Beyond Women's Health Intake form

Visit Date: _____

PATIENT INFORMATION	
Patient Name (Last, First):	Preferred Name:
Age:	

ALLERGIES :

	Reaction:
	Reaction:

CURRENT MEDICATIONS: (*Include prescribed, over-the-counter drugs, supplements):*

Name of medication	Dose	Name of Medication	Dose

MEDICAL PROBLEMS (Circle all that apply):

	High blood pressure Migraines High cholesterol Blood clotting Disorder Heart Disease Stroke		Diabetes Cancer Seizure Disorder Liver Disease Gallbladder Disease		Depression Anxiety Other:

SURGICAL HISTORY (Date/Procedure):

FAMILY HISTORY (Relatives on Maternal or Paternal side):

Breast Cancer: Ovarian Cancer: Pancreatic Cancer:	**Colon Cancer:** **Thyroid Cancer:** **Bleeding/Clotting Disorders:**

SOCIAL HISTORY :

Do you smoke cigarettes? ☐ Yes - How many per day?
Do you drink alcohol? **Number of drinks per week:**
Do you currently use any recreational drugs?
Do you have any history of emotional, physical or sexual abuse?
Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

PREGNANCY SUMMARY:

TOTAL PREGNANCIES ____ FULL TERM ____ MISCARRIAGES ____ ABORTIONS ____ ECTOPIC ____ Living_____	
GYNECOLOGIC HISTORY *(skip questions that do not apply):*	
Age at first period:	Menstrual periods: ☐ Regular ☐ Irregular
First Day of Last Period:	Flow (check one): ☐ Light ☐ Moderate ☐ Heavy
Days between cycles:	Do you have pain with periods? ☐ Yes ☐ No
Do you pass blood clots?	**Postmenopausal Bleeding?**

Last Pap Smear:	
Have you ever had an abnormal Pap Smear?	What year:
Have you ever had a LEEP or Cone Biopsy?	What year:
Have you received the **Gardasil Vaccine** ?	Did you complete the series?
Number of Lifetime Partners:	
Current method of birth control:	
STD HISTORY (Circle all that apply):	
Chlamydia **Gonorrhea**	**Genital Herpes** **Pelvic Inflammatory Disease**
PREVENTIVE CARE:	
Last Mammogram:	**Location:**
Bone Density Scan:	

Beyond
WOMEN'S HEALTH

Antoaneta Mueller M.D. F.A.C.O.G.
Obstetrics & Gynecology

PATIENT INFORMATION FOR MEDICAL RECORDS/ REGISTRATION

_____ D.O.B: ____/____/____
LAST FIRST MIDDLE

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

MARITAL STATUS: S M W D SEP SOCIAL SECURITY# ____-____-____

HOME PHONE: (___) _____ WORK: (___) _____ EMAIL: _____

NOTIFY IN EMERGENCY: _____ (___) _____
NAME RELATIONSHIP ADDRESS PHONE

Ethnicity/ Race: _____

WHO REFERRED YOU TO THIS OFFICE ? _____

PRIMRY CARE FAMILY PHYSICIAN'S NAME: _____

Phone: _____ Fax: _____

Name, phone number and address of your pharmacy: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PLEASE SIGN AND RETURN TO RECEPTIONIST

I, the undersigned, have insurance covered with _____
(Name of Insurance)

and assign directly ANTONETA MUELLER M.D. F.A.C.O.G. all surgical and/or medical benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

DATE: _____ PATIENT SIGNATURE: _____

Antoaneta Mueller M.D. F.A.C.O.G.
Obstetrics & Gynecology

Beyond
WOMEN'S HEALTH

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is *(day)*_____ between *(time)*_____

Signed: _____ Date: ____/____/____

Witness:_____ Date: ____/____/____

Patient Financial Responsibility Form/ Self-Pay Waiver

Thank you for choosing Beyond Women's Health for your medical needs, we are committed to providing you the highest quality healthcare. We ask that you read, make the appropriate selection, and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care. **PLEASE CHECK ONE BELOW:**

☐ Check here if you agree to the **self-pay rate for services rendered, at time of service.**

☐ Check here if you elect to use available medical insurance for visit coverage. Self pay rates **will not** apply after date of service.

- We will bill your insurance for you; however, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of co-pays, co-insurance, deductibles, and **all other procedures or treatment not covered by their insurance plan.**
- Copays are due at the time of service.
- Coinsurance, deductibles, and non-covered items are due after your insurance(s) have responded.
- Patients may incur, and are responsible for payment of additional charges, if applicable.
- Annual exams due not include discussion/evaluation of medical problems and may incur an extra charge

By my signature below, I hereby authorize assignment of financial benefits directly to Beyond Women's Health and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient Name: _____ Date: _____

Patient/ Guardian Signature: _____

BEYOND WOMEN'S HEALTH

ANTOANETA MUELLER M.D. F.A.C.O.G.

3655 LOMITA BLVD. SUITE #321

TORRANCE, CA 90505

Patient Intake form

Dear valued patient.

Please take some time to review the following intake form so we can better address your personal needs.

Your responses to this form will help us provide care and tailored services to meet your health and wellness goals

Name: _____ Date of Birth:_____

Do you experience any of the following symptoms? (Check all that apply)

- ☐ Hot flashes
- ☐ Night sweats
- ☐ Mood swings
- ☐ Sleep disturbances
- ☐ Fatigue
- ☐ Heart palpitations
- ☐ Vaginal dryness
- ☐ Painful intercourse
- ☐ Decreased libido
- ☐ Difficulty concentrating/brain fog
- ☐ Irritability
- ☐ Worsening PMS
- ☐ Irregular periods
- ☐ Heavy periods
- ☐ Painful periods
- ☐ Joint pain/stiffness
- ☐ Muscle aches
- ☐ Changes in skin texture
- ☐ Weight gain
- ☐ Inability to lose weight
- ☐ Other: _____

Have you used Hormone Replacement Therapy (HRT) in the past?

- ☐ Yes
- ☐ No
- ☐ I would be interested in a consultation for HRT.

BEYOND WOMEN'S HEALTH

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Have you considered working closely with a nutritionist to review and manage your current meal plan and help optimize your personal goals?

- ☐ Yes
- ☐ No

Are you interested in optimizing your current supplement regimen?

- ☐ Yes
- ☐ No

Have you experienced any of the following skin concerns? (Check all that apply)

- ☐ Acne/Blemishes
- ☐ Enlarged Pores
- ☐ Fine lines/wrinkles
- ☐ Skin laxity (face/neck/body)
- ☐ Thinning skin
- ☐ Dryness and dullness
- ☐ Sun damage
- ☐ Stretch marks
- ☐ C-section scar healing
- ☐ Hair loss
- ☐ Skin redness/rosacea

How would you rank the following health goals in order of importance to you?

(1 = most important, 5 = least important)

__Improve energy

__Manage menopause and Perimenopause symptoms

__Weight/Nutritional management

__Enhance overall wellness

__Improve skin appearance