Allison van Haastert, MD
Jessica Goldberger, MD
Meagan Byrne, DO

Women's Care of Alaska

Katie Ulmer, ANP
Migel Hadley, ANP
Wendy Koehler, ANP

Wynd Counts, MD * Wendy Cruz, MD

2741 DeBarr Road, Suite C205 Anchorage, AK 99508 * (907)279-2273 Fax (907)258-7705 www.wcakobgyn.com

COMPLETE ENTIRE FORM

PATIENT:

Patient Name _____ DOB _____ SS# _____

Preferred Ph# _____ Email Address: _____

Mailing Address _____ City _____ State ____ Zip _____

Employer Name _____ Occupation _____

Employer Address _____ City _____ State ____ Zip _____

Relationship Status:_____ Pronouns: _____ Gender Identity:_____ Sexual Orientation:_____

(please circle)
Race: *White * Black * Asian * Pac. Islander/Nat. Hawaiian * Amer. Indian/AK Native*

(please circle)
Ethnicity: *Latino/Hispanic * Not Latino/Hispanic * Other*

IF PATIENT IS A MINOR

Who may authorize treatment? _____ *Relationship* _____ *Contact#:* _____

PARTNER:

Partner Name _____ DOB _____ SS# _____

Preferred Ph# _____ Email Address: _____

Mailing Address SAME (or) _____ City _____ State ____ Zip _____

Employer Name _____ Occupation _____

Employer Address_____ City _____ State ____ Zip _____

INSURANCE:

PRIMARY INSURANCE COMPANY: _____

Subscriber Name_____ DOB _____ SS# _____

Subscriber ID# _____ Group# _____ Relationship to Patient _____

Employment Status _____ Occupation _____ Employer Name_____

Employer Address_____ City _____ State ____ Zip _____

SECONDARY INSURANCE COMPANY: _____

Subscriber Name_____ DOB _____ SS# _____

Subscriber ID# _____ Group# _____ Relationship to Patient _____

Employment Status _____ Occupation _____ Employer Name_____

Employer Address_____ City _____ State ____ Zip _____

EMERGENCY CONTACT:

Emergency Contact Name _____ Relationship _____ Ph# _____

Emergency Contact Name _____ Relationship _____ Ph# _____

AUTHORIZATION Please initial each line, and sign the bottom

_____ I hereby authorize release of any information required to process insurance claims related to my medical and/or surgical care.

_____ I authorize direct payment to the provider(s) for my medical and/or surgical care.

_____ I understand that I am responsible to pay any non-covered charges or services.

_____ I understand that if I am uninsured, I am responsible to pay for any services provided.

_____ I have read and agree to the PATIENT FINANCIAL POLICY for Women's Care of Alaska.

How did you hear about our practice? _____

Patient Signature _____ **Date**: _____

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PROTECTED HEALTH INFORMATION (PHI) AUTHORIZATION

PATIENT NAME: _____ **DOB:** _____
Month Day Year

CHECK ALL METHODS OF COMMUNICATION, THAT YOU AUTHORIZE

☐ YOUR CELL PHONE	☐ YOUR WORK TELEPHONE	☐ RESIDENCE TELEPHONE
Number: ( ) _____	Number: ( ) _____	Number: ( ) _____
☐ Leave a call back number only; Do NOT leave a message	☐ Leave a call back number only; Do NOT leave a message	☐ Leave a call back number only; Do NOT leave a message
☐ OK to leave detailed message with person or on voicemail	☐ OK to leave detailed message with person or on voicemail	☐ OK to leave detailed message with person or on voicemail

MY PREFERRED CONTACT NUMBER IS: ( ) _____ - _____

If you would like to authorize us to speak with another individual, such as a spouse/partner, or other relative regarding your PHI, please fill in their name, relation to you, and their contact number below. This information can be changed at any time, per your request. Examples of PHI include, but are not limited to:

(T) Treatment	**(P) Payment**	**(O) Healthcare Operations Activities**
Test results	Insurance questions/problems	Messages returned, Referral options, Records Release
Prescriptions/refills	Account balance/payment options	

CIRCLE WHAT TO RELEASE:

Name: _____/_____/_____ (T) (P) (O)
PLEASE PRINT (Relation to Pat.) (CONTACT#)

Name: _____/_____/_____ (T) (P) (O)
PLEASE PRINT (Relation to Pat.) (CONTACT#)

PATIENT SIGNATURE: _____ **DATE:** _____

PATIENT PORTAL ACCESS

Our patient portal is set up through www.myhealthrecords.com. The portal allows us to send you automated appointment reminders and messages. In addition, it allows you the ability to directly and securely message your provider, view your medical records, and much more. Activating your Patient Portal is simple. We will send you an email invitation, simply follow the instructions in the email to set up your Patient Portal Account.

