits, I am responsible for paying the total charges for all services rendered.

_____ _____

Patient Name (Please print) Patient DOB

_____ _____

Patient Signature Date

_____ _____

Responsible Party Signature (if different from patient) Date

Revised Feb 2014

MYRIAD myRisk® Hereditary Cancer

Cancer Family History Questionnaire

Personal Information			
Patient Name	Date of Birth	Healthcare Provider	Today's Date

Instructions: Your personal family history of cancer is important to provide you with the best care possible. Please complete the chart below based upon your personal and family history of cancer. Leave blank what you do not know. The following relatives should be considered: Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family.

Do you have a personal history of:	Yes (Y) or No (N)	Which Cancer?	Age at diagnosis?
Breast, ovarian, or pancreatic cancer at any age	☐ Y ☐ N		
Colorectal or uterine cancer at 64 or younger	☐ Y ☐ N		

Do you have a family history of:	Yes (Y) or No (N)	Which Relative?	Maternal (M) or Paternal (P) side	Age at diagnosis?
Breast Cancer at age 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Two breast cancers (bilateral) in one relative at any age	☐ Y ☐ N		☐ M ☐ P	
Three breast cancers in relatives on the same side of the family at any age	☐ Y ☐ N		☐ M ☐ P	
Ovarian cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Pancreatic cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Male breast cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Metastatic prostate cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Colon cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Uterine cancer at age 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Ashkenazi Jewish ancestry with breast cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Do you have a family history of other cancers?	☐ Y ☐ N	List them here:		
Have you or anyone in your family had genetic testing for hereditary cancer?	☐ Y ☐ N	Who?	What gene(s)?	What was the result?

Cancer Risk Assessment Review: (To be completed after discussion with your healthcare provider)

Patient Signiture_____ Date_____

Healthcare Provider Signiture_____ Date_____

Office Use Only Patient offered hereditary cancer genetic testing? ☐ Yes ☐ No ☐ Accepted ☐ Declined

If yes, which test? ☐ BRAC*Analysis*® with Myraid myRisk® ☐ Multisite 3BRAC*Analysis*® REFLEX to BRAC*Analysis*® with Myraid myRisk®

☐ COLORIS®Plus with Myraid myRisk® ☐ COLORIS AP®Plus with Myraid myRisk® ☐ Single Site Testing ☐ Myraid myRisk® Update

☐ Other:_____

Follow-up appointment scheduled? ☐ Yes ☐ No Date of next appointment_____