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Carol Anderson, D.O. • Leslie Ollar-Shoemake, D.O. • Lisa Waterman, D.O. •
Daphne Lashbrook, M.D. • M. Dianne Chambers, M.D., P.C.

Patient Registration Information

Patient Name: _____ DOB: ____ / ____ / ____
First Middle Initial Last

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Driver's License and State: _____ Social Security Number: _____

Employer Name: _____

Employer Address: _____

Work Phone: _____ Your Occupation: _____

Marital Status: Married Single Divorced Widowed

If Married: Spouse's Name: _____ DOB: ____ / ____ / ____

Spouse's Cell Phone: _____ Spouse's Work Phone: _____

Spouse's Employer: _____

If patient is a minor, Parent's Name: _____

Parents Employer: _____ Work Phone: _____

INSURANCE/RESPONSIBLE PARTY INFORMATION:

Primary Insurance Company Name: _____

Insurance Company Address: _____ Phone: _____

Name of Policy Holder: _____

Relationship with Insured: _____

Policy Holder's DOB: ____ / ____ / ____ Policy Holder's SSN: _____

Employer Name: _____

ID # _____ Group #: _____

Secondary Insurance Company Name: _____

Insurance Company Address: _____ Phone: _____

Name of Policy Holder: _____

Relationship with Insured: _____

Policy Holder's DOB: ____ / ____ / ____ Policy Holder's SSN: _____

Employer Name: _____

ID # _____ Group #: _____

EMERGENCY CONTACT (Not at same address): Name: _____

Relationship: _____ Phone Number: _____

Referred by: _____

Name(s) of other physicians that you have seen in our office: _____

Date: ____ / ____ / ____ Signature: _____



Women's Healthcare

OF NORMAN

Women Caring for Women



Carol Anderson, D.O. • Leslie Ollar-Shoemaker, D.O. • Lisa Waterman, D.O. • Daphne Lashbrook, M.D. • M. Dianne Chambers, M.D. • Allison Carter M.D.

First Name: _____ **Middle Initial:** _____ **Last Name:** _____ **Date:** _____

Date of Birth: _____ **Age:** _____ **Marital Status:** Married Single Divorced Widowed

Referring Physician: _____ **Your Occupation:** _____

Reason for Visit: _____

This form is to help us understand your health history. It will allow us to ensure your records are complete so we can provide the best care possible at the time of your visit. We understand that your answers are very personal, and we will maintain them in the strictest confidence, as is all of your medical information.

PAST MEDICAL HISTORY:

List any medical illnesses: _____

List any drug allergies: _____

Do you smoke?: Yes No

If yes, how much? _____

Do you drink alcohol?: Yes No

If yes, how much? _____

Do you use any illegal drugs?: Yes No

Date of last Mammogram: _____

Date of last Dexa Bone Scan: _____

Date of last Colonoscopy: _____

OB HISTORY:

Are you currently pregnant?: Yes No

How many pregnancies have you had? _____

Number been born before 37 weeks? _____

How many living children do you have? _____

Have you had a miscarriage? Yes No

If yes, how many? _____

Have you had an abortion? Yes No

If yes, how many? _____

Have you had a C-Section? Yes No

If yes, how many? _____

FAMILY HISTORY:

Have you had or any members of your family had:

	You	Family (List who and what side)
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/> _____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/> _____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/> _____
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/> _____
Hepatitis (Type____)	<input type="checkbox"/>	<input type="checkbox"/> _____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/> _____
Anemia or Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/> _____
AIDS or HIV	<input type="checkbox"/>	<input type="checkbox"/> _____
Birth Defects or Inherited Diseases	<input type="checkbox"/>	<input type="checkbox"/> _____
Cancer (If Yes List Type)	<input type="checkbox"/>	<input type="checkbox"/> _____

List any medications (Name, Dosage, How often it is taken):

List any SURGERIES and YEAR it was performed:

GYN HISTORY:

First Day of Last Menstrual Period: _____

Age of First Period: _____

How often do you have a period: _____

How many days does your period last: _____

Date of last pap smear: _____

Have you ever had an abnormal pap smear?:

Yes No *If yes, when?* _____

Treated with: Follow-up Pap Smear Colposcopy LEEP

Are you currently sexually active?:

Yes No

How many partners have you been with?:

None One 2-5 More than 5

Have you ever had a sexually transmitted disease?:

