



*Women's Center/ HealthCare Physicians, PLLC*  
*"Treating each patient as if she was the only one."*

**Barbara A. Hannah, M.D., FACOG**  
Obstetrics and Gynecology

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Dear New Patient:

Please allow me and my office staff to welcome you to Women's Center/Health Care Physicians, PLLC. It is the goal of this office to provide you with the most current and quality obstetrical and/or gynecological care available.

Please take a moment to review the new patient packet. In preparation for your office visit complete the three page medical history, financial policy, confidential patient information and release authorization. Please bring the completed forms with you. You will need a copy of Adobe Acrobat Reader on your computer. If unavailable, you may download it from this site at no charge to you.

Your driver's license or state ID along with a current health insurance card are also required. Please bring any necessary referrals from your primary care physician. If you have any questions and or concerns we hope that you will bring them to our attention so we may better serve you.

I hope this is the beginning of a mutually rewarding relationship.

Sincerely,

Barbara A. Hannah, M.D., FACOG

WOMEN'S CENTER/HEALTH CARE PHYSICIANS MEDICAL HISTORY

Today's Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name \_\_\_\_\_

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

Why are you seeing the doctor? \_\_\_\_\_

PRESCRIPTION MEDICATIONS (INCLUDING FREQUENCY & DOSING)

\_\_\_\_\_  
\_\_\_\_\_

What over the counter medications do you take? \_\_\_\_\_

What medications are you allergic to? \_\_\_\_\_

Are you allergic to latex? \_\_\_\_\_

PAST MEDICAL HISTORY

Gynecological (menopausal patients may skip questions 3 - 5)

1) What is the first day of your last menstrual period? \_\_\_\_\_ 2) How old were you when your menses started? \_\_\_\_\_ 3) How often do you menstruate? (how many days from the beginning of one period to the next? \_\_\_\_\_ 4) How many days does it last? \_\_\_\_\_ 5) Do you have any menstrual irregularities? \_\_\_\_\_

HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING?

(Circle N for no and Y for yes)

Chlamydia	N	Y	Pelvic Infection	N	Y	Infertility	N	Y
Gonorrhea	N	Y	Trichomonas	N	Y	Herpes	N	Y
AIDS/HIV	N	Y	Syphilis	N	Y	Genital Warts	N	Y
Endometriosis	N	Y	Gyn Cancer	N	Y	Pelvic Pain	N	Y
Fibroid Tumors	N	Y	Vaginitis	N	Y	Abnormal Paps	N	Y

When was your last pap smear? \_\_\_\_\_

Have you had a mammogram? \_\_\_\_\_ When was your last mammogram? \_\_\_\_\_

Have you ever had an abnormal mammogram? \_\_\_\_\_

## Sexual History

Are you sexually active? \_\_\_\_\_

What type of birth control do you use? \_\_\_\_\_

Have you had any problems with any birth control? \_\_\_\_\_

Do you douche? \_\_\_\_\_

If so, how often do you douche? \_\_\_\_\_

## Obstetrical History

How many pregnancies have you had? \_\_\_\_\_ How many full term? \_\_\_\_\_

Preterm (less than 37 weeks)? \_\_\_\_\_ Abortions? \_\_\_\_\_

Miscarriages? \_\_\_\_\_ Ectopics? \_\_\_\_\_

How many C-sections have you had? \_\_\_\_\_ Why? \_\_\_\_\_

How much did your largest baby weigh? \_\_\_\_\_

How old is (are) your children? \_\_\_\_\_

What complications did you have with any of your pregnancies and/or deliveries?

\_\_\_\_\_

## ADDITIONAL PAST MEDICAL HISTORY

Do you or have you had any problems with any of the following? If so please describe. (circle N for no and y for yes)

			Please describe yes responses
HIGH BLOOD PRESSURE	N	Y	_____
DIABETES	N	Y	_____
TB	N	Y	_____
EARS & EYES	N	Y	_____
NOSE & THROAT	N	Y	_____
LUNG (INCLUDES ASTHMA)	N	Y	_____
HEART	N	Y	_____
STOMACH	N	Y	_____
SEIZURES	N	Y	_____
LUPUS/ARTHRITIS	N	Y	_____
BLOOD DISEASE	N	Y	_____
BREAST	N	Y	_____
MUSCULOSKELETAL	N	Y	_____
BLOOD CLOTS/STROKES	N	Y	_____
BLADDER	N	Y	_____
SKIN DISEASE	N	Y	_____
CANCER	N	Y	_____
PSYCHOLOGICAL	N	Y	_____
KIDNEY	N	Y	_____
THYROID	N	Y	_____
LIVER	N	Y	_____
Other			_____

SURGICAL HISTORY

List the surgeries that you have had along with the date and any complications.

