Bruce Farringer, M.D., F.A.C.O.G.

Leah Najima, M.D., F.A.C.O.G.

Marao Walker, PA-C

DATE____

PATIENT NAME____AGE_____________________
(First) (Middle) (Last)

DATE OF BIRTH________________________SOCIAL SECURITY #___________________________MARITAL STATUS____________

MAILING ADDRESS____CITY________________________STATE_____ZIP____________

HOME TELEPHONE______________________CELL TELEPHONE______________________EMAIL____________________________

EMPLOYER____REFERRED BY____

POSITION OCCUPIED_______________________________________WORK TELEPHONE____________________EXT____________

SPOUSE OR PARENT____DATE OF BIRTH_______________________________

MAILING ADDRESS____HOME TELEPHONE_____________________________

EMPLOYER____SOCIAL SECURITY #____

EMERGENCY CONTACT NOT LIVING WITH YOU____________________________________RELATIONSHIP____________________

ADDRESS____TELEPHONE___________________________

YOU MUST BRING YOUR INSURANCE CARD WITH YOU AT THE TIME OF YOUR VISIT.

YOUR INSURANCE COMPANY____

POLICY/ID #____GROUP#____

POLICY HOLDER NAME____ RELATIONSHIP ______________________________________

POLCY HOLDER BIRTH DATE _______ _______ _______ POLICY HOLDER SS# ____

I hereby authorize Sierra Women's Health to furnish to my insurance company all medical information which my insurance company may request concerning my medical condition.

____
(Patient Signature)

I hereby authorize payment of medical benefits to Sierra Women's Health for medical or surgical services rendered to me by Sierra Women's Health. I understand that I am financially responsible for charges not covered by this authorization.

____
(Patient Signature)

Sierra Women's Health has offered me a copy of their Notice of Privacy Practices _________Please Initial

Do you have an Advanced Directive? ( )Yes ( )No If so, please allow our office to keep a copy in your medical record.

IMPORTANT - PLEASE READ CAREFULLY: MOST INSURANCE COMPANIES REQUIRE THAT THE INSURED USE A CONTRACT FACILITY (HOSPITAL, LABORATORY, RADIOLOGY DEPARTMENT, ETC.) IN ORDER TO OBTAIN MAXIMUM REIMBURSEMENT. PRIOR TO YOUR VISIT, YOU SHOULD CONTACT THE PERSON HANDLING YOUR INSURANCE TO FIND OUT IF THIS APPLIES IN YOUR CASE. **IT IS YOUR RESPONSIBILITY TO ADVISE US IF A CONTRACT FACILITY IS TO BE USED.**

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Consent to Disclose Protected Health Information

By signing this authorization, I authorize Sierra Women's Health to disclose protected health information about me to the following individual(s):

Name: ______________________________ Relationship: ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

I understand that NO PROTECTED HEALTH INFORMATION (other than as outlined by the Health Insurance Portability and Accountability Act) can be released to anyone, including spouses, parents, other family members, significant others or friends without this authorization. I understand that I have the right to revoke this authorization in writing at any time. However, any disclosure that occurred prior to the date of revocation is not affected.

Please list daytime telephone number(s) at which you prefer to be reached.

______________________ ______________________ ______________________

Can we leave a message regarding your protected health information at the number (s) you have provided above?

- ❑ Yes
- ❑ No

Signature: ____ Date: ____________________

Print patient name: ____

NOTE TO MINORS AND PARENTS: The health information of minors is protected. Therefore in order for Sierra Women's Health to disclose any protected health information to parents, we must have written authorization from the minor patient. Minor patients should be aware that claims cannot be submitted to a parents' insurance company without disclosure of protected health information.

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IMPORTANT INSURANCE MESSAGE

Today, most insurance companies require that the patient be aware of the particulars of her insurance coverage. Further, the patient must fulfill certain requirements prior to being seen by a physician. Your failure to company may result in reduced payment or denial of your entire claim.

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING BELOW

- I have been advised that if services rendered by Sierra Women's Health are considered to be "non-covered services" by my insurance company, I will be financially responsible.

- I have been advised that if Sierra Women's Health is not a contracted provider for my insurance company, I will be financially responsible for any and all charges rendered to me. I further understand that my insurance company may or may not cover charges for any tests, hospitalizations or procedures ordered for my by Sierra Women's Health.

- I have been advised that if my insurance company will not cover charges for services rendered without a referral from my primary care physician, and if I elect to receive care without this referral, I will be financially responsible for any and all charges for services provided by Sierra Women's Health.