Yes No

Method of birth control: _____

Have you ever used Gardasil? Yes No

Have YOU ever had any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Stomach, Bowel or Gallbladder Problems | <input type="checkbox"/> Syphilis Type: _____ |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Herpes (HSV) Type: _____ |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Chlamydia Type: _____ |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Gonorrhea Type: _____ |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Breast Problems |
| <input type="checkbox"/> Kidney or Bladder Problems | <input type="checkbox"/> Sexual Problems |
| <input type="checkbox"/> Sexual Abuse or Domestic Violence | |



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Financial Policy

Dear Patient:

Your physician is honored that you have chosen her. The following is her Financial Policy. Her main concern is that you receive the proper and optimal treatment needed. Therefore, if you have any questions or concerns about the payment policies, please do not hesitate to ask the billing department. All patients are asked to read and sign the Financial Policy as well as complete the Patient Registration form prior to see their doctor.

Payment for services is due at the time services are rendered. Your doctor accepts cash, checks, MasterCard, Visa, Discover, and American Express. The office staff will be happy to file your insurance claim for you. However, please be aware that, although your physician has contracts with several insurance companies, she is not on all PPO or network plans. Please be sure to inquire as to your physician's status with your particular insurance company, as this may affect the amount you are responsible for paying.

Please note that if you are a member of an HMO or Managed Care program and/or have a primary care physician (PCP), you are responsible for contacting your PCP for a referral number prior to your visit, if applicable. If you fail to do so, your visit(s) may not be covered by your insurance, making you financially responsible.

All charges are your responsibility whether your insurance pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services along with unpaid deductibles and co-payments are due at the time of treatment. If the insurance company does not pay your claim within a reasonable time frame, you will be required to follow up with them and/or pay the balance.

During the course of your medical care, it may be necessary for one or more physicians to assist with your medical treatment. You agree to acknowledge that any overpayment or credit balance that you may have with one of the practices within the office is hereby assigned to any of the other practices within the office to which you may have a debt or outstanding balance due. To the extent that you have no balance due to any of the practices within the office upon completion of your medical treatment, any overpayment will be refunded.

Temporary financial problems may affect timely payment of your balance. It is imperative that you communicate such problems to the billing department so that they can assist you in the management of your account.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorized the doctor and staff to release all information necessary to secure the payment of benefits.

PRINT NAME _____ Date of Birth _____ / _____ / _____

Patient's Signature _____ Date _____ / _____ / _____

Again, thank you for choosing us as your health care provider. Your physician appreciates your trust and appreciates the opportunity to serve you.



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Important Information for our Patients Regarding Annual Well Woman Exams

Our office makes every effort to follow the current coding practices for reporting medical services as dictated by Federal Law and the American Medical Association (AMA). These regulations can be quite complicated and generate many questions from our patients. The purpose of this handout is to clear up any confusion caused by these complicated rules regarding the billing of Preventative and Screening Services.

The Well Woman or Preventative Medicine charges for our practice include:

- A complete history and examination in addition to a breast and pelvic exam. There will be questions about other medical conditions and counseling on risk factors such as: sexually transmitted disease prevention, diet and exercise, stress management, smoking cessation, Self Breast Exams, birth control, menopausal symptoms and hormone replacement therapy;
- The collection/preparation of Pap Smear specimen is included if indicated; it will be submitted to a lab and will be billed by that entity.
- Appropriate laboratory and diagnostic tests, such as a mammogram and DEXA, may be ordered and will be billed by those entities.
- Immunization administration, vaccine/toxoid products and other procedures are not included.

As outlined above, discussions about problems and conditions you are being treated for, that are under control, are considered an integral part of the Well Woman exam and cannot be billed as a “sick visit” under Federal Compliance rules.

If a separate problem is identified, addressed or treated during the course of the Annual Exam, we are required to submit our claims based on the documentation in the medical record of the service provided to you. This may result in a second office visit charge and/or second co-pay.

If at the time of scheduling your Well Woman Exam, you are aware of problems you would like to discuss, we recommend scheduling a separate “problem appointment”. If you are scheduled for your Well Woman Exam today and are aware of problems you would like to discuss, please inform the nurse. In this event, your appointment may be converted to a “problem appointment” due to the time restraints and to avoid additional costs to you.

You as the insured will be responsible for payment as dictated by your insurance plan of all co-payments and deductibles at the time of service. Again, if an additional problem is treated or addressed during this exam, there may be an additional charge that you will be responsible for.

