



Dear New Patient:

Thank you for selecting Meridian Women's Health as your medical provider. In order to provide the very best and most efficient care please complete the enclosed forms describing your health status and concerns. This will save you time and help us make your visit much more productive.

Please read all of the information enclosed in this new patient packet. It is essential that you bring all of the following items:

1. Picture Identification (i.e. drivers license)
2. Insurance card and co-pay (if applies)
3. Completed Patient Registration form (enclosed)
4. Completed Health Questionnaire (enclosed)

If you misplace the forms listed above they can be found on our website www.meridianwomenshealth.com. Valuable information, as well as our clinic policies can also be found on this website.

Due to the large volume of patients in our practice we require at least 24-hour notification of a cancellation. This enables us to offer your appointment time to another patient. Our office is available to take cancellation calls from 8:00am to 4:00pm Monday, Tuesday, Wednesday, Thursday and Friday 8:00am-12:00pm. Please note that calls made to the answering service after hours will be considered less than a 24-hour notification.

For our patient's convenience, we collect all lab specimens in our office and they are sent to an outside laboratory. Your services will be billed directly from Northwest Clinical Labs or Cellnetix. If you have any questions regarding this policy please let the office know prior to your appointment.

Your health is our most important concern. If we have the most complete and accurate information we can provide the finest care and service to you. Thank you for your preparation, we look forward to meeting you in the near future.

Sincerely,

Dawn Frankwick, MD

Patricia Rodrigues, MD

Carol Salerno, MD

Danae Vu, MD

MERIDIAN WOMEN'S HEALTH
10330 Meridian Avenue N. #200
Seattle, WA 98133
(206) 368-6644

PLEASE COMPLETE ALL SECTIONS - IN BLUE OR BLACK INK

| | | | | | |
|---|---------------|------------|-------------------------|--------|------|
| PATIENT NAME: | | | DATE: | | |
| Last: | First: | MI: | | | |
| NAME YOU LIKE TO BE CALLED: | | | | | |
| MAIDEN NAME: | | | | | |
| Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced | | | | | |
| Address: | | Apt#: | City: | State: | Zip: |
| Home Phone: () | | | Cell Phone: () | | |
| Social Security #: | | | | | |
| Birthdate: | | Age: | Primary Care Physician: | | |
| Employer: | | | | | |
| Work Phone: () | | | | | |
| Responsible Billing Party/Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Partner/Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent | | | | | |
| <i>(give address and phone if different than above)</i> | | | | | |
| Spouse or Partner's Name/Parent's Name (if patient is a minor): | | | | | |
| Spouse, Partner or Parent's Phone: () | | | | | |
| Whom shall we call in an emergency? (Please give name, address, area code and phone number of someone not living with you) | | | | | |
| <i>Relationship to You:</i> | | | | | |
| Reason for visit: | | | | | |

| | | |
|--|--|--------------|
| Primary Medical Insurance Carrier: | | Member #: |
| Subscriber Name & DOB: | | Group #: |
| Medicare Number: | | |
| Secondary or Medicare Supplement Insurance Carrier: | | Member #: |
| Subscriber Name & DOB: | | Group #: |
| <i>I have no insurance. I agree to pay today for services provided to me by Meridian Women's Health.</i> | | |
| SIGNATURE: | | Date: |
| Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for the balance due. I also authorize the doctor or insurance company to release any information required for this claim. | | |
| SIGNATURE: | | Date: |
| I acknowledge receipt of Northwest Hospital & Medical Center's Notice of Privacy Practices. | | |
| SIGNATURE: | | Date: |
| <i>How did you hear about Meridian Women's Health?</i> | | |
| Referred by Dr. _____ | | Other: _____ |

Thank you!

Our office continues to grow due to your referrals. We are pleased to care for your friends and family.



**Authorization to Leave Personal Health Information
By Alternate Means**

Patient Name: _____ Date of Birth: _____

Patient Mailing Address: _____

(Please check all that apply)

- May leave detailed message on voicemail at **home #**: _____
- May leave detailed message on voicemail at **work #**: _____
- May leave information with **spouse (name) and #**: _____
- May leave information with other **family member (name) and #**: _____
- May leave detailed message on **cellular phone #**: _____
- May leave detailed message at a **different phone #**: _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

Patient or legally authorized individual signature

Date

MERIDIAN WOMEN'S HEALTH

NEW PATIENT HEALTH QUESTIONNAIRE

Name _____

(please print)

