CMG HARMONY HEALTH FOR WOMEN
A Division of Mercy Medical Center

Please complete the following forms and return them to our office. The information is confidential and will only be used to determine a suitable fit for you and our practice. We have two providers: Dr. Faye Ameredes DO and Mitzi Thompson WHCNP with combined experience of over 30 years. They work closely together as a team.

The paperwork can be returned by:

- malling back to the above address or,
- dropped off at our office during business hours (found below) or,
- faxed to 541.677.3379

If you have any questions, please feel free to call our office at 541.677.4463.

We are located on the first floor of the Stewart Park Medical Building across the street from Sherm's.

Office Hours

Monday - Thursday 9:00 am - 5:00 pm
(closed 12:00 pm - 1:30 pm for lunch)
Friday 9:00 am - 12:00 pm

Faye Ameredes, DO, FACOG • Mitzi Thompson, MSN, WHNP, NCMP
2460 NW Stewart Parkway, Suite 104 • Roseburg, OR 97471 • Phone 541.677.4463 • Fax 541.677.3379

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PATIENT INFORMATION FORM

PATIENT INFORMATION

Patient's Name: _____ ❑ Male ❑ Female
Last First Middle Initial

Mailing Address: _____
P.O. Box/Street City State Zip

Street Address: _____
P.O. Box/Street City State Zip

Date of Birth: _____ SS#: _____ Marital Status: ❑ S ❑ MID ❑ W ❑ Other

Race: ❑ White ❑ Hispanic ❑ American Indian or Alaska Native ❑ Asian
❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino Preferred Language _____

Email: _____

Home Phone: _____ Message Contact: _____

Phone: _____

Emergency Contact: _____ Relationship: _____

Phone: _____

RESPONSIBLE PARTY for the patient

Please check one: ❑ Self ❑ Spouse ❑ Parent ❑ Stepparent ❑ Legal Guardian
❑ Power of Attorney ❑ In-law _____

Name: _____ Responsible Party's Phone: _____

Mailing Address: _____
P.O. Box/Street City State Zip

Employer: _____ Work Phone: _____

Additional Guardian Information: _____ Cell Phone: _____

OTHER RESPONSIBLE PARTY for the patient

Please check one: ❑ Self ❑ Spouse ❑ Parent ❑ Stepparent ❑ Legal Guardian
❑ Power of Attorney ❑ In-law _____

Name: _____ Responsible Party's Phone: _____

Mailing Address: _____
P.O. Box/Street City State Zip

Employer: _____ Work Phone: _____

Additional Guardian Information: _____ Cell Phone: _____

PRIMARY INSURANCE for the patient

Please check one: ❑ Self ❑ Spouse ❑ Parent ❑ Stepparent ❑ Legal Guardian
❑ Power of Attorney ❑ In-law _____

Insured/Employee's Name: _____
Last First Middle Initial

Insurance Name: _____ Group Name/Employer: _____

Group #: _____ Policy ID#: _____ Effective Date: _____

Insured's Date of Birth: _____ Insured's SS#: _____

SECONDARY INSURANCE for the patient

Please check one: ❑ Self ❑ Spouse ❑ Parent ❑ Stepparent ❑ Legal Guardian
❑ Power of Attorney ❑ In-law _____

Insured/Employee's Name: _____
Last First Middle Initial

Insurance Name: _____ Group Name/Employer: _____

Group #: _____ Policy ID#: _____ Effective Date: _____

Insured's Date of Birth: _____ Insured's SS#: _____

THIRD PARTY PAYOR

Please check one: ❑ Auto ❑ Worker's Comp ❑ Home Owner's Policy ❑ Other: _____

Date of Injury: _____ Place of Injury: _____ Claim #: _____

Insurance Company: _____ Employer/Owner: _____

Insurance Phone: _____ Claim Representative: _____

ADDITIONAL INFORMATION

Please provide a list of all the parties we may speak with or leave a message with regarding the patient's medical care, appointment scheduling, or payment information.

_____
Name Relationship Phone

_____
Name Relationship Phone

_____
Name Relationship Phone

_____
Name Relationship Phone

May we leave a message on your answering machine, if so at what phone number? ❑ Yes ❑ No

Phone number: _____

May we contact you at work? ❑ Yes ❑ No

The undersigned patient or individual acting on the behalf of the patient agrees as follows:

1. Authority is granted to CMG Harmony Health For Women to render needed treatment to the above named patient.
2. I authorize CMG Harmony Health For Women to release needed treatment to the above named patient.
3. I authorize payment of medical benefits to CMG Harmony Health For Women for services rendered.
4. I understand that I am responsible for all charges incurred through CMG Harmony Health For Women.
5. Authorization Period: ❑ From _____ to _____ OR ❑ Lifetime

I request that payment under the medical insurance program be made to the provider named above on any bills for services furnished me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original. If this becomes necessary to effect Collection of my account the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and court costs.