I understand the above information and agree to pay any charges incurred due to discussion/treatment of a problem during a Well Woman Exam.

PRINT NAME

_____/_____/_____
Date of Birth

Patient Signature

_____/_____/_____
Today's Date



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 Dianne Chambers, M.D. • Allison Carter, M.D.
 500 E. Robinson St, Suite #2400, Norman, OK 73071 • (405) 360-1264

STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

I. INDIVIDUAL INFORMATION (FOR PERSON WHOSE INFORMATION WILL BE SHARED)

Name (Please PRINT)	Date of Birth
Address	City
Area Code & Telephone Number	State Zip

II. SCOPE & PURPOSE FOR SHARING INFORMATION

I understand protected health information is information that identifies me. The purpose of this authorization is to allow Women's Healthcare of Norman, LLC to share my protected health information.

III. AUTHORIZATION & INFORMATION TO BE SHARED

I authorize Women's Healthcare of Norman, LLC as set forth below, to share my protected health information for reasons in addition to those already permitted by law.

A. Persons/Organizations Authorized to Receive My Information: *(Please do not include other physicians or your employer in this list)*
 (Name, Address, Phone & Fax) Relationship Purpose

B. Information to be shared

1. Check one or more boxes below. (Please check the appropriate box's for authorization)

- Entire Medical Record (includes all records except Psychotherapy Notes)
- Psychotherapy Notes
- Mental Health Records
- Pathology Report History and Physical Operation Report(s)
- Progress Notes Consultation Report(s) Discharge Summary
- EKG Report(s) Laboratory Report(s) Radiology Report(s)
- Physician's Orders Radiology Films Alcohol or Drug Abuse Records
- Other

2. Covering Services Between _____ and _____ *(Insert either date(s) or "all.")*

IV. EXPIRATION & REVOCATION

A. This Authorization will Expire (must choose one):

- 3 years after last office encounter other *(insert date or event):* _____

B. Right to Revoke

I understand I may change this authorization at any time by writing to the address listed at the bottom of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

V. ACKNOWLEDGEMENTS & SIGNATURES

A. Acknowledgements

- 1. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.
- 2. I understand if the person/organization authorized to receive my protected health information is not a health plan or healthcare provider, privacy regulations may no longer protect the information.
- 3. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the address listed at the bottom of the form.
- 4. I understand Carol Anderson, D.O, Leslie Oller-Shoemake, D.O., Lisa Waterman, D.O., Daphne Lashbrook, M.D., Dianne Chambers, M.D., and Allison Carter, M.D. collectively known as Women’s Healthcare of Norman, LLC as members of Oklahoma Physician Health Exchange (OPHX), may utilize an electronic network to exchange my protected health Information with other providers unless I choose not to participate.
- 5. **I acknowledge information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.**
- 6. **Acknowledgement of Notice of Privacy Practice:** A complete description of how my medical information will be used and disclosed by Women’s Healthcare of Norman is in the “Notice of Privacy Practice”, which I should read before signing this agreement. A copy has been offered to me and is posted in the clinical site.

B. Signature

This document must be signed by the individual or the individual’s legal representative.

Signature (Patient or Legal Representative) Date

Printed Patient or Legal Representative Name Capacity of Legal Representative (if applicable)

Physicians and Clinic Address:

Carol Anderson, D.O, Leslie Oller-Shoemake, D.O., Lisa Waterman, D.O., Daphne Lashbrook, M.D.,
Dianne Chambers, M.D., and Allison Carter, M.D. collectively known as Women’s Healthcare of Norman, LLC
500 E. Robinson Suite #2400 Norman, Oklahoma 73071



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Pregnancy Questionnaire

First Name: _____ Middle Initial: _____ Last Name: _____ Date: _____

Date of Birth: _____ Age: _____

OB HISTORY:

When was the first day of your last period: _____ / _____ / _____ *Don't Know*

Were you on birth control at the time of conception? Yes No *If Yes, which one?* _____

How many TOTAL pregnancies have you had, including this one? _____

How many living children do you currently have? _____

What is your occupation? _____

Do you come in contact with hazardous chemicals or do any heavy lifting (>20) while on the job? Yes No

If Yes, please explain: _____

Marital Status: Married Single Divorced Widowed

Height: _____ Pre-pregnancy Weight: _____

Name of the baby's father: _____

Baby's Father's Contact Phone Number: _____

PERSONAL MEDICAL HISTORY

This section of questions pertains to YOUR medical history. Please indicate if YOU have had any of the following:

High Blood Pressure: Yes No

Heart Disease: Yes No

Autoimmune Disorder: Yes No

Kidney Disease/Stone/ UTI: Yes No

Neurologic Disorder/Seizures: Yes No

Depression/Postpartum Depression: Yes No

History of other Mental Disorder: Yes No

If Yes, what disorder and are you currently under treatment?: _____

Hepatitis/Liver Disease: Yes No

Varicosities/Phlebitis: Yes No

Thyroid Dysfunction: Yes No

Sexual Abuse/Domestic Violence: Yes No

History of Blood Transfusion: Yes No

Alcohol/Drug Use: Yes No

Tobacco Use: Yes No

If Yes, How many packs a day? _____

Pulmonary Disorder (TB/Asthma): Yes No

Seasonal Allergies: Yes No

Drug/Latex Allergy: Yes No

If Yes, please list allergy and reaction: _____

Breast Disorder/Surgery: Yes No

Gynecologic Surgery: Yes No

Anesthetic Complications: Yes No

If Yes, what complication? _____

History of Abnormal Pap: Yes No

Uterine Anomaly/DES Exposure: Yes No

Infertility: Yes No

Diabetes: Yes No

PERSONAL MEDICAL HISTORY (CONTINUATION)

Please list all the medications you are currently taking, including any supplements or herbal preparations. Also include dosage and how often you are taking it.

MEDICATIONS	DOSAGE

Please list any surgeries you have had and the date:

SURGERY	DATE

Please list any previous hospitalizations and the approximate date:

REASON FOR HOSPITALIZATION	DATE

IMMEDIATE FAMILY MEDICAL HISTORY

The following section of questions pertains to YOUR immediate family, (Parent, Grandparent and/or Siblings).

Do you have a FAMILY history of:

Heart Disease: Yes No

High Cholesterol: Yes No

High Blood Pressure: Yes No

Cancer: Yes No

If Yes, list who and what type: _____

Thyroid Problems: Yes No

Hepatitis: Yes No

AIDS or HIV: Yes No

Diabetes: Yes No

GENETICS HISTORY

The following section of questions pertains to YOU, the BABY'S FATHER or EITHER OF YOUR FAMILIES.

Is there any history of:

Thalassemia Yes No

(Italian, Greek, Mediterranean, or Asian Descendent)

Neural Tube Defect Yes No

Congenital Heart Disease Yes No

Down Syndrome Yes No

Tay-Sachs Disorder Yes No

Sickle Cell Disease or Trait Yes No

Hemophilia or other Blood Disorder Yes No

Multiple Sclerosis Yes No

Cystic Fibrosis Yes No

Mental Retardation/Autism Yes No

If Yes, was the person tested for fragile X? Yes No

Other inherited Genetic or Chromosomal Disorder Yes No

Recurrent pregnancy loss or stillbirth? Yes No

Patient or Father of Baby had other child with birth defects not listed? Yes No

If you answered Yes to any of the above questions, please explain: _____

INFECTION HISTORY

Do you live with someone with TB or have you been exposed to TB? Yes No

Do you or your partner have history of herpes? (Oral or Genital) Yes No

Have you had a rash or viral illness since your last period? Yes No

Have you had Hepatitis B or C exposure? Yes No

Have you had an STD in the past year? Yes No

RISKS

Have you had the following with a PREVIOUS pregnancy?

- | | | |
|---|------------------------------|-----------------------------|
| Uterine or Cervical Malformation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Suspect Pelvis (not large enough to accommodate baby) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rh Negative (Negative Blood Type) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Failure to Gain Weight (< 20 lbs.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Excessive Weight Gain (> 40 lbs.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Abnormal Fetal Presentation (Breech/Transverse Lie) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Post-Term Delivery (> 40 weeks) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Acute Pyelonephritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sexually Transmitted Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcohol use with Pregnancy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes with Pregnancy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hypertension (High Blood Pressure) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Thrombophlebitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Herpes (Oral or Genital) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rh Sensitization | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Uterine Bleeding | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Polyhydramnios (High Amniotic Fluid Level) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Oligohydramnios (Low Amniotic Fluid Level) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mild Pre-Eclampsia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Severe Pre-Eclampsia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fetal Growth Retardation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Premature Rupture of Membranes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Multiple Pregnancy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcohol or Drug Abuse | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