Date _____ Age: _____

Problems to discuss today _____

MEDICAL HISTORY

Circle any past medical problems:

| | | | | |
|---------------------|------------|----------------|------------|-----------------|
| High blood pressure | Diabetes | Heart murmur | Angina | Heart attack |
| Tuberculosis | Asthma | Pneumonia | Bronchitis | Thyroid disease |
| Sickle cell trait | Anemia | Glaucoma | Cancer | Osteoporosis |
| Kidney infections | Depression | Headache | Arthritis | Seizures |
| Indigestion | Hepatitis | Diverticulosis | Ulcers | |

Any other significant medical problems: _____

Previous surgeries (include dates) _____

Current Medications/Vitamins/Over the counter meds or herbs _____

Allergies to medications _____

Date of last cholesterol screening _____ Date of last sigmoidoscopy / colonoscopy _____

History of blood transfusion? _____

GYNECOLOGICAL HISTORY

of pregnancies _____ # of children _____

First day of last period _____ Period occurs every _____ days Regular? _____ Period lasts _____ days

Age at 1st period _____ Age at menopause _____ Date of last pap smear _____

Method of birth control currently used _____ Date of last mammogram _____

If menopausal, are you on hormone replacement? _____ Hormones used _____

Are you sexually active? _____ New sexual partner? _____

Do you wish to be checked for sexually transmitted diseases? _____ Do you feel safe at home? _____

Circle GYN problems you have had in the past:

| | | | |
|---------------|--------------|-----------------------------|---------------|
| Endometriosis | Infertility | Fibroids | Genital warts |
| Gonorrhea | Chlamydia | Breast problems | Herpes |
| Ovarian cysts | Abnormal Pap | Pelvic Inflammatory Disease | |

PATIENT SOCIAL HISTORY

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

Current Occupation _____

Spouse (name, age, medical problems) _____

Children (names, ages, medical problems) _____

Use of Alcohol: Drinks/week _____ Quit when _____ Have you ever felt the need to cut down? _____

Use of Caffeine, Cups per Day: Coffee _____ Soda _____ Tea _____

Use of Tobacco: Never _____ Previously, but quit _____ Current Packs/Day _____

Use of Drugs: Never _____ Previously, but quit _____ Type / Frequency _____

Exercise: Never _____ Rarely _____ Weekly _____ Daily _____ Type of Exercise _____

FAMILY MEDICAL HISTORY: Do you know of any blood relative who has or had: (indicate relationship)

Breast Cancer _____ Bleeding Tendency _____

Ovarian Cancer _____ Heart Disease _____

Colon Cancer _____ High Blood Pressure _____

Diabetes _____ Mental Illness _____

Osteoporosis _____ TB _____

ADDITIONAL QUESTIONS ON BACK OF FORM

NAME _____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING:

CONSTITUTIONAL SYMPTOMS

- Unexplained weight gain or loss yes no
- Fever or chills yes no
- Night sweats/Hot flashes yes no
- Fatigue yes no

HEMATOLOGIC/LYMPHATIC

- Bleeding or bruising tendency yes no
- Anemia yes no

EYES

- Blurred or double vision yes no

EARS/NOSE/MOUTH/THROAT

- Chronic sinus problem or rhinitis yes no
- Hay fever yes no

CARDIOVASCULAR

- Chest pain or angina yes no
- Irregular heart rate yes no
- High blood pressure yes no

RESPIRATORY

- Shortness of breath yes no
- Asthma or wheezing yes no

GASTROINTESTINAL

- Loss of appetite yes no
- Change in bowel movements yes no
- Nausea or vomiting yes no
- Frequent diarrhea yes no
- Painful bowel movements or constipation yes no
- Rectal bleeding or blood in stool yes no
- Abdominal pain yes no

GENITOURINARY

- Frequent urination yes no
- Painful urination yes no
- Blood in urine yes no
- Urination at night (> 1/night)? yes no
- Urinary incontinence yes no
- Sexual difficulty yes no
- Infertility yes no
- Pain with periods yes no
- Irregular periods yes no

MUSCULOSKELETAL

- Joint pain yes no
- Back pain yes no

INTEGUMENTARY (skin, breast)

- Rash or itching yes no
- Breast pain yes no
- Breast lump yes no
- Breast discharge yes no

NEUROLOGICAL

- Frequent or recurring headaches yes no
- Light headed or dizzy yes no
- Convulsions or seizures yes no
- Numbness or tingling sensations yes no

OTHER

- Nervousness yes no
- Depression/Anxiety/Panic yes no
- Insomnia yes no
- Current emotional or physical abuse yes no

Other concerns:

Physician's Initials: _____

Date: _____