Signature: _____ Date: _____

Signature: _____ Date: _____

HARMONY HEALTH FOR WOMEN
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PAYMENT and INSURANCE POLICY

Welcome to our practice. We hope the following will answer any questions you have regarding our payment and insurance policy. If you have any questions please feel free to call our office.

Uninsured/Charity: If you have no insurance a $100 deposit is required at the time of service regardless of any financial assistance granted through the Centennial Medical Group Charity Policy. If you have any questions, please contact our office for an application.

Co-pays: The patient is responsible for any Co-pay for visits. Co-pays will be collect at the time of check in. For convenience we accept cash, check, Visa, MasterCard and Discover.

Insurance/Deductible Balance: The patient is responsible for any insurance deductible of balance and it will be collected at the time of check in for your appointment. For convenience we accept cash, check, Visa, MasterCard and Discover.

Insurance: As a courtesy, our office will bill the primary insurance company. It is the patient's responsibility to provide us with accurate, current insurance information. Please bring current insurance cards to the appointment.

If the patient has secondary insurance coverage and provides us with the current valid information, we will bill secondary insurance after we have received response from primary insurance.

Coverage and Benefits: Please be aware, it is the patient's responsibility to verify optimal coverage, benefits and limitations with their insurance company. Please call your insurance company if you have any questions regarding your coverage.

_____ _____

Signature of Acceptance Date

2460 NW Stewart Parkway, Suite 104 • Roseburg, OR 97471 • Phone 541.677.4463 • Fax 541.677.3379

INDIVIDUAL DOCUMENT ACKNOWLEDGEMENT FORM

I, _____ [Insert individual name] acknowledge that I received a copy of Mercy Medical Center's Notice of Privacy Practices dated January 2017.

_____ (Individual's signature or initials)
(Sign here)

_____ (Personal representative of individual if patient unable to sign)

_____
Date

_____ (Witness signature)

Individual (or personal representative of the individual) did not sign the acknowledgement for the following reason:

(Check (√) one of the reasons below)

- ☐ Individual refused
- ☐ Individual refused, stating that he/she has already signed an acknowledgement
- ☐ Individual unable to sign because of medical condition
- ☐ There was not a personal representative of the individual available to sign
- ☐ Other: (explain) _____

_____

_____

_____ _____
Witness Date

CMG A DIVISION OF MERCY MEDICAL CENTER

PATIENT LABEL

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Consent / Authorization to Treat

Patient Full Name: _____ Patient Date of Birth: _____

I agree my health information may be used to assist with my treatment, seek payment for health care services and products, and in routine practice operations, and I have received this office's Notice of Privacy Practices. _____

I agree **Centennial Medical Group/Harmony Health for Women** may furnish my insurance companies with all information they request concerning my treatment, including all of my personal health information. _____

I understand there may be contact with a behavioral/mental health consultant and from time to time other persons may be observing or facilitating my care. Such persons may include but not limited to; students of the health profession, administrative or health care professionals in orientation or training. _____

I assign to **Centennial Medical Group/Harmony Health for Women** all payments I become entitled to receive for services and products provided to me by **Centennial Medical Group/Harmony Health for Women.** _____

I understand I must pay all co-payments, deductibles, and other charges not covered by insurance companies or other benefit programs. I understand that if these benefits stop for any reason, I must pay for all services and products provided. _____

I agree to pay for services and products provided if for any reason insurance companies and other benefits plans do not pay. If I do not provide complete and correct insurance information, I may have to pay charges that would otherwise be covered by insurance. If my insurance requires a referral, and I do not have the necessary referral I will be responsible for paying for all services and products provided. If I file a Workers' Compensation claim, I authorize **Centennial Medical Group/Harmony Health for Women** to release my personal health information, including information about my condition and treatments, to the Workers' Compensation insurance company, my employer, and my lawyer. I understand I may request a copy of my own health information, propose changes or additions, and receive a list of non-treatment related disclosures of the information. _____

I understand this office participates in the DCIPA Community Health Record Database. This means **Centennial Medical Group/Harmony Health for Women** will enter my health information, including chart notes, prescription records, operatory notes, radiographs and scans, lab results, and other health information in a secure shared database accessible only to other participating community healthcare providers. My other medical providers participating in the shared database do the same thing, permitting all participating providers ready access to up to date information regarding my condition and care. Participating in this shared database allows my healthcare providers to provide me better care with less hassle. By signing below, I agree **Centennial Medical Group/Harmony Health for Women** may upload my health information onto the database, view all of my personal health information on the database, and share my personal health information with other participating providers through the database. I understand that, with certain expectations, if I refuse to permit my health information to be included in this shared database, **Centennial Medical Group/Harmony Health for Women** may refuse to treat me. _____