CURRENT EMAIL ADDRESS: _____ @ _____

(√) CHECK THE WAYS YOU WISH TO RECEIVE YOUR APPOINTMENT REMINDERS/MESSAGES?

☐Voice Call ☐Text ☐Email ☐Do Not Contact Me for Reminders

PATIENT SIGNATURE: _____ **DATE:** _____

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INFORMED CONSENT – TELEMEDICINE APPOINTMENT

Telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he/she is located at a different location than the healthcare provider. This may be for the purpose of diagnosis, treatment, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with you or other health professionals through use of interactive video, audio, or other telecommunication technology. Additionally, a physical examination of you may take place, and video, audio and/or photo recordings may be taken.

ANTICIPATED BENEFITS:

- Improved access to medical care by enabling a patient to remain in their location while the healthcare provider provides care from a distant site.
- Limiting the spread of COVID-19.
- More efficient medical evaluation and management.

POSSIBLE RISKS:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- It may be determined that that information transmitted is of poor quality, requiring a face to face visit or rescheduled telemedicine visit. This may cause a delay in medical evaluation / treatment.
- Security protocols could fail or not be available, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to all your medical records may result in adverse drug reactions or allergic reactions or other judgment errors.

BY SIGNING THIS FORM, I UNDERSTAND THE FOLLOWING:

- I understand that I may expect anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed.
- I understand that all efforts will be taken to protect the privacy and security of health information, and that no information obtained in the use of telemedicine which identifies me will be intentionally disclosed without my authorization.
- I understand that during the COVID-19 Pandemic, security measurements may be lessened in accordance with U.S. Department of Health and Human Services to ensure improved access to care.
- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time without affecting my right to future care or treatment.
- I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My healthcare provider has explained the alternative to my satisfaction.
- I understand that certain fees for service may be waived during the COVID-19 Pandemic depending on my insurance carrier. While all efforts will be made to follow guidelines during this fluid situation, I understand that I am still responsible for any co-payments or co-insurance that may apply, and if my medical insurance coverage is not sufficient to satisfy any excess cost(s), I will be responsible for payment.

I have read and understand the information provided above regarding telemedicine:

☐ I ***DO*** consent to Telemedicine Appointments.

☐ I ***DO NOT*** consent to Telemedicine Appointments.

_____ _____

PRINTED NAME DATE OF BIRTH

_____ _____

PATIENT SIGNATURE DATE

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Patient Name: _____ DOB: _____ DATE: _____

What brings you to our office today?_____

ALLERGIES ☐N/A – No known drug allergies

LIST DRUG, ENVIRONMENTAL AND FOOD ALLERGIES	REACTION

CURRENT MEDICATIONS ☐N/A – No medications

DRUG NAME	DOSE	DRUG NAME	DOSE

GYN HISTORY / ANNUAL UPDATE ☐N/A – I no longer have a menstrual cycle Age _____

Date last menstrual period began: _____ Menstrual cycles are: ☐Regular ☐Irregular

Age when periods started? _____ Menstrual bleeding is: ☐Light ☐Moderate ☐Heavy Periods last:_____days

Cramps are: ☐N/A ☐Mild ☐Moderate ☐Severe Cramps last: _____days

Spotting occurs between periods: ☐Yes ☐No Spotting occurs after intercourse: ☐Yes ☐No

EXAM HISTORY

Date of last dental exam: _____ Date of last mammogram: _____ ☐Normal ☐Abnormal

Date of last eye exam: _____ Date of last PAP: _____ ☐Normal ☐Abnormal

Date of last colon screening: _____ ☐Normal ☐Abnormal

STD HISTORY ☐N/A – I have never had a sexually transmitted disease

Have you ever had any of the following STDs? (√ all that apply):

☐Chlamydia ☐Gonorrhea ☐Genital Warts ☐Herpes ☐Trichomonas ☐Syphilis ☐PID

Have you ever tested positive for HIV? ☐Yes ☐No

SEXUAL HISTORY ☐N/A – I have never been sexually active

Are you currently sexually active? ☐Yes ☐No - ☐ Male ☐ Female ☐ Both

Did you begin sexual activity before the age of 16? ☐Yes ☐No If yes, what age did you start? _____

