Medical Arts Building ● 350 Park Street, Suite 203
Bowling Green, KY 42101
Phone: (270) 781-0075 ● Fax: (270) 781-0143
Toll Free: 1-866-997-5784
www.WomensHealthSpecialists.net

NEW OB PATIENT PACKET

Congratulations on your pregnancy and "Thank You" for choosing Women's Health Specialists to provide quality care to you and your unborn child.

At your first prenatal appointment, we set aside plenty of time to devote our attention totally to you and to understanding your needs and concerns. We view good health as a partnership, which requires close involvement and good communication between you and your provider. Please understand that this first appointment usually takes at least an hour to complete as a complete health history will be reviewed for the mother and father of the baby, as well as a full physical of the mother, usual lab work, and in some cases an Ultrasound.

Early detection of any disease or illness usually means early treatment and a higher success rate. Thus, appointments that are not kept pose an increased risk to your health as well as the health of your unborn child. If you are unable to keep an appointment, please notify us as soon as possible. It is important you arrive on time for your scheduled appointment(s). Arriving late causes us to get behind schedule, which in turn makes all other patients' appointments run late. Therefore, if you are late, we will require you to reschedule your appointment. Because of our concern with closely monitoring the health of all our patients, patients who fail to show up for an appointment or fail to call and reschedule more than two times may be discharged from the practice.

We also ask that you be patient with us and understand that we are an obstetrical practice, so unexpected delays may occur. While we try to keep these delays from interrupting your scheduled appointment, it is a natural occurrence that is beyond our control. If your provider has to leave the office, we may have to reschedule your appointment or ask you to see another provider during your routine prenatal appointment.

Please complete the attached paperwork and bring it with you to your appointment along with your Insurance Card(s) and picture ID. Completing all paperwork will expedite your appointment. If you are unable to complete the enclosed paperwork, please arrive earlier than requested to receive assistance in completion / processing. If you have any questions or concerns, always feel free to contact our office.

It is a pleasure to serve you and we look forward to seeing you in our office soon!

Appointment Date: ________________________

Time: ________________________

Provider: ________________________

Office Location: ________________________

Please plan to arrive 30 minutes early for processing of all paperwork!

Thank You

Revised 05/2014

Medical Arts Building ● 350 Park Street, Suite 203
Bowling Green, KY 42101
Phone: (270) 781-0075 ● Fax: (270) 781-0143
Toll Free: 1-866-997-5784
www.WomensHealthSpecialists.net

PARKING & ENTRANCE

Women's Health Specialists is located in the Medical Arts Building which is connected to The Medical Center. Although our address is Park Street, the Medical Arts Building entrance is on High Street. Designated parking for the Medical Arts Building is available on High Street.

Women's Health Specialists is located in Suite 203, on the second floor of the Medical Arts Building. If you have problems locating us, please feel free to call our office for directions.

Patients are also seen in Franklin on select days. If you are scheduled at that location, we are located on The Medical Center – Franklin campus in the Franklin Medical Plaza building at 1030 Brookhaven Road.

Medical Arts Building ● 350 Park Street, Suite 203
Bowling Green, KY 42101
Phone: (270) 781-0075 ● Fax: (270) 781-0143
Toll Free: 1-866-997-5784
www.WomensHealthSpecialists.net

PATIENT INFORMATION (Please Print)

Patient Name ____
(Last, First, Middle Initial)

Date of Birth ________________ Age __________ Social Security # ____________________

Marital Status (Please Circle) Single Married Widowed Divorced Separated

Mailing Address ____

____

Home Phone # _________________ Cell Phone # _______________ Work Phone # ______________

E-mail Address: ______________________________

Preferred Method to Confirm Appointments (Please Circle one) Text Home Phone Cell Phone Work Phone

Employer ______________________________Occupation (Indicate if a Student) ______________________

Name of Insured or Parent_______________________________________ Date of Birth _______________
(Last, First, Middle Initial)

Social Security # ____________________ Relationship to Patient _________________________

Insured's Employer ____

Emergency Contact Name _________________________________ Phone # _________________________

Relationship to Patient ____

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite Insurance Carrier payments. The patient is responsible for all fees, regardless of Insurance Coverage. Payment is due at the time services are rendered unless other arrangements have been made in advance. KRS 194A.505 requires every person to disclose all sources of Insurance Coverage, at each visit. Failure to do so is fraudulent. Our office is required and will report all such misrepresentations.

INSURANCE AUTHORIZATION (Please Read & Sign)
I HEARBY AUTHORIZE WOMEN'S HEALTH SPECIALISTS TO FURNISH TO INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONCERNING MY (MY DEPENDENT'S) ILLNESS AND TREATMENT AND I HEARBY ASSIGN TO WOMEN'S HEALTH SPECIALISTS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

____ ____________________________
Signature of Patient or Parent Date

Patient Name ______________________________
Date of Birth ______________ Age __________
Social Security # ________________
Marital Status (Please Circle) S M W D S Race ________
Patient Occupation ______________________________
Highest Level of Education Completed ________________

GYNECOLOGICAL / OBSTETRICAL HISTORY

Baby's Father Name ____________________ Phone # ____________ Age __________ Race____________

Baby's Father's Occupation / Employer____

Emergency Contact Name ______________________ Phone # ______________ Relationship ____________

GENERAL HISTORY – SELF & FAMILY

Please mark if you or any family member (children, sisters, brothers, grandparents, aunts, uncles) have had any of the following conditions. **IF YOU ARE UNSURE OF A CONDITION, PLEASE CIRCLE IT.**

