Axia WOMEN'S HEALTH | PREMIER WOMEN'S HEALTH OF SOUTH JERSEY

axiawh.com

Your Name: _____ Date of Birth: _____

Today's Date: _____

Last Menstrual Period _____

Please list all allergies and type of reaction: _____

_____

_____

_____

Please list all medications that you take, as well as quantity and frequency:

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Elmer | 340 West Front Street, Hofmann Professional Building, Suite 201, Elmer, NJ 08318 | P: 856-223-8930 F: 855-475-6191
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Woolwich | 100 Lexington Road, Building 100, Woolwich Township., NJ 08085 | P: 856-223-8930 F: 855-475-6191

Axia WOMEN'S HEALTH

REGISTRATION UPDATE FORM

Patient Information

Last Name: _____ First Name: _____ Today's Date: _____

Other Name: _____ Date of Birth: _____

Address (street): _____ City, State, Zip: _____

Email Address: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____ Ext _____

PCP: _____ PCP Telephone # _____

Birth Sex: ☐ Male ☐ Female **Gender Identity:** ☐ Male ☐ Female ☐ Genderqueer, neither exclusively male nor female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partner

Pharmacy Update Information

Pharmacy Name: _____ ☐ Local ☐ Mail away

Address: _____ City, State, Zip: _____

Pharmacy Name: _____ ☐ Local ☐ Mail away

Address: _____ City, State, Zip: _____

Insurance Information

PRIMARY CARRIER NAME: _____

ID/Cert #: _____ Group/Plan #: _____ Effective Date: _____

SECONDARY CARRIER NAME: _____

ID/Cert #: _____ Group/Plan #: _____ Effective Date: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Electronic Communications

Email: I understand Axia will **not** share my email address with any third parties. My address will be used to communicate important announcements about my care center or provider, such as office closings, changes in services, and other non-clinical announcements pertaining to Axia or my care center. Axia offers secure electronic communications between patients and their office via the Patient Portal.

☐ Yes, I want to participate. Please use the email address above. ☐ No, I do not wish to participate.

Automated Reminders: Axia Women's Health offers automated reminders via text messages or automated calls. If I choose to participate, I understand my cell phone listed above will be used.

☐Yes, I agree to participate. (Please choose one method) ☐ Text messages ☐ Voice calls

☐No, I **do not** wish to participate.

I agree that Axia Women's Health and/or it's agents may contact me by cell phone, including via text messages or automated calls, which may result in charges to me.

Medical Chaperone

I request a female chaperone to be present during my examination? ☐ Yes ☐ No ☐ Other (family member, partner, etc. will be present)

Patient Signature

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my provider or insurance company to release any information required to process my claims.

Patient Signature: _____ Date: _____

Medical History Form

Name:	DOB: / /	Date:
LIMITATION TO CARE: ☐ Disability:		
Translator Needed: ☐ Spanish ☐ American Sign Language ☐ Other:		
Other Preferences:		

CURRENT MEDICATIONS: List all Current and Over the Counter Medications

MEDICAL HISTORY: Select all that apply

☐ Alcohol Abuse ☐ Anemia ☐ Anxiety Depression ☐ Arthritis ☐ Autoimmune Disorder ☐ Blood Transfusion ☐ Breast Problems ☐ Cholesterol ☐ Clotting Disorder ☐ Diabetes	☐ DVT/PE ☐ Eating Disorder ☐ Endometriosis ☐ Fibroids ☐ GI Issues ☐ Heart Disease ☐ Hepatitis/Liver Disease ☐ High Blood Pressure ☐ Kidney Disease	☐ Kidney Stones ☐ Lung Problems ☐ Migraine Headaches ☐ Osteoporosis ☐ Polycystic Ovarian Syndrome ☐ Stroke ☐ Substance Abuse ☐ Thyroid Disease ☐ Other: Please Specify _____	☐ Breast Cancer ☐ Cervical Cancer ☐ Colon Cancer ☐ Endometrial Cancer ☐ Ovarian Cancer ☐ Rectal Cancer ☐ Uterine Cancer ☐ Other: Please Specify _____

ALLERGIES: List All Known Drug Allergies

☐ No Known Drug Allergies		

GYN HISTORY

GYN Testing: answer all that apply

▪ Last Pap Smear	/ /
▪ Result of Last Pap Smear [ ] Normal [ ] Abnormal [ ] No pap ever	
▪ Last HPV Testing	/ /
▪ Last Colposcopy	/ /
▪ Last Mammogram	/ /
▪ Last Pelvic Ultrasound	/ /
▪ Last Colonoscopy	/ /
▪ Date of Last Bloodwork	/ /

MENOPAUSE: if menopausal

▪ Began at age:	years old

▪ **Current Menopausal Symptoms:**
[ ] None [ ] Hot Flashes [ ] Memory Loss
[ ] Headache [ ] Irritability [ ] Weight Gain
[ ] Loss of Libido [ ] Vaginal Dryness
[ ] Other: please specify

