

WOMENCARE, INC.

A Healthy Woman is a Powerful Woman

BRENDA M. BARRY, M.D., FACOG

MARIA I. BORS, M.D., FACOG

KATIE A. HARRIS, A.R.N.P.

F. IMOGENE WHITE, M.D., FACOG

930 Lake Baldwin Lane

Orlando, FL 32814

Phone: (407) 898-1500

Fax: (407) 898-3022

Email: Womencare@cfl.rr.com

Web Site: www.DrBrendaBarry.com

We would like to welcome you to our practice and thank you for choosing WomenCare for your gynecological needs. In preparation for your upcoming appointment, please complete the enclosed forms and bring them to your first visit. We request that you not mail them in advance. We would appreciate you arriving 10 minutes before your appointment so that we can process your paperwork at that time.

In addition, please bring the following information with you to your first appointment:

- Insurance card(s)
- Medical records/test results (applicable to your condition)
- Authorization/Referral from your Primary Care Physician (if required)
- List of your medications/dosages and any allergies

If you are unable to keep your scheduled appointment, please call our office at least 24 hours in advance.

We look forward to seeing you soon.

Sincerely,

WomenCare Staff

IT IS VERY IMPORTANT THAT YOU COMPLETE ALL OF THESE FORMS & BRING THEM WITH YOU TO YOUR APPOINTMENT.

Welcome to WomenCare, Inc.

Your Name Last	First	MI
Social Security	Date of Birth	Age
Home Address		
City	State	Zip
Home Phone	Cell Phone	
Work Phone	Employer	
Occupation	If student:	Full time Part time
Email Address		
Marital Status (circle one): Single Married Partner Legally Separated Divorced Widowed		
Spouse Name	Spouse Work Phone	
Primary Care Physician:	Referring Provider:	
Do you have an advance directive? (Living Wills, Durable Power of Attorneys, Health Care Surrogates)		Yes No
Emergency Contact	Phone	Relationship
Race (circle one): Asian Hawaiian Black White Hispanic Pacific Islander Other		
Ethnicity (circle one): Hispanic or Latin Not Hispanic or Latin		
Preferred Language (circle one): English Spanish Other:		
Insurance Information		
Payment is requested at time of service unless prior arrangements have been made		
Insurance Company	Policy/Member ID/Subscriber #	
Group #	Is this policy in your name?	Yes No
If the policy is not in your name please complete the following		
Policy Holder Name	Relationship	
Policy Holder Date of Birth	Policy Holder SSN	
Policy Holder Employer	Policy Holder Phone	
Policy Holder Address	Same as mine	
Pharmacy Information		
Name of Pharmacy		
Pharmacy Address		
Pharmacy Phone	Pharmacy Fax	
Release of Confidential Information to Family and/or Friends		
<p>It is our office policy not to release any information regarding your history to anyone without your permission. This includes spouses & parents regardless of who is responsible for payment. If you want us to discuss your medical case with someone other than yourself please indicate it below:</p> <p style="text-align: center;">I do not wish you to discuss my medical case with anyone besides myself You have my permission to discuss my medical case with the following individual(s):</p>		
<p>I authorize payment of insurance and/or Medicare benefits directly to WomenCare, otherwise payable to me, for their services performed in providing my care. In addition, I authorize the release of any medical information necessary to allow the insurance company and/or Medicare to process any claims filed.</p> <p>I have received WomenCare's Privacy Practices Brochure which states that the practice may leave me phone messages, send me reminder cards and or send me emails related to my care.</p>		
Signed:		Date:

Gynecology Health History

Date: _____

Name: _____ Name Preference/Nickname: _____

Last
First
MI

Date of Birth: _____ Age: _____ Race: _____

Marital Status (Select One): Single Married Widowed Domestic Partner Other

Employer: _____ Occupation: _____

Referring Physician: _____ Family Doctor: _____

I am a Established Patient New Patient

Reason For Today's Visit

<input type="checkbox"/> Annual Exam	<input type="checkbox"/> ER Follow-Up	<input type="checkbox"/> Pessary Fitting/Cleaning
<input type="checkbox"/> Abnormal Pap	<input type="checkbox"/> Fibroid, Uterine	<input type="checkbox"/> Rash/Sore
<input type="checkbox"/> Bleeding, Abnormally	<input type="checkbox"/> Hormone Consult	<input type="checkbox"/> Second Opinion
<input type="checkbox"/> Birth Control	<input type="checkbox"/> Irregular Period	<input type="checkbox"/> Sexually Transmitted
<input type="checkbox"/> Breast Problem	<input type="checkbox"/> Ovarian Cyst Follow-Up	<input type="checkbox"/> Disease Screening
<input type="checkbox"/> Discharge, Vaginal	<input type="checkbox"/> Pelvic Pain	<input type="checkbox"/> Urinary Problems
<input type="checkbox"/> Emergency Contraception	<input type="checkbox"/> Pelvic Pressure/Prolapse	<input type="checkbox"/> Vaginal/Vulvar Mass
<input type="checkbox"/> Other (explain): _____		

