Gary K. Fowers, MD
Barry A. Noorda, MD
David A. Kirkman, MD
Anne S. Blackett, DO

The comfort of home, the care of professionals

Amy Billings, PAC
Anna Lara, PAC
D'Anne Moon, CNM
Kenneth A. Wade, PAC

Fill out the enclosed forms, registration, medical history and insurance. Please send it back to us as soon as possible. Please bring your insurance card with you to your appointment which is scheduled for:

1. Payment for services is the responsibility of the patient and is expected at the time of service unless other arrangements are made. All co-payments are due at time of service. There may be a $20.00 billing charge in addition to your co-payment if not paid at time of visit.

2. Medicaid patients must have a current card at time of service and co-pay if noted on your card.

3. FOR YEARLY PHYSICALS ONLY - For patients age 35 and older you may require blood work. Please fast for twelve hours before your appointment. Please DO drink a lot of water with this fast as it makes it easier to draw your blood. YOU DO NOT NEED TO FAST FOR SURGERY CONSULTS, OR OTHER TYPES OF APPOINTMENTS. THIS IS FOR YEARLY PHYSICALS ONLY.

Thank you for your time and consideration.

Please feel free to contact our office if you have any questions

1325 North 600 East, Suite 102 · Logan, Utah 84341 · Phone 435-753-9999 · Fax 435-753-2301

PLEASE FILL OUT COMPLETELY

PATIENT INFORMATION

Today's Date _____

Patient Name _____
Last First Middle

Address _____ P.O. Box _____

City _____ State _____ Zip _____ Email _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell ( ) _____

Date of Birth _____ Age _____ Sex: M / F SS# _____

Race _____ Ethnicity _____ Primary Language _____

Employer Name _____ Address _____ Phone _____

Employment Status: Full Time / Part Time Marital Status: Single / Married / Divorced / Other Driver's License# _____

Spouse's Name _____ DOB _____ SS# _____

Spouse's Employer _____ Address _____ Phone _____

INSURANCE INFORMATION

(Primary) Insurance Company _____ Employer _____

Subscriber Name _____ Relationship to Subscriber _____

Policy # _____ Group # _____ Policy start date _____

Policy Holder DOB _____ Policy Holder SS# _____

Secondary Insurance Company _____ Employer _____

Subscriber Name _____ Relationship to Subscriber _____

Policy # _____ Group # _____ Policy start date _____

Policy Holder DOB _____ Policy Holder SS# _____

EMERGENCY INFORMATION

_____
Emergency Contact Name Address Phone # Cell #

_____
Emergency Contact Name Address Phone # Cell #

***Do we have permission to leave appointment information on your answering machine or with family members? Yes / No**
***Do we have permission to leave test results on your answering machine or with family members? Yes / No**

*I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by me or my insurance company at any given time in writing. I also authorize payment to be made directly to the doctor from my insurance company.

Signature _____ Date _____

* We have updated our HIPAA Notice of Privacy Practices. Please visit our website, at cvwomenscenter.com and click on the "forms" tab. Please read the updated notice and initial and date here once it has been read. Initial_____Date_____ If you are unable to read this online, or would like a copy of this notice, please contact our office at 435-753-9999

Office Financial Policy

Cache Valley Women's Center provides their services to you, not your insurance company. Because of this fact you are responsible for payment of any bill incurred in this office. We cannot provide services assuming that the insurance company will come through with payment. Although as a courtesy to you we will bill your primary insurance company within 60 days we will expect you to pay the balance in full. It will then be your responsibility to collect from the insurance company. We will also be happy to send a bill to your secondary insurance as well. You are responsible for all deductibles and charges not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, that is your responsibility. Please contact your insurance company to inquire if we are a provider for your insurance.

All Co-payments and/or percentages that your insurance required you to pay must be made at the time of visit. We accept cash, personal checks, and most major cards.

Often our patients find themselves without any insurance coverage. It is our policy that payment is to be made in full at the time of service unless prior arrangements have been made.

Any account that has been left unpaid after 30 days will be charged an interest rate of 2% monthly (24% annually) or a minimum fee of $3.00. In the event that an account is left unpaid the undersigned agrees to pay costs charged by our collection agency (50% of the unpaid balance) and all limited reasonable attorney's fees.

Thank you for taking the time to read our financial policy. If you have any further questions or concerns, please call the office.

I agree to and understand the above financial policy.