I authorize **Centennial Medical Group/Harmony Health for Women** to render medical products and services, including diagnosis and treatment, laboratory testing, x-rays and scans, and other medical services as deemed necessary by my physician. _____

I agree **Centennial Medical Group/Harmony Health for Women** may from time to time take photographs of me and keep them with my medical records. I agree that all my medical providers may use these photographs for identification purposes, to prevent fraud, and to assist with my medical care. _____

Patient Signature: _____ Date: _____

Other Signature or Legal Guardian: _____

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GYNECOLOGY PATIENT QUESTIONNAIRE

Name: _____ Date of Birth: _____ Today's Date: _____

Name of your Primary Care Provider: _____

Pharmacy you choose for prescriptions: _____

Briefly describe reason for visit: 1. _____

2. _____

3. _____

Have you recently had any of the following? Check Yes or No.

Vaginal itching	❑ Yes ❑ No	Hot Flashes	❑ Yes ❑ No
Vaginal burning	❑ Yes ❑ No	Night sweats	❑ Yes ❑ No
Abnormal vaginal discharge	❑ Yes ❑ No	Early morning awakening	❑ Yes ❑ No
Abnormal vaginal bleeding	❑ Yes ❑ No	Vaginal dryness	❑ Yes ❑ No
Pelvic Pain	❑ Yes ❑ No	Bleeding after menopause	❑ Yes ❑ No
Abdominal bloating	❑ Yes ❑ No	Bleeding after intercourse	❑ Yes ❑ No
Urinary urgency	❑ Yes ❑ No	Weight gain or loss	❑ Yes ❑ No
Poor appetite	❑ Yes ❑ No	Urinary leakage/wetting	❑ Yes ❑ No

Pain:

Are you in pain today? ❑ Yes ❑ No If yes, Location: _____ Cause: _____

Do you have chronic pain? ❑ Yes ❑ No If yes, Location: _____ Cause: _____

Do you use any of the following: (Check which applies)

Tobacco: ❑ Current ❑ Previous ❑ Never Type: _____ Amount: _____

Caffeine: ❑ Current ❑ Previous ❑ Never Type: _____ Amount: _____

Alcohol: ❑ Current ❑ Previous ❑ Never Type: _____ Amount: _____

Illegal Drugs ❑ Current ❑ Previous ❑ Never Type: _____ Amount: _____

Exercise: ❑ Current ❑ Previous ❑ Never Type: _____ Amount: _____

Seatbelt use: ❑ 100% ❑ 75% ❑ 50% ❑ 25% ❑ 0%

Date of Last Pap Smear: _____ **Was it Normal?** ❑ Yes ❑ No

Have you ever had an abnormal pap? ❑ Yes ❑ No If yes explain: _____

Have you completed the Gardasil vaccine series? ❑ Yes ❑ No

Date of Last Mammogram: _____ **Was it Normal?** ❑ Yes ❑ No

The first day of your last menstrual period: _____ or Hysterectomy or Menopause

Number of days from 1st day of period until 1st day of next period: _____

Usual number of days of flow (including spotting): _____

Flow is usually (please check): ❑ Light ❑ Moderate ❑ Heavy

Pain from cramping is (please check): ❑ Mild ❑ Moderate ❑ Severe

What do you do to prevent becoming pregnant? _____

Do you believe you may be currently pregnant? _____

GYNECOLOGY PATIENT QUESTIONNAIRE

Medical History: Have you ever had any of the following? Please check Yes or No.

Total number of pregnancies _____ Number born to term _____ Number of preterm _____

Number of miscarriages _____ Number of ectopics _____ Number of abortions _____

Anemia/Blood disease	❑ Yes ❑ No	Bladder infection	❑ Yes ❑ No	Kidney infection	❑ Yes ❑ No
Kidney Stones	❑ Yes ❑ No	Renal Failure	❑ Yes ❑ No	Hypothyroidism	❑ Yes ❑ No
Hyperthyroidism	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No
High Blood Pressure	❑ Yes ❑ No	High Cholesterol	❑ Yes ❑ No	Asthma	❑ Yes ❑ No
COPD	❑ Yes ❑ No	Diverticulosis	❑ Yes ❑ No	Diverticulitis	❑ Yes ❑ No
GERD (Reflux)	❑ Yes ❑ No	Arthritis	❑ Yes ❑ No	Migraines	❑ Yes ❑ No
Heart Disease	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No	Osteopenia	❑ Yes ❑ No
Blood clot in leg or lung	❑ Yes ❑ No	Immune Deficiency	❑ Yes ❑ No	Colon/intestine	❑ Yes ❑ No
Bacterial Vaginosis	❑ Yes ❑ No	Endometriosis	❑ Yes ❑ No	Pelvic inflammatory disease	❑ Yes ❑ No
Syphilis	❑ Yes ❑ No	Trichomonas	❑ Yes ❑ No	Genital Herpes	❑ Yes ❑ No
Genital warts	❑ Yes ❑ No	Gonorrhea	❑ Yes ❑ No	Chlamydia	❑ Yes ❑ No
Sleep Apnea	❑ Yes ❑ No	If yes, what treatment used? _____			
Cancer	❑ Yes ❑ No	If yes, please list type and stage: _____			
Other	Please explain: _____				