List All Known Medical Allergies: None Known

Current Medications (include over the counter, birth control) None

Medical History (If you did this portion on the web portal skip it here)

Have you or anyone in your family had any of the following? Please specify who in the family and indicate if paternal or maternal.

You	Family	Condition:	Comments:	You	Family	Condition:	
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV	_____	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	_____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	_____	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder, Stomach,	_____
<input type="checkbox"/>	<input type="checkbox"/>	Anemia/Blood Disorder	_____	<input type="checkbox"/>	<input type="checkbox"/>	Bowel Problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/Depression	_____	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	_____
<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune Disorders	_____	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	_____
<input type="checkbox"/>	<input type="checkbox"/>	Birth Defect	_____	<input type="checkbox"/>	<input type="checkbox"/>	Hereditary Disorder	_____
<input type="checkbox"/>	<input type="checkbox"/>	Blood Clot, Leg/Lung	_____	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	_____
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	_____	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Breast	_____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease/Stones	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Cervical	_____	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease/Hepatitis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Colon	_____	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Ovarian	_____	<input type="checkbox"/>	<input type="checkbox"/>	Psychological Disorder	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Skin	_____	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Uterine	_____	<input type="checkbox"/>	<input type="checkbox"/>	Suicide	_____
<input type="checkbox"/>	<input type="checkbox"/>	Connective Tissue Disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins/Phlebitis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorders	_____				

Provider Comments: _____

Name: _____
Last First MI

Date: _____

Surgical History (If you did this portion on the web portal skip it here)

- | | |
|---|---|
| <input type="checkbox"/> No Previous Surgery | <input type="checkbox"/> Gallbladder Removed |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Laparoscopy |
| <input type="checkbox"/> Bladder Procedure | <u>Hysterectomy:</u> |
| <u>Breast:</u> | <input type="checkbox"/> Ovaries Removed <input type="checkbox"/> Ovaries Remaining |
| <input type="checkbox"/> Augmentation <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Cervix Removed <input type="checkbox"/> Cervix Remaining |
| <input type="checkbox"/> Biopsy <input type="checkbox"/> Reduction | <input type="checkbox"/> Myomectomy (removal of fibroids) |
| <input type="checkbox"/> Lumpectomy | <u>Removal of:</u> |
| <input type="checkbox"/> Caeserean-Section | <input type="checkbox"/> Left Ovary <input type="checkbox"/> Right Ovary |
| <input type="checkbox"/> Cancer Surgery (other than breast or gyn) | <input type="checkbox"/> Both Ovaries <input type="checkbox"/> Ovarian Cyst |
| Type: _____ | <u>Repair of:</u> |
| <input type="checkbox"/> D&C | <input type="checkbox"/> Cystocele <input type="checkbox"/> Rectocele |
| <input type="checkbox"/> Endometrial Ablation | <input type="checkbox"/> Pelvic Prolapse |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Other: _____ | |

Provider Comments: _____

Gynecologic History

Age Your Period Started: _____ First Day of Last Period: _____
Number of Days Between Periods: _____ Days of Flow: _____
Pregnancies: _____ # Abortions: _____ # Miscarriages: _____ # Premature Births: _____
Living Children: _____ # Ectopic Pregnancies: _____ # Vaginal Deliveries: _____ # C-Sections: _____

Have you ever been sexually active? Yes No
Are you sexually active now? Yes No
Are you sexually active with? Men Women Both