Signature _____ Date _____

Amended

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Cache Valley Women's Center

1325 North 600 East, Suite 102, Logan, Utah 84341 435-753-9999

OB/GYN Intake History

Name: _____ DOB _____ Date _____

Name of spouse or partner _____ Number in household _____

ALLERGIES _____ Referred By _____

REVIEW OF SYMPTOMS:

Please check ☐ if the following are a significant problem for you NOW.

- ☐ Abdominal pain
- ☐ Abnormal periods
- ☐ Anxiety
- ☐ Asthma
- ☐ Bloating
- ☐ Blood in urine
- ☐ Bloody stool
- ☐ Bruising easily or often
- ☐ Chest pain
- ☐ Constipation
- ☐ Coughing blood
- ☐ Crying often
- ☐ Depression
- ☐ Diarrhea
- ☐ Dizziness
- ☐ Dry skin or rashes
- ☐ Ear aches or ringing
- ☐ Enlarged lymph nodes
- ☐ Excessive thirst
- ☐ Fatigue
- ☐ Headaches, type _____
- ☐ Hot flashes
- ☐ Incomplete emptying
- ☐ Incontinence
- ☐ Joint pain or stiffness
- ☐ Nausea
- ☐ Night sweats
- ☐ Pain with urination
- ☐ Painful intercourse
- ☐ Painful periods
- ☐ Palpitations or "heart racing"
- ☐ Premenstrual syndrome
- ☐ Reflux or heartburn
- ☐ Seizures
- ☐ Sexual concerns or questions
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Sleeping problems
- ☐ Sore throat
- ☐ Sore(s) that won't heal
- ☐ Urgency
- ☐ Urinary frequency
- ☐ Vaginal discharge
- ☐ Vaginal dryness
- ☐ Vaginal irritation
- ☐ Vision changes
- ☐ Vomiting
- ☐ Weight gain
- ☐ Weight loss
- ☐ _____

Personal PAST History

- ☐ Anemia
- ☐ Anorexia
- ☐ Anxiety
- ☐ Asthma
- ☐ Blood Clot
- ☐ Blood transfusion
- ☐ Bowel trouble
- ☐ Bulimia
- ☐ Cancer, type _____
- ☐ Celiac disease
- ☐ Depression
- ☐ Fracture (which broken bone) _____
- ☐ Graves Disease
- ☐ Hashimoto's
- ☐ Heart trouble
- ☐ Hepatitis A, B, or C (circle one)
- ☐ Herpes
- ☐ High blood pressure
- ☐ HIV
- ☐ HPV
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Insomnia
- ☐ Jaundice
- ☐ Joint pain
- ☐ Kidney infections
- ☐ Kidney stones
- ☐ Migraines
- ☐ Murmur
- ☐ Osteoarthritis
- ☐ Pneumonia
- ☐ Rheumatoid Arthritis
- ☐ Seizures/epilepsy
- ☐ Staph infection
- ☐ Stroke
- ☐ Type I Diabetes
- ☐ Type II Diabetes
- ☐ Ulcers
- ☐ _____

Name: _____

Medications and dosing: _____

_____

SURGERIES:

Surgery/Reason	Date	Surgery/Reason	Date

OB/GYN HISTORY

Number of pregnancies _____ Number of children _____ Abortion _____

Miscarriage _____ Full term deliveries _____ Birth Control type _____

Last Menstrual Period _____ Menses lasts approximately _____

Are menses regular/irregular? (Circle one)

FAMILY HISTORY Please list maternal or paternal grandparents

ILLNESS	YES	WHO?	AGE DIAGNOSED	Family Member ILLNESS	YES	WHO?
Breast Cancer				Diabetes, Type I		
Colon Cancer				Diabetes, Type II		
Other Cancer				Stroke		
Ovarian Cancer				Blood Clots		
Depression				Heart Disease		
Anxiety				High Blood Pressure		
Drinking Problem				High Cholesterol		
Drug Problem				Thyroid Problems		

SOCIAL HISTORY

	Yes	No	Never	
Tobacco				Packs per day How many years
Tobacco in the last five years				If yes, when did you quit?
Alcohol				Drinks per day Drinks per week
Social Drugs				Name of Drug(s)
Regular Exercise				Hours per day Hours per week
Caffeine				Ounces per day Name of drinks
Sexually Active				

Has anyone ever touched you inappropriately? _____

Do you feel safe at home? _____

PERSONAL PROFILE

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Significant other

School completed: ☐ High School ☐ College ☐ Graduate degree ☐ Other

Current Job (if any) _____ ☐ Full time ☐ Part time

This form completed by: Patient RN/MA MD/PA

Patient Signature _____ **Date** _____