WOMEN LIVING WELL
OBSTETRICS & GYNECOLOGY

Welcome and thank you for choosing Women Living Well!

Before coming to your appointment, the following steps will make your visit more seamless:

- Complete the enclosed registration and medical history forms.
- If you have not already done so, request a copy of your previous medical records. The records can be mailed or faxed (302-239-2001) to our office prior to your appointment. For your convenience, we have included a medical release form.
- Please bring your insurance card.
- Please bring a Photo ID.
- Copays are expected at the time of your visit.

Please arrive 15 minutes prior to your scheduled appointment. This will allow adequate time to complete any additional forms, make a copy of your insurance card, and answer any questions you may have. Please feel free to contact the office with any further questions or concerns.

Thank you for choosing Women Living Well for all your OB/GYN needs. We look forward to working together.

Sincerely,

Kirsten Smith, MD

Jessica Apel, DO

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REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Last name:	First:	Middle:	☐ Ms. ☐ Mrs. ☐ Dr.	Marital status ☐Single ☐Mar ☐Div ☐Sep ☐Widow

Is this your legal name? ☐Yes ☐No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:

Street address:	Social Security:	Home/Cell phone #:

P.O. Box:	City:	State:	Zip Code:

Occupation:	Employer:	Employer phone #:

Referred to WLW by (please check one box): ☐Dr. ☐ Insurance Plan
☐ Family ☐ Friend ☐ Internet ☐ Social Media ☐ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance

Subscriber's name:	Subscriber's S.S.#:	Birth date: / /	Policy #: Group #:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Policy #:	Group #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone #: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone #: ( )

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PHARMACY INFORMATION	
Preferred Local Pharmacy	Name:
	Address:
	Phone:
	Fax:
Mail Order Pharmacy	Name:
	Address:
	Phone:
	Fax:

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home/Cell #:	Work #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Women Living Well or insurance company to release any information required to process my claims.

Printed Name **Patient Signature** **Date**

HIPAA ACKNOWLEDGEMENT

I hereby acknowledge that I have received or had the opportunity to review a copy of Women Living Well Obstetrics & Gynecology (WLW) *Notice of Privacy Practices* and I further authorize WLW to release medical information to my insurance carrier, physician's office, any treating facility, or Power of Attorney. I also acknowledge that past medication history will be obtained from my pharmacy benefit manager in order to assist my providers with my care.

I give my permission to release information regarding appointment dates/times and my protected health information, including but not limited to, insurance, address, phone number, test results, health care information, and treatment to the following:

	Name of Person	Relationship to Patient
1.		
2.		

Printed Name **Patient Signature** **Date**

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FINANCIAL POLICY

Thank you for choosing Women Living Well Obstetrics & Gynecology (WLW), a division of Women First, LLC. We are dedicated to providing our patients with compassionate and comprehensive care and services. We would like you to take a moment to review some of our office policies.

1. We accept cash, check, Visa, or MasterCard. Returned checks are subject to a $30 service charge.
2. All payment are due at the time of service unless previous arrangements have been made.
3. If an account is delinquent and placed with our outside collection agency, you will be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.
4. Medicare usually covers routine exams and pap smears every two years. You are responsible for any deductibles or coinsurance not covered by Medicare
5. We require 24 hour notice of cancellations of your appointment. If proper notice is not given, you may be subject to a $25 missed appointment fee.
6. We require at least 7 days' notice if you need to reschedule or cancel your outpatient or inpatient surgical procedure. If notice is not given, you will subject to a $50 fee.
7. We will be happy to complete FMLA/Disability forms. This is subject to a $20 administrative fee. Please allow 7-10 business days for completion of any forms.
8. Copies of Medical Records will be subject to a fee schedule as defined by Delaware Law. Please allow 7-10 days for completion of your request.
9. Please verify with your insurance company which lab and radiology facilities you may utilize. Each insurance company has different preferred providers.
10. It is the patient's responsibility to check with the insurance company to determine if authorization or referrals are needed. If you need our office to process an authorization or referral for services, we require 48 hours' notice to complete the request.