Surgical History: Check which applies, list other surgeries, the reason for the surgery, and the year they occurred

❑ Hysterectomy	Reason: _____	Year: _____
❑ Ovaries Removed	Reason: _____	Year: _____
❑ Bladder Suspension	Reason: _____	Year: _____
❑ Tubal Ligation	Reason: _____	Year: _____
❑ Appendectomy (removal of appendix)	Reason: _____	Year: _____
❑ Cholecystectomy (removal of gallbladder)	Reason: _____	Year: _____
❑ Laparoscopy	Reason: _____	Year: _____
❑ Surgery: _____	Reason: _____	Year: _____
❑ Surgery: _____	Reason: _____	Year: _____
❑ Surgery: _____	Reason: _____	Year: _____
❑ Surgery: _____	Reason: _____	Year: _____
❑ Surgery: _____	Reason: _____	Year: _____
❑ Surgery: _____	Reason: _____	Year: _____
❑ Surgery: _____	Reason: _____	Year: _____
❑ Surgery: _____	Reason: _____	Year: _____

Have you had any of the following in the last month? Check Yes or No

Fevers	❑ Yes ❑ No	Nausea	❑ Yes ❑ No	Skin rash	❑ Yes ❑ No
Chills	❑ Yes ❑ No	Vomiting	❑ Yes ❑ No	Skin itching	❑ Yes ❑ No
Breast pain	❑ Yes ❑ No	Abdominal pain	❑ Yes ❑ No	Boils	❑ Yes ❑ No
Breast Lumps	❑ Yes ❑ No	Heartburn	❑ Yes ❑ No	Severe Depression	❑ Yes ❑ No
Nipple discharge	❑ Yes ❑ No	Constipation	❑ Yes ❑ No	Severe Anxiety	❑ Yes ❑ No
Chest pain	❑ Yes ❑ No	Diarrhea	❑ Yes ❑ No	Plans for Suicide	❑ Yes ❑ No
Edema	❑ Yes ❑ No	Unable to empty bladder	❑ Yes ❑ No	Dizzy Spells	❑ Yes ❑ No
Irregular heartbeat	❑ Yes ❑ No	Painful urination	❑ Yes ❑ No	Fatigue (chronic)	❑ Yes ❑ No
Wheezing	❑ Yes ❑ No	Urinary Frequency	❑ Yes ❑ No		
Coughing	❑ Yes ❑ No				
Shortness of breath	❑ Yes ❑ No				

GYNECOLOGY PATIENT QUESTIONNAIRE

Family History: Please indicate the relationship of any family member who had any of the following: (example: Paternal Grandmother, Maternal Grandfather, Mother, Sister, Uncle, etc.)

Heart disease _____
Diabetes _____
High blood pressure _____
Stroke _____
Thyroid disease _____
Epilepsy _____
Asthma _____
Arthritis _____
Mood disorders or mental illness _____
Tuberculosis _____
Endometriosis _____
Osteoporosis _____
Breast Cancer _____
Lung Cancer _____
Ovarian Cancer _____
Other Cancer (list type) _____
_____

Please list all Medications and Supplements: (pills, patches, inhaler, vitamins, herbs, and implants)

1. _____ Dosage: _____ How often: _____ Reason: _____
2. _____ Dosage: _____ How often: _____ Reason: _____
3. _____ Dosage: _____ How often: _____ Reason: _____
4. _____ Dosage: _____ How often: _____ Reason: _____
5. _____ Dosage: _____ How often: _____ Reason: _____
6. _____ Dosage: _____ How often: _____ Reason: _____
7. _____ Dosage: _____ How often: _____ Reason: _____
8. _____ Dosage: _____ How often: _____ Reason: _____
9. _____ Dosage: _____ How often: _____ Reason: _____
10. _____ Dosage: _____ How often: _____ Reason: _____

Medication Allergies:

1. _____ Effect: _____
2. _____ Effect: _____
3. _____ Effect: _____
4. _____ Effect: _____
5. _____ Effect: _____
6. _____ Effect: _____
7. _____ Effect: _____

Comments: _____
_____
_____
_____
_____