- I have been advised that if I do not provide complete insurance information prior to my visit, Sierra Women's Health will be unable to determine whether or not I require a contract provider and/or a referral. If I elect to receive care under these circumstances, I understand that I will be financially responsible for any and all charges for services rendered until coverage for such services can be verified.

Patient Signature: ____ Date: _______________________

Print patient name: ____

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If your insurance company requires the use of a preferred laboratory and/or pathologist, please let us know.

My preferred laboratory is:

- ❑ Lab Corp
- ❑ Renown
- ❑ Quest

Patient Signature: ________________________________ Date: ___________________

Print patient name: ____

1500 E. Second St., Suite 202
Reno, Nevada 89502

Bruce Farringer, M.D., F.A.C.O.G.
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Margo Walker, PA-C

IF YOU ARE 30 YEARS OF AGE OR OLDER, YOU NOW HAVE THE OPTION OF HAVING AN HPV TEST ALONG WITH YOUR REGULAR PAP SMEAR

SCREENING FOR CERVICAL CANCER

Dear Patient,

At Sierra Women's Health we try to provide our patients with advanced preventive care. We now offer an FDA-approved high-risk HPV (human papillomavirus) test. This new test is a highly sensitive viral test used in conjunction with a Pap test for cervical cancer screening in women aged 30 and older. Persistent infection with high-risk human papillomavirus (HPV) is the primary cause of cervical cancer. A few important things to know about HPV and cervical cancer screening.

- Many women will have HPV at some point during their lives but very few will develop cervical cancer.
- Cervical cancer can develop if an HPV infection persists for years.
- The Pap test looks for abnormal cell changes on the cervix that occur as a result of a persistent high-risk HPV infection. The HPV test looks for an HPV infection.
- When used together, these tests can show with nearly 100% certainty that you do NOT have cervical disease. Women who test negative for high-risk HPV, AND have a normal Pap test, have virtually no risk of developing cervical cancer before their next scheduled visit.
- Knowing your HPV status helps you and your provider determine how often you should be screened. Early detection of pre-cancerous cell changes is the key to preventing cervical cancer.
- HPV can lie dormant in cervical cells for months or years before causing disease.

Some insurance companies cover some or all of the cost of the high-risk HPV test when used with a Pap test for cervical cancer screening of women 30 and over. However, the individual benefits you or your employer purchased may or may not cover the test. To learn whether or not this is a covered service, you should call the benefit telephone number shown on your insurance card. Should you elect to have the test and it is not covered by your insurance, you will receive a bill from the laboratory. Our office staff can give you an estimate on the cost of this test, but please keep in mind the actual cost depends on the individual laboratory and my change at any time.

(   ) I have read the above information and Agree to have the HPV test with my Pap test. I also agree to pay for the HPV test should my insurance not cover the cost.

(   ) I have read the above information and DO NOT wish to have the HPV test done at this time.

______________________________________ ____________________________
Patient Signature Date

____
Please print your name

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Name	Date of Birth	Age	Date

Pharmacy	Location

Allergies – List Reaction	Medication s & Dosage – Include Vitamins/Herbs

Past Gynecologic History

Last Pap	Sexually Active ❑ Yes ❑ No
Last Mammogram	Your partner is ❑ Male ❑ Female ❑Both
Age at 1st period	Contraception
Last menstrual period	Age of Menopause History of IUD use ❑ Yes ❑ No
Duration of flow	Bone Density ❑ Yes – when__________________, ❑ No
Cramps? Mild / Mod / Severe / None	Colonoscopy ❑ Yes – when__________________, ❑ No
Time between periods	Osteopenia ❑ Yes ❑ No Osteoporosis ❑ Yes ❑ No

Please check if you have or Previously had the following	Comments
❑ Abnormal Vaginal Bleeding	
❑ Vaginal Bleeding After Intercourse	
❑ Vaginal Bleeding After Menopause	
❑ History of Abnormal Paps	When___________ Diagnosis________________ Treatment__________________
❑ History of Infertility	
❑ Uterine Fibroids	
❑ Endometriosis	
❑ Ovarian Cyst	
❑ Incontinence	
❑ Prolapse Bladder / Rectum / Uterus	
❑ Infections	❑Yeast ❑Bacterial Vaginosis ❑PID
❑ Sexually Transmitted Disease	❑Herpes ❑Gonorrhea ❑Chlamydia ❑HPV ❑Syphilis ❑HIV ❑Trichomonas

❑ Cancer	❑Breast ❑Uterine ❑Ovarian ❑ Vulvar ❑Colon ❑Other

Physical Complaints within the last year (Check all that apply and explain if necessary)