▪ **Treatment:** [ ] None [ ] Hormone [ ] OTC

SELF-BREAST EXAMINATION

▪ **Do you perform Self-Breast examinations?**
[ ] Monthly [ ] Sometimes [ ] Do not perform

MENSTRUATION: if menopausal skip

▪ **Age of Onset:** At what age did your periods start?	yrs old
▪ **LMP:** What was the date of your last period?	/ /

▪ **Time Between Periods:**
[ ] Irregular [ ] 21-32 days apart [ ] < 21 days apart
[ ] 33-44 days apart [ ] > 45 days apart

▪ **Duration:** How long does your period last?
[ ] < 7 days [ ] 2-7 days [ ] 3 days

▪ **Pad or Tampon use per day:**
[ ] 1-3 per day [ ] 4-6 per day [ ] 7 + per day

▪ **How would you describe your period?**
With: [ ] severe pain [ ] mild discomfort [ ] moderate pain
[ ] without moderate pain [ ] light [ ] heavy

MENSTRUAL SYMPTOMS: select all that apply

[ ] None [ ] Headaches [ ] Bloating [ ] Irritability
[ ] Migraines [ ] Weight Gain [ ] Mood Swings [ ] Nausea

▪ Cramping : [ ] Mild [ ] Moderate [ ] Severe

Medical History Form

Axia WOMEN'S HEALTH

Name:	DOB: / /

BIRTH CONTROL: please specify

☐ None	☐ Nexplanon	☐ Nuva Ring	☐ Kyleena IUD
☐ Condoms	☐ Diaphragm	☐ Bilateral Tubal Ligation	☐ Liletta IUD
☐ Depo Provera	☐ Ortho Evra Patch	☐ Vasectomy	☐ Mirena IUD
☐ Oral Contraceptives	☐ Spermicide	☐ Withdrawal method	☐ Paragard IUD
			☐ Skyla IUD

SEXUAL ACTIVITY: please specify

☐ Currently sexually active		☐ Not currently sexually active	
▪ Age of first sexual activity	years old	▪ Total # of Lifetime Partners	please specify: _____

Currently or in the past, I have had sex with: [ ] Men [ ] Women [ ] both, Men and Women

Have you been trying to get pregnant without success? ☐ Yes ☐ No

SEXUALLY TRANSMITTED INFECTIONS (STI'S): please specify

[ ] None [ ] Human Papilloma Virus (HPV) [ ] Chlamydia [ ] Herpes Simplex Virus (HSV) [ ] Gonorrhea [ ] Syphilis
[ ] Trichomoniasis [ ] Hepatitis B [ ] Hepatitis C [ ] Human Immunodeficiency Virus (HIV)

URINARY INCONTINENCE

Do you ever leak urine you cough, sneeze, laugh, or exercise?	☐ Yes	☐ No
Do you ever leak urine on the way to the bathroom or can't get to the bathroom on time?	☐ Yes	☐ No
Do you go to the bathroom frequently more than seven times a day and/or get up more than two times at night?	☐ Yes	☐ No

Other:

OB HISTORY

Total # of Pregnancies		Total Living Children	
Number of full-term pregnancies (37 weeks or greater)		Number of preterm Pregnancies (less than 37 weeks)	
Number of Miscarriages/Abortions		Number of Ectopic (tubal) Pregnancies	

Please fill out the following to the best of your recollection regarding your prior pregnancies:

	Date MO/YEAR	SEX	GA WEEKS	TYPE of DELIVERY	BIRTH WEIGHT	ANESTHESIA	LENGTH of LABOR	WEIGHT GAIN
Preg 1		M F		Vaginal C-Section	lbs. oz.			
Comments and complications:								
Preg 2		M F		Vaginal C-Section	lbs. oz.			
Comments and complications:								
Perg 3		M F		Vaginal C-Section	lbs. oz.			
Comments and complications:								
Preg 4		M F		Vaginal C-Section	lbs. oz.			
Comments and complications:								

Medical History Form

Axia WOMEN'S HEALTH

Name:	DOB: / /

SURGICAL HISTORY: In Date Order, please list all surgeries and c-sections (including minor surgery)

☐ Denies Past Surgical History

Mo/Year	Type of Surgery

HOSPITALIZATION: Please list any hospitalization

☐ Denies any Hospitalization ☐ See Surgical History Above

Mo/Year	Please Specify:

FAMILY HISTORY: Please check all that apply for the corresponding family members by placing an "X" in the appropriate boxes.

☐ **Patient Adopted**

	Heart	Diabetes	Hypertension	Breast	Ovarian	Heart	Colon	Stroke	Mental Illness
Mother									
Father									
Maternal Grandmother									
Maternal Grandfather									
Paternal Grandmother									
Paternal Grandfather									
Daughter									
Son									
Sister									
Brother									

List all other Family Genetic Disorder(s) and specify the relationship:

SOCIAL HISTORY

Tobacco: Are you a Tobacco Smoker? ☐ Non-Smoker ☐ Yes, Current Smoker ☐ Former Smoker

If *yes*, please answer the following:

How often do you smoke cigarette's? ☐ Everyday ☐ Somedays, but not everyday

If "current smoker": How many cigarettes a day do you smoke?

☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more

Are you interested in quitting? ☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit

Non-Tobacco Use: I am *not* using tobacco, but I am currently:

☐ using an E-Cigarette ☐ Vaping ☐ using Marijuana

Medical History Form

Axia WOMEN'S HEALTH

Name:	DOB: / /

SOCIAL HISTORY

Alcohol:

- Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No
- If yes, how often did you have a drink containing alcohol in the past year?

☐ Never ☐ Monthly or less ☐ 2-4 times a month
☐ 2-3 times a week ☐ 4 or more times a week

Drugs

- Have you used drugs other than those for medical reasons in the past year? ☐ Yes ☐ No
- **If yes, please select all that applies:**

☐ Heroin ☐ PCP ☐ Prescription Opiates ☐ LSD
☐ Cocaine ☐ Ketamine ☐ Ecstasy ☐ Crack
☐ Marijuana ☐ Methamphetamine

- If yes, How many months ago did you use? [_____] months ago
- Are you in a treatment program? ☐ Yes ☐ No
- Have you ever injected drugs? ☐ Yes ☐ No
- Are you still using? ☐ Yes ☐ No
- Is there a minor 18 years or younger at home? ☐ Yes ☐ No
- How many children at home under 18 years old? ☐ Yes ☐ No

Miscellaneous:

Occupation:

Please describe Caffeine Intake:

☐ None ☐ 1-2 cups per day ☐ 2-3 cups per day
☐ 3-4 cups per day ☐ More than 4 cups per day

Any history of domestic violence?

☐ None ☐ History in the past ☐ Has restraining order
☐ Feels unsafe at home ☐ Have safety plan

Any history of verbal abuse?

☐ None ☐ Occasional ☐ Frequent
☐ Seeking Counseling ☐ Has safety plan

- Has your partner ever threatened you or made you feel afraid? ☐ Yes ☐ No
- Does your partner or someone important to you hurt you physically or emotionally? ☐ Yes ☐ No

IMMUNIZATIONS: Have you had any of the following?

Chicken Pox	☐ Yes	☐ No	Year	Hepatitis B	☐ Yes	☐ No	Year
DTAP	☐ Yes	☐ No	Year	Pneumonia	☐ Yes	☐ No	Year
Flu	☐ Yes	☐ No	Year	Rubella	☐ Yes	☐ No	Year
Gardasil	☐ Yes	☐ No	Year	Tetanus	☐ Yes	☐ No	Year

Would you object to blood products in the event of an emergency?

- Choose one: ☐ No, I will not object to blood products. ☐ Yes, I will object to blood products.

Patient Name: (please print)	Date
Patient Signature:	

Axia Women's Health

Patient's Name: _____ DOB: _____

Authorization for Treatment & Payment of Medical Benefits
Patient Financial Responsibility

Thank you for choosing our practice, an Axia Women's Health Care Center, as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment, and patient financial policies. If you would like to receive a more detailed explanation of our financial policies, please request a copy.

Authorization for Treatment & Payment of Medical Benefits

I give permission to the practice to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to the practice.

Use of Photography

I agree that any photo identification taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of identification.

Patient Financial Responsibilities

- I (or patient's guardian, if a minor) understand that I am ultimately responsible for the payment of my treatment and care.
- You will assist me by billing my contracted insurers. However, I understand that I am required to provide you with the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, and most major credit cards. Patient Responsibility and Benefit information provided by Axia Women's Health are based on information provided by your insurer at the time of service. Axia is not responsible for the accuracy of this information. ACTUAL AMOUNT DUE TO AXIA WILL BE PROVIDED ONCE CLAIM IS ADJUDICATED BY PAYER.
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include (but are not limited to):
    - Charge for returned checks.
    - Charge for the copying and distribution of patient medical records.
    - Charge for forms completion.
    - Charge for missed appointments.

Patient Authorizations

- By my signature below, I hereby authorize the practice, an Axia Women's Health Care Center, to release medical and other information to the necessary insurance companies and third-party payers required for payment of rendered health services.
- By my signature below, I hereby authorize assignment of financial benefits directly to the practice, an Axia Women's Health Care Center. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

I have read, understand, and agree to the provisions of this Authorization for Treatment & Payment of Medical Benefits and Patient Financial Responsibility Form:

_____

Signature of Patient or Guardian Date

Axia WOMEN'S HEALTH | PREMIER WOMEN'S HEALTH OF SOUTH JERSEY

axiawh.com

Patient Name _____

Date of Birth _____

Dear Patient:

The State of New Jersey mandates that every physician office document any barrier to care including physical impairments, cultural and linguistic needs in their medical records.

Please assist us by answering the following questions:

Do you have any impairment – Visual, hearing, speech, learning, physical or language/cultural barrier?

What language do you speak, read or write?

Do you have any religious or culture customs that the provider should know about?

Patient Signature _____

Date _____