PATIENT NAME: _____

CONTRACEPTION ☐N/A – I am not currently using any form of birth control

Current Birth Control Method: ☐Condoms ☐Birth Control Pills ☐Tubal Ligation ☐Vasectomy

Depo Provera ☐ Natural / Rhythm ☐IUD ☐Nexplanon® ☐Other _____

PREGNANCY HISTORY

Total number of times pregnant		Number of Cesarean Sections		Number of miscarriages	
Number of full-term deliveries		Number of living children		Number of elective abortions	

PERSONAL / FAMILY MEDICAL HISTORY √ Box for Personal History or Family History of condition

Condition	Pers. Hx	Family Hx		Pers. Hx	Family Hx		Pers. Hx	Family Hx
Anemia			Fibroids			Liver Problems		
Anxiety			Fracture(s)			Lung Disease		
Arthritis			GI Reflux Disease			Migraine		
Asthma			GI (other) Disease			Osteopenia/Osteoporosis		
Autoimmune Disease			Heart Disease			Ovarian Cyst		
Cancer (type)			Hepatitis			PCOS		
Clotting Disorder			High Blood Pressure			Seizures		
Depression			High Cholesterol			Thyroid Disease		
Diabetes			Joint Pain			Tuberculosis		
Endometriosis			Kidney Infections/stones			OTHER		

SURGICAL HISTORY

_____

_____

_____

_____

_____

SOCIAL HISTORY / HABITS / PERSONAL SAFETY

Do you follow a Special Diet? ☐Yes ☐No If yes, type?: _____

Do you exercise? ☐Never ☐Rarely (1-2x/yr) ☐Occasionally (1-2x/month) ☐Often (1-2x/wk) ☐Regularly (3-5x/wk)

Tobacco/Smoking: ☐Yes ☐No ☐Former Packs/day: _____ Number of years: _____ Quit Date: _____

Alcohol Use: ☐Yes ☐No ☐Former Drinks/day: _____ Drinks per week: _____ Quit Date: _____

Drug Use: ☐Yes ☐No ☐Former Type? _____ Number of years: _____ Quit Date: _____

Has anyone close to you, ever threatened to, or physically hurt you? ☐Yes ☐No

Has anyone, including your partner, ever forced you to have sex? ☐Yes ☐No

Do you fear harm from anyone at home, or school, or anywhere else? ☐Yes ☐No

Do you have any concerns about your body image? ☐Yes ☐No

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REVIEW OF SYSTEMS

Patient Name: _____ DOB: _____ Date: _____

What brings you to our office today? _____

☑ **Check only those conditions that you are CURRENTLY having now.**

CONSTITUTIONAL		NOTES	GENITOURINARY		NOTES
Fever			Abnormal Bleeding		
Chills			Vaginal Discharge/odor		
Fatigue			Vaginal Itching/burning		
Weight Loss			Pelvic Pain		
Weight Gain			Menstrual Cramps		
EYES			Painful Intercourse		
Change in Vision			Genital Lump		
Double Vision			Fertility Concerns		
HEENT			Menopausal Concerns		
Earaches			**MUSCULOSKELETAL**		
Ringing in ears			Muscle Weakness		
Sinus Problems			Joint Stiffness		
Sore Throat			Joint Pain		
Mouth Sores			Joint Swelling		
Dry Mouth			**SKIN/BREAST**		
CARDIOVASCULAR			Breast Pain		
Chest Pain			Nipple Discharge		
Diff. breathing w/exertion			Breast Lumps		
Swelling of legs			Rash		
Palpitations			Ulcers		
Heart Murmurs			**PSYCHIATRIC**		
RESPIRATORY			Depression		
Wheezing			Mood Swings		
Spitting up blood			Anxiety		
Shortness of Breath			Suicidal Thoughts		
Cough			Homicidal Thoughts		
GASTROINTESTINAL			**ENDOCRINE**		
Diarrhea			Abnormal Thirst		
Constipation			Hot Flashes		
Nausea/vomiting			Tremors		
Bloody Stool			Cold/Heat Intolerance		
Abdominal Pain			**HEMATOLOGIC**		
Indigestion			Frequent Bruising		
Bloating			Cuts do not stop bleeding		
Liver Problem/Hepatitis			Enlarged Lymph nodes		
GENITOURINARY			**OTHER**		
Blood in Urine					
Pain with Urination					
Urgency					
Urinary Incontinence					
Urinary Frequency					