Do you currently use contraception? <input type="checkbox"/> Yes <input type="checkbox"/> No	In the past, what kind of contraception have you used?
If yes, what kind?	<input type="checkbox"/> None <input type="checkbox"/> Condoms
<input type="checkbox"/> Pills <input type="checkbox"/> Condoms	<input type="checkbox"/> Pills <input type="checkbox"/> Diaphragm
<input type="checkbox"/> Nuva-Ring <input type="checkbox"/> Diaphragm	<input type="checkbox"/> Nuva-Ring <input type="checkbox"/> Depo-Provera
<input type="checkbox"/> Spermicide <input type="checkbox"/> Depo-Provera	<input type="checkbox"/> Spermicide <input type="checkbox"/> Male Sterilization
<input type="checkbox"/> IUD <input type="checkbox"/> Male Sterilization	<input type="checkbox"/> IUD <input type="checkbox"/> Female Sterilization
<input type="checkbox"/> Patch <input type="checkbox"/> Female Sterilization	<input type="checkbox"/> Patch

Have you received the Gardasil vaccination? Yes No

Any Past History of:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Abnormal Pap | <input type="checkbox"/> DES Exposure | <input type="checkbox"/> Infertility | <input type="checkbox"/> Post-Menopausal Bleeding |
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Domestic Abuse | <input type="checkbox"/> LEEP Procedure | <input type="checkbox"/> Recurrent Yeast |
| <input type="checkbox"/> Bacterial Vaginosis | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Ovarian Cyst | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> Breast Lump, Benign | <input type="checkbox"/> Fibrocystic Breasts | <input type="checkbox"/> Molluscum Contagiosum | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Cervical Dysplasia | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Pelvic Prolapse | <input type="checkbox"/> Uterine Fibroids |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Pelvic Inflammatory Disease (PID) | |
| <input type="checkbox"/> Cone Biopsy | <input type="checkbox"/> High Risk HPV | <input type="checkbox"/> Polycystic Ovaries (PCOS) | |
| <input type="checkbox"/> Cryosurgery | <input type="checkbox"/> Hormone Replacement | | |

Provider Comments: _____

Name: _____
Last First MI

Date: _____

Social History (If you did this portion on the web portal skip it here)

Do you exercise regularly? Yes No

If yes, what type of exercise?

Hours per week? _____

Do you drink alcohol? Yes No

If yes, how often do you drink? _____

How many drinks do you consume? _____

Do you smoke? Yes No

If yes, how much? _____

How long have you been smoking? _____

If you no longer smoke, when did you quit? _____

Do you drink more than 2 caffeinated beverages a day? Yes No If yes, how many? _____

Do you use any street drugs? Yes No If yes, what kind? _____ How often? _____

Tell Us When You Last Had These Tests:

Last Pap:	Date (Month & Year) _____	The Results Were:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Last Mammogram:	Date (Month & Year) _____	The Results Were:	<input type="checkbox"/> Normal	<input type="checkbox"/> Follow-up Needed
Last Bone Density:	Date (Month & Year) _____	The Results Were:	<input type="checkbox"/> Normal	<input type="checkbox"/> Osteopenia <input type="checkbox"/> Osteoporosis
Last Colonoscopy:	Date (Month & Year) _____	The Results Were:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Last Bloodwork:	Date (Month & Year) _____	The Test was for:	<input type="checkbox"/> Screening	<input type="checkbox"/> Problem Oriented

Additional Comments or Questions Regarding Today's Visit:

Patient Signature:

***** PLEASE REMEMBER TO PRINT YOUR NAME AT THE TOP OF EACH PAGE *****

Do NOT Write Below Here. This section is for Provider comments.

MD/ARNP Signature:

See Dictation

WOMENCARE

A Healthy Woman is a Powerful Woman

Name: _____

Date: _____

URINARY QUESTIONNAIRE

	Yes	No
1. Do you leak urine when you cough, sneeze, laugh, or exercise?		
2. Do you ever have such a strong need to urinate that if you do not reach the toilet quickly you will leak?		
3. Do you wear a pad because you are leaking urine?		
4. Do you have pain or discomfort when you urinate?		
5. Do you now or have you ever had blood in your urine?		
6. Do you find it hard to start urinating?		
7. Does it take you a long time to empty your bladder?		
8. After urinating, do you have dribbling or feel that your bladder is still full?		
9. How many times during the day do you urinate? _____		
10. How many times do you urinate after going to bed? _____		
11. How often do you leak urine? _____		