I have read and fully understand the office and financial policies set forth. I agree to the terms of the above policies. I also understand and agree that the terms of the financial policy may be amended by the practice at any time without prior notification to the patient.

_____ _____ _____

Printed Name **Patient Signature** **Date**

I authorize the release of any information necessary to process claims on my behalf.
I authorize payment of medical benefits to the physician or supplier for services rendered.
I authorize release of pertinent medical information to Christiana Care Health Services, and in the event of an abnormal Pap smear or abnormal Mammogram, to the facility performing the study.

_____ _____ _____

Printed Name **Patient Signature** **Date**

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MEDICAL HISTORY

Today's Date: _____ Name: _____ Date of Birth: _____

MEDICAL HISTORY

Age when your period started?		What is your normal cycle length? (time between periods)	days
How long is your period?	days	Flow rate	Light Medium Heavy
When was your last menstrual period?		Age Menopause Began?	
What do you use for Birth Control?		Are you on Hormone Replacement Therapy?	
Do you have breakthrough bleeding between cycles?			

Do you think of yourself as (circle): Heterosexual Homosexual Bisexual Other:_____

Allergies to medications, environment, or dyes:

_____

Current Medications:

_____

_____

_____

Did you receive Gardasil (HPV vaccination): Yes No

Please circle all that apply to YOUR health (previous or current conditions):

Alcoholism	Arthritis	Asthma	Blood Clot/DVT/PE	Cancer
Chlamydia	Depression	DES Exposure	Diabetes	Drug Addiction
Eating Disorder	Genital Warts	Gonorrhea	Headaches/Migraines	Heart Disease
Hepatitis	Herpes	High Blood Pressure	High Cholesterol	HIV
Kidney Disease	Lupus	Mental Health Disease	Osteoporosis	Seizures
Syphilis	Stroke	Thyroid Disease		

If you circled YES to any of the above, please explain:

_____

_____

_____

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SURGICAL HISTORY

Surgery Name & Date

_____

_____

_____

FAMILY HISTORY

Please note family member & maternal (M) or paternal (P)

Breast Cancer: _____
Diabetes: _____
Heart Disease: _____
Kidney Disease: _____
Osteoporosis: _____
Ovarian Cancer: _____
Colon Cancer: _____
Genetic Disorders: _____
High Blood Pressure: _____
Lung Cancer: _____
Uterine Cancer: _____
Thyroid Disease: _____
Stroke/DVT/Clotting/Bleeding Disorder: _____
Other: _____

SOCIAL HISTORY

Do you smoke: Yes No If yes, amount: _____
Do you drink alcohol: Yes No If yes, amount: _____
Any drug use: Yes No If yes, type, & amount: _____

OB HISTORY

TOTAL # OF PREGNANCIES		TOTAL # OF MISCARRIAGES		TOTAL # OF ABORTIONS	

	DATE	SEX	METHOD OF DELIVERY	EARLY LABOR?	COMPLICATIONS	LOCATION OF DELIVERY
1						
2						
3						
4						
5						

HEALTH MAINTENANCE

TEST/PROCEDURE	DATE	TEST/PROCEDURE	DATE
LAST DEXA		LAST MAMMOGRAM	
LAST COLONOSCOPY		LAST PAP SMEAR	

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RELEASE OF MEDICAL RECORDS

Patient's Name: _____

Date of Birth: _____ Social Security: _____

Other Names (example: maiden name): _____

Previous Healthcare Provider:

Name: _____

Address: _____

_____

_____

Fax Number: _____

I hereby authorize and request you to release my complete medical records to:

Women Living Well
6300 Limestone Road
Suite A & B
Hockessin, DE 19707
302-635-9800 phone
302-239-2001 fax

I understand that the Medical Records to be released may contain information related to HIV status, AIDS, venereal diseases, alcohol or drug use or mental health services. I hereby authorize release of this information.

Patient Signature: _____ Date: _____