Constitutional ❑Weight Loss ❑Fever ❑Fatigue ❑Other	Genitourinary ❑Burning with urination ❑Blood in urine ❑Urinary frequency/urgency ❑Other
Neck ❑Pain ❑Difficulty swallowing ❑Lumps ❑Other	Skin/Breast ❑Rash ❑Lumps in breast ❑Nipple discharge ❑Pain in breast ❑Other
Cardiovascular ❑Palpitations (Rapid heart rate) ❑Irregular heart beat ❑Chest Pain ❑Shortness of Breath ❑Other	Neurological ❑Frequent headaches ❑Dizziness ❑Weakness ❑Numbness/Tingling where? ❑Other
Abdomen ❑Pain ❑Bloating ❑Blood in stool ❑Constipation ❑Diarrhea ❑Poor appetite ❑Other	Psychiatric ❑Insomnia ❑Depression ❑Anxiety ❑Moodiness ❑Other
Respiratory ❑Cough ❑Pain with breathing ❑Shortness of breath ❑Other	Lymphatic ❑Lumps in groin, under arms, or in neck ❑Other

Past Medical History

Diabetes ❑ Yes ❑ No Comments	Kidney Disease ❑ Yes ❑ No Comments	Blood Clots Leg/Lung ❑ Yes ❑ No Comments
High Blood Pressure ❑ Yes ❑ No Comments	Urinary Tract Infections ❑ Yes ❑ No Comments	Neurologic/Epilepsy ❑ Yes ❑ No Comments
Heart Disease ❑ Yes ❑ No Comments	Thyroid Dysfunction ❑ Yes ❑ No Comments	Gastrointestinal ❑ Yes ❑ No Comments
Rheumatic Fever ❑ Yes ❑ No Comments	Tuberculosis ❑ Yes ❑ No Comments	Hepatitis/Liver Disease ❑ Yes ❑ No Comments
Mitral Valve Prolapse ❑ Yes ❑ No Comments	Asthma ❑ Yes ❑ No Comments	In Utero DES ❑ Yes ❑ No Comments
Psychiatric ❑ Yes ❑ No Comments	Anesthesia Complications ❑ Yes ❑ No Comments	Other ❑ Yes ❑ No Comments

Immunization History

Have you been vaccinated against HPV? ❑ Yes ❑ No
Have you been vaccinated against Hepatitis B? ❑ Yes ❑ No
Have you been vaccinated against Influenza? ❑ Yes ❑ No
Have you been vaccinated against Pneumonia? ❑ Yes ❑ No
Have you been vaccinated against Tetanus? ❑ Yes ❑ No
Have you had chicken pox? ❑ Yes ❑ No If no, have you been vaccinated? ❑ Yes ❑ No
Have you had Rubella (German Measles)? ❑ Yes ❑ No If no, have you been vaccinated? ❑ Yes ❑ No
Have you had a TB skin test? ❑ Yes ❑ No If yes, ❑ positive or ❑ negative

Family History – Please indicate relative and if it is on maternal or paternal side of family.

Breast Cancer ❑ Yes ❑ No Who:	Anesthesia Complications ❑ Yes ❑ No Who:
Ovarian Cancer ❑ Yes ❑ No Who:	Birth Defects/Hereditary Disorders ❑ Yes ❑ No Who:
Uterine Cancer ❑ Yes ❑ No Who:	High Blood Pressure ❑ Yes ❑ No Who:

Colon Cancer ❑ Yes ❑ No Who:	Heart Disease ❑ Yes ❑ No Who:
Osteoporosis ❑ Yes ❑ No Who:	Diabetes ❑ Yes ❑ No Who:
Gynecological Problems ❑ Yes ❑ No Who:	Psychiatric Disorder ❑ Yes ❑ No Who:

Social History

Marital Status ❑Single ❑Married ❑Divorced ❑Widowed	Tobacco ❑ Yes ❑ No Pack/day: For how long: Quit date:
Occupation	Abuse/Domestic Violence ❑ Yes ❑ No Past or Present Relationship
Alcohol ❑ Yes ❑ No Type: Amount: How often:	Carbonated Beverage ❑ Yes ❑ No Amount:
Social Drug Use ❑ Yes ❑ No Type: Amount: How often:	Weight Bearing Exercise ❑ Yes ❑ No Frequency:

Past Obstetrical History – To include miscarriages, ectopics and abortions.

Date (Mo./Yr.)	Birth Weight	Gender/Name	Type of delivery (Vaginal/C-sec.)	Place of delivery	Complications

Surgeries and Hospitalizations

Surgeries (Reason and Year)	**5.**	**Hospitalizations (Reason and Year)**
1.	**6.**	**1.**
2.	**7.**	**2.**
3.	**8.**	**3.**
4.	**9.**	**4.**