Self	Family	Condition	Self	Family	Condition
◯	◯	Cancer	◯	◯	Twins
◯	◯	High Blood Pressure	◯	◯	Infertility
◯	◯	Heart / Valve Disease	◯	◯	Blood Clots / Varicose Veins
◯	◯	Rheumatic Fever	◯	◯	Blood Transfusions
◯	◯	Lung Disease	*Sexually Transmitted Diseases:*		
◯	◯	Stomach / Bowel Problems	◯		Genital Herpes
◯	◯	Kidney Disease	◯		Condylomata (Genital Warts)
◯	◯	Urinary Problems	◯		Chlamydia
		(including infections/malformations)	*Infectious Disease:*		
◯	◯	Diabetes Mellitus	◯		Hepatitis
◯	◯	Anemia / Blood Disorders	◯		Turberculosis
◯	◯	Other Endocrine / Hormone Disorders	*Other Diseases or Illnesses:*		
◯	◯	Nervous / Mental Disorders	◯		PKU
◯	◯	Convulsive Disorders / Epilepsy	◯		DES Exposure
◯	◯	Abnormal Babies	◯		Other ____________________
◯	◯	Genetic Diseases			

Does the baby's father, or his family, have any history of abnormal babies or genetic disease? ◯ Yes ◯ No

Are you ever around cats? ◯ Yes ◯ No

Do you have a hot tub? ◯ Yes ◯ No

Do you exercise regularly? ◯ Yes ◯ No

Do you, or have you, used drugs (marijuana, cocaine, etc)? ◯ Yes ◯ No

TOBACCO & CAFFEINE

Coffee/Tea _________cups a day
Cola or other caffeinated drinks _______ a day
Cigarettes – Now _______ a day _______ years
Cigarettes – Ever _______ a day _______ years
When stopped: _______________

ALCOHOL

Do you drink Alcohol?
◯ Yes ◯ No
_______ Drinks a day
_______ Drinks a week

ALLERGIES/SENSITIVITIES

Antibiotics: ________________
Pain Medication: _____________
Anesthesia: _________________
Other: _____________________

Please list all times you have been hospitalized, operated on, or seriously injured

Year **Operation, Illness, or Injury** **Hospital & City**

____
____
____

Pregnancy History				Grav		Term	Preterm	Abortion	Living	C.Section
No. of Preg	Mo / Yr	Baby's Sex	Birth Wgt	Wks Gestat.	Hrs. Labor	Delivery Type	Detail Complications - Maternal / Newborn / Anesthesia if a C.Section, list incision type			
1										
2										
3										
4										
5										
6										

Medical Arts Building ● 350 Park Street, Suite 203
Bowling Green, KY 42101
Phone: (270) 781-0075 ● Fax: (270) 781-0143
Toll Free: 1-866-997-5784
www.WomensHealthSpecialists.net

HEALTH PROFILE

Patient Name ______________________________________ Today's Date ____________________
(Last, First, Middle Initial)
Date of Birth ________________ Age __________ Social Security # ____________________

Home Phone # _________________ Cell Phone # _______________ Work Phone # ______________

Why are you seeing the Doctor? ____
When was the first day of your last menstrual period? ______________________________________
How often do you get your period? ________________________ How long does the bleeding last? _________________
How severe is the cramping with your period (none / mild / severe)? ___________________________________
Are you doing anything for Birth Control right now? Yes No If yes, what? ___________________________
When was your last PAP smear? ____________________ Ever had an abnormal PAP? Yes No When? ____________
When was your last Mammogram? _________________ Ever had an abnormal mammogram? Yes No When? _______
What medications are you currently taking (name & dose)? ____
____
Preferred Pharmacy _____________________________ Location (City, State) ___________________________
Do you smoke? Yes No If yes, how many packs of cigarettes per day? _____________________________
Do you use alcohol (beer, wine, etc.)? Yes No If yes, what kind? _________________________________
How many times have you been pregnant? ______________ How many babies have you delivered? _______________
How many miscarriages have you had? __________________How many abortions have you had? _________________
Have you ever had a Cesarean Section? Yes No
What surgeries have you had? (Please list all & year) ____
____
Do you have any medical problems (i.e. Diabetes, thyroid disease, high blood pressure, heart disease, asthma, joint problems, etc.)? Please list any ____
____
Do you have a history of seizures? ____
Has anyone in your family had any of the following problems?
Cancer _______________ Who______________ What kind / location (i.e. breast, colon, etc.) ____________________
Diabetes _______________ Who ______________ High Blood Pressure _______________ Who ____________________
Heart Disease ___________ Who ______________ Asthma _________________________ Who ____________________

Any other major medical problems to note, Please list ____

Latex Allergy Screening Tool

1. Do you have a confirmed latex sensitivity, or do you have spina bifida? Yes No
2. Have you ever had a reaction after handling/using poinsettia plants, balloons, rubber products or spandex? Yes No
3. Have you ever had one of the following after a medical /dental appointment: itching, tearing, fatigue, sneezing or running nose? Yes No
4. Have you ever reacted after eating bananas, avocados, kiwi, or chestnuts? Yes No

For patients who have responded in the affirmative to most of these questions, latex precautions will be utilized, unless otherwise stipulated by the physician. The suspected allergy will be documented in the patient's chart and the referring physician will be contacted.

_____________ ________________________________ ______________________________________
Date Employee Signature Patient Signature

Revised 05/2014