OSTEOPOROSIS SCREENING QUESTIONNAIRE

NAME: _____ **AGE:** _____ **DATE:** _____

Yes	No	Question
		Do you have a family history of osteoporosis?
		Has one of your parents ever fractured their hip?
		Have you had any bone fractures?
		Are you postmenopausal?
		Have you had an early (before age 40) or surgically induced menopause?
		Have you lost height? If yes, approximately how many inches?
		Do you have a petite or small, thin frame and/or do you weigh less than 127 pounds?
		Are you Caucasian or Asian?
		Have you been taking thyroid medications?
		Have you been taking cortisone or other steroids? If yes, how long?
		Do you have Rheumatoid Arthritis?
		Is your diet low in dairy products or other sources of calcium?
		Do you exercise less than three times a week?
		Do you smoke cigarettes?
		Do you drink more than two (2) caffeinated beverages a day?
		Do you drink three (3) or more units per day of alcohol?
		TOTAL NUMBER OF YES ANSWERS

Results
Empty space for results

When was your last bone density test? Date: _____ or Never _____

Osteoporosis is preventable if bone loss is detected early and steps are taken to help prevent it. The more times you answer “yes” to the questions listed above, the greater your risk of developing Osteoporosis. Osteoporosis is often called a “silent disease” because bone loss occurs without symptoms. A Bone Density test can measure the strength of your bones. The bone density test available here at WomenCare is a simple, painless procedure that screens for the presence of osteoporosis.

Patient Acknowledgement of Practice Policies, Procedures & Privacy Practices

Thank you for choosing WomenCare for your healthcare. We are committed to your care being successful and your experience in our office being pleasant. Information on our key office policies follow.