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Do you have any problems with anesthesia? \_\_\_\_\_

FAMILY HISTORY

Is your mother living? \_\_\_\_\_ Father living? \_\_\_\_\_

Do you have a family history of any of the following? (circle N for no and Y for yes)

			Relationship to you
HIGH BLOOD PRESSURE	N	Y	_____
DIABETES	N	Y	_____
CANCER	N	Y	_____
if yes what type of cancer?			_____
BLOOD CLOTTING DISEASE	N	Y	_____
HEART DISEASE	N	Y	_____
OTHER			_____

SOCIAL HISTORY

Marital Status (circle one)

Single          Married          Separated          DivorcedWidowed

With whom do you reside? \_\_\_\_\_

Do you smoke cigarettes? \_\_\_\_\_ How many packs? \_\_\_\_\_

How long have you smoked? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How often? \_\_\_\_\_ How much? \_\_\_\_\_

Do you use street drugs? \_\_\_\_\_ What kind? \_\_\_\_\_

In summation I have carefully read all the above questions and the information I have provided is complete and accurate to the best of my knowledge.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

## FINANCIAL POLICY

Payment reimbursement for medical care provides unique challenges for physicians. Insurance companies provide varying degrees of coverage. Although we try to stay aware of the differences in policies, it is not always possible. *It is your responsibility to be aware of your own individual insurance plan and the benefits provided.*

Please remember that benefit plans are between the patient and insurance company not between the physician and the insurance company. Please have your current and appropriate insurance card at your visits along with any changes in your demographic information.

Our office will submit your claim to your insurance company. If your account has not been paid in full by your insurance company you will be responsible for the balance.

Payment for service and co-pays are due at the time of service. Allowable forms of payment are cash, check, Visa and Master Card. A \$5 rebilling fee for each additional statement sent after the first one will be applied. All checks returned for non-sufficient funds will be subject to a fee. *It is the policy of this office not to carry patient balances.* A collection service will be employed for outstanding balances. All collection fees incurred are the responsibility of the patient which can total up to 35%.

Master Medical through Blue Cross payment is expected at the time of service and the insurance company will reimburse you. HMO patients are required to bring the necessary referral/authorization from their primary care physician before the service is rendered.

Please sign below and bring this copy of the financial policy with you to your visit.

I have read and agree to this financial policy.

\_\_\_\_\_

Name

\_\_\_\_\_

Date

CONFIDENTIAL PATIENT INFORMATION

Name (first) \_\_\_\_\_ (last) \_\_\_\_\_ (m.i.) \_\_\_\_\_

SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_

Place of Employment \_\_\_\_\_ How long employed? \_\_\_\_\_

Work phone \_\_\_\_\_ Occupation \_\_\_\_\_

SOMETIMES IT IS REQUIRED THAT WE BE ABLE TO CONTACT YOU IMMEDIATELY. MAY WE USE ANY OF THE ABOVE PHONE NUMBERS TO CONTACT YOU? \_\_\_\_\_

Spouse or Parent (first ) \_\_\_\_\_ (last) \_\_\_\_\_ (mi) \_\_\_\_\_

SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_

Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency contact (name) \_\_\_\_\_ Relationship \_\_\_\_\_

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

Your Primary insurance company \_\_\_\_\_ Group # \_\_\_\_\_

Contract # \_\_\_\_\_ Effective date \_\_\_\_\_

Your Secondary insurance company \_\_\_\_\_ Group # \_\_\_\_\_

Contract # \_\_\_\_\_ Effective date \_\_\_\_\_

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. SOME INSURANCE FORMS WILL BE COMPLETED BY THE OFFICE BUT THE PATIENT IS RESPONSIBLE FOR FEES DESPITE INSURANCE COVERAGE. PAYMENT IS EXPECTED AT THE TIME OF SERVICE. I AUTHORIZE *WOMEN'S CENTER/HEALTHCARE PHYSICIANS, PLLC* TO FURNISH INFORMATION TO MY INSURANCE CARRIER.

PLEASE INITIAL \_\_\_\_\_

AUTHORIZATION TO RELEASE INFORMATION / PAY BENEFITS DIRECTLY TO  
WOMEN'S CENTER/HEALTH CARE PHYSICIANS

I authorize Women's Center/HealthCare Physicians, PLLC to release information contained in my medical records including information concerning HIV, AIDS and ARC (AIDS related complex) if any, protected under Michigan Public ACT 174 of 1969 as amended; substance abuse information, if any, protected under 42 code of Federal Regulations, Part 2 and social and psychological services information, if any, including communications made to a social worker or psychologist to:

a) any third party payer (insurance agency) or carriers which are responsible in whole or part for paying my expenses associated with my care

b) any health care facility or physician for the purpose of facilitating continuing care and treatment.

I recognize that my records are governed by HIPAA rules and this office is HIPAA compliant.

\_\_\_\_\_  
Signature of insured

\_\_\_\_\_  
Date