ASHEVILLE
WOMEN'S
MEDICAL CENTER

YOUR CENTER OF EXCELLENCE FOR PERSONALIZED HEALTHCARE

We are delighted that you have chosen Asheville Women's Medical Center, P.A. as your health care provider. We appreciate the opportunity to serve you and are committed to your treatment and well-being. In an effort to reduce your wait time in the office, we have enclosed our patient information forms for you to complete and bring with you to the office on the day of your appointment. In addition to these information forms, please bring your current insurance card as well as a picture ID.

As a courtesy, we will file an insurance claim for you. However, you will be responsible for making your co-payment and/or deductible payment on the day of your appointment. Members of managed care plans need to obtain the appropriate authorization from their primary care physician if necessary. If you do not have insurance coverage, you are expected to pay for your visits at the time of each appointment. If you need to make financial arrangements prior to your appointment, please call our financial counselor at 258-9191 ext 314.

Please bring any pertinent medical records from other physicians with you to your visit, along with a complete list of all current medications. Patients having a mammogram will need to have any previous films sent to us.

Please notify us at least 24 hours in advance if you cannot keep your scheduled appointment. Our office will call to confirm your ability to keep your scheduled appointment one week prior. If you fail to confirm through the automated system or to call at least 24 hours prior to that appointment, you will be charged a $25 fee. Please be aware that if you fail to come in for your appointment, or do not give at least 24 hours of cancellation, we may not be able to reschedule your appointment for a future date.

We look forward to seeing you soon. In the mean time, do not hesitate to call me directly if you have any questions. You can feel confident that the doctors and staff of Asheville Women's Medical Center will provide the care you need and deserve.

143 Asheland Avenue
Asheville, NC 28801
(828) 258-9191

310 Long Shoals Road, Suite 202
Arden, NC 28704
(828) 687-2955

ASHEVILLE WOMEN'S MEDICAL CENTER

A Comprehensive Health Care Questionnaire

Chart#_____ Date_____

Name_____ Date of Birth_____Age_____
First Last Middle

Address_____
Street City State Zip

Occupation_____Place of Employment_____Marital Status S M W D

Your Phone Numbers (H) _____(W) _____Spouse or Support Person_____Phone_____

Where were you born? _____Education_____

Family Physician_____ Who were you referred by? _____

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Medications and Dose

(Include over-the-counter, prescription drugs, and herbal remedies

_____
_____
_____
_____

Menstrual History

Age of onset_____
Frequency_____
Duration of flow in days_____
Pain with menstrual flow(0 1 2 3 4 5)
Do you lose work due to menses? Y/N
Do you take medication for menses? Y/N

Birth Control

(circle type used)

Birth control pills/patch/ring/depo provera
Barrier: condom/ foam gel / diaphragm
tubal / male vasectomy / IUD

Allergies to Medication:

_____
_____

Surgeries and/or Biopsies (Including date, type, hospital and surgeon)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Pregnancy History

How many times pregnant? _____
How many children? _____
Miscarriages ? Y / N
Abortions? Y / N
Ectopics? Y / N
C-Section? Y/ N
Complications of pregnancy? Y / N
If yes, please describe:_____
_____
_____
_____
_____

Family and Social History

Living situation_____
Children names and date of birth:
_____
_____
_____
Sexually active Y / N
Have you / Do you smoke? Y / N
Packs per day_____
Do you use tobacco in other forms? Y / N
Describe_____
How much alcohol do you use? units/day ____
Do you drink caffeinated drinks? units/day____
Do you exercise regularly? Y / N

****

Do you now have or did you ever have:

Abnormal Pap Test	Yes	No	Asthma	Yes	No	Bladder infection	Yes	No
Bleeding disorder	Yes	No	Bloody or tarry stools	Yes	No	Bone or joint problems	Yes	No
Breathing problems	Yes	No	Bloody urine	Yes	No	Blood transfusion	Yes	No
Change in bowel habits	Yes	No	Chest pain/heart trouble	Yes	No	Cancer any site	Yes	No
Colitis	Yes	No	Depression/related illness	Yes	No	Diabetes	Yes	No
DES exposure	Yes	No	Elevated cholesterol	Yes	No	Excessive loss of urine	Yes	No
"Female" cancer	Yes	No	Hepatitis/Jaundice	Yes	No	High blood pressure	Yes	No
Infertility	Yes	No	Kidney disorder	Yes	No	Migraine headaches	Yes	No
Miscarriage/abortion	Yes	No	Mental illness	Yes	No	Pelvic Infection(nonvaginal)	Yes	No
Sexual assault/familyviolence	Yes	No	Shortness of breath	Yes	No	Thyroid problems	Yes	No
Weight control problems	Yes	No	Water retention/edema	Yes	No			

Family History: parents/grandparents/siblings

Birth defects	Yes	No	Breast cancer	Yes	No	Colon Cancer	Yes	No
Diabetes	Yes	No	Heart attack	Yes	No	Heart disease	Yes	No
High blood pressure	Yes	No	Osteoporosis	Yes	No	Ovarian cancer	Yes	No
Stroke	Yes	No						

Health Screening History

Last colonoscopy/sigmoidoscopy normal?	Yes	No	Date_____	Last bone density normal?	Yes	No	Date_____	
Last breast ultrasound normal?	Yes	No	Date_____	Last blood work normal?	Yes	No	Date_____	
Last pap test normal?	Yes	No	Date_____	Last mammogram normal?	Yes	No	Date_____	

Cancellation and Missed Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call the Asheville Women's Medical Center promptly if you are unable to keep an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment:

To cancel appointments, please call 828-258-9191. If you do not reach the receptionist, you may leave a detailed message on our voicemail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

Late Cancellations:

A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 24-hour advance notice.

No Show Policy:

A "no-show" is someone who misses an appointment without cancelling it in an adequate time frame and manner. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show."

- First missed appointment: $25 fee will be billed to your account
- Second missed appointment: $50 fee will be billed to your account
- Third missed appointment: $50 fee will be billed to your account and you may be discharged from our practice

Please sign and date below indicating that you have read and agree to this policy.

Name_____ Date_____

ASHEVILLE WOMEN'S MEDICAL CENTER

REGISTRATION FORM

(Please Print)

Today's date	Chart#	Social Security #

PATIENT INFORMATION

Patient's Last Name	First	Middle Initial	Address

City:	State	Zip Code	Home #	Work #	Cell #

Date of Birth / /	Employer/School	**Employed** ☐ FT ☐ PT ☐ Self ☐ Military	**Student** ☐FT ☐ PT	**Preferred Language** ☐ Spanish ☐ Russian ☐ Sign Language	☐ English ☐ Other ☐ Decline

Email Address (if applicable)	**Race** ☐ American Indian or Alaska Native ☐ Asian ☐ Other ☐ Black or African American ☐ Native Hawaiian ☐ White ☐ Pacific Islander ☐ More than One Race ☐ Decline

Primary Care Physician	**Primary Care Phone #**	**Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

We must have this information in order to file your insurance

Primary Insurance Company Name:

Subscriber's Name	Subscriber's S.S. #	Subsriber's Birth date / /	Group #/ ID #	Policy #	Co-Payment $

Patient's relationship to subscriber	☐Self	☐Spouse	☐Child	☐Other

Subscriber's Employer	Employer Address	Employer Phone #

Secondary Insurance Company Name: (if applicable)

Subscriber's Name	Subscriber's S.S. #	Subsriber's Birth date / /	Group #/ ID #	Policy #	Co-Payment $

Patient's relationship to subscriber	☐Self	☐Spouse	☐Child	☐Other

Subscriber's Employer	Employer Address	Employer Phone #

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to patient	Home phone #	Work phone #

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Asheville Women's Medical Center to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance. **As the responsible party, I agree that all charges not directly paid by my insurance company will be my responsibility.**

Patient/Guardian signature _____ Date _____