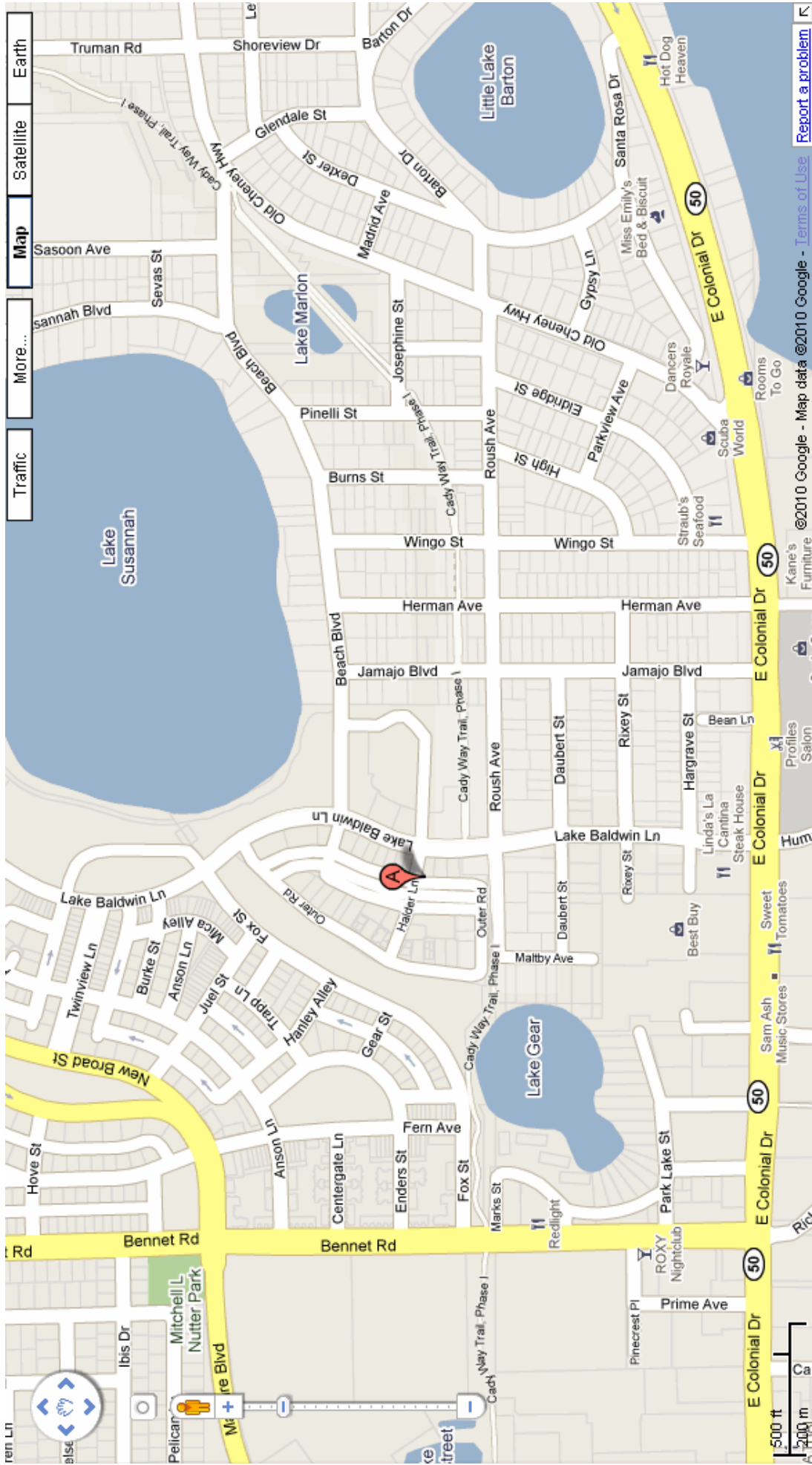
- **Every time you visit our office:**
 - There will be paperwork to review and/or complete.
 - You may be asked to show us your insurance card so please bring it with you.
 - You will be asked to pay your copay or coinsurance for the visit.
- **We value your time and strive to have you in and out of our office within an hour of your scheduled appointment time.**
 - If you are late for your appointment you should expect a delay in being seen and that we may need to reschedule you to an appointment later in the day &/or with another provider other than who you initially were scheduled to see. In some instances, you may be asked to reschedule your appointment to another day.
 - If you are more than 15 min's early for your appointment please plan to wait until your scheduled appointment time to be seen.
- **Annual Well Women/Preventative vs. Sick/Problem Visits:**
 - Problems that you are having may not be able to be addressed at your annual well woman visit.
 - Usually, we prefer to address your problems before we do your annual well woman examination.
 - Insurance benefits are often different for well/preventive vs. sick/problem visits and we must comply with your insurance company contracts.
 - We try to avoid addressing multiple concerns in a single visit because the time your provider is allotted for your visit may not allow them to do so thoroughly. If you have multiple concerns, please understand that your provider may need to ask you to come back to complete your annual exam and/or address your problem(s).
- **Standards of Care**, developed by the American College of OB/GYN and/or required by insurance companies, are adhered to by our providers. This means routine recommended tests will be performed in accordance with their guidelines. Most often these tests are paid for by your insurance but we have found occasionally some of the sexually transmitted disease (STD) tests are not; it depends on your insurance coverage.
- **Test Results** are discussed during office visits. Please understand our providers and staff see patients during office hours and are not available to discuss test results with you over the phone.
- **Medication and Rx refills** are filled during office visits. We do not prescribe or refill Rx's over the phone.
- **Medical Records:** All medical record requests must be submitted in writing. Please allow 7-10 business days for records processing. Charges will apply to records copied for patients but not when sent directly to other physicians.
- **Fee for Lost Prescriptions and Other Forms:** A prepayment of \$15.00 per lost prescription or form is required due to the additional time that must be spent reviewing your chart &/or completing the additional paperwork by our providers and staff. Please allow 1-3 days to replace lost prescriptions & 7-10 business days to complete other forms.
- **Fees for Appointment Cancellation and No-Shows:** We require 24-48 hours advance notice to reschedule or cancel your appointment depending on the type of appointment. The fees are \$35 or \$50.
 - **Regular office visits:** Must be cancelled or rescheduled **24 hours** in advance to avoid a \$35 fee.
 - **Procedures:** Must be cancelled or rescheduled **48 hours** in advance to avoid a \$50 fee.
- **Privacy Practices:**
 - Our Notice of Privacy Practices provides information about how we use and disclose protected health information. You are entitled to a copy of our Notice of Privacy Practices.
 - If you want our office to discuss your care with your family or a friend you need to authorize us to do so in writing.
 - In accordance with the law, your protected health information may be disclosed by us to allow us to effectively treat you, to get paid by your insurance company for your care, and to effectively operate our office.
 - To effectively operate our office we leave appointment and other health care reminders via phone messages, email, & US mail.
- **Communication Preferences:**
 - Please indicate the best way(s) for us to communicate with you. Please check ALL that apply.
Preferred phone: Home phone ___ Cell phone ___ Best time to call: Morning ___ Afternoon ___ Evening ___
Email Messages ___ Text Messages: ___
 - If you have an email address, we can set you up to use our secure web portal. The web portal will give you access to your test results, other health information as well as the ability to communicate with our office using secure messaging.
Set me up to use web portal: Yes ___ No ___

I have read and understand the above policies and procedures.

Print Name

Signature

Date



Traffic

More...

Map

Satellite

Earth

Search

Layers

Street View

Scale

500 ft

200 m

©2010 Google - Map data ©2010 Google

Report a problem

