
**Nadine Antonelli, MD**
**1500 Medical Center Drive Wilmington, NC 28401**
**Phone: 910.833.7199 Fax: 910.833.7203** info@seashorewomenshealth.com

| | | |
|---|---|---|
| **Add to Cancellation list _____Yes _____No** | | |
| **Patient Information** | | |
| Patient Name: | | |
| DOB: AGE: | SS#: | Primary Phone: |
| Current Address: | | |
| City: | State: | Zip: |
| Email: | Other Phone: | Other Phone: |
| **Employment / School Information** | | |
| Employer/School Name: | | |
| Employer/School Address: | | |
| City: | State: | Zip: |
| **Responsible Party (If Other Than Patient)** | | |
| Name/relationship to patient: | | |
| Address: | | Phone: |
| City: | State: | Zip: |
| Emergency Contact Name: | | |
| Relationship: | Phone: | Phone: |
| **Primary Insurance Information** | | |
| Primary Insurance: | ID#: | Group#: |
| Policy Holder Name: | Relationship to Insured: | Policy Holder DOB: |
| Policy Holder Employer Name: | Employer Phone #: | Policy Holder SS#: |
| **Secondary Insurance Information** | | |
| Secondary Insurance: | ID#:: | Group# |
| Policy Holder Name: | Relationship to Insured: | Policy Holder DOB: |
| Policy Holder Employer Name: | Employer Phone#: | Policy Holder SS#: |
| **Authorization & Consent** | | |
| I HEREBY AUTHORIZE THIS PRACTICE TO RELEASE INFORMATION TO MY INSURANCE COMPANY. I ALSO AUTHORIZE THIS PRACTICE TO RELEASE MY MEDICAL INFORMATION TO ANY HOSPITAL, PHYSICIAN OR PROVIDER FOR REFERRAL PURPOSES. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE PHYSICIAN AND I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE CLAIMS FORMS. I AUTHORIZE A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. | | |
| **Patient / Authorized Signature** | | **Date:** |

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# PATIENT MEDICAL HISTORY FORM

Name_____ Date of Birth____/____/____

Single_____ Married_____ Partnered_____ Separated_____ Divorced_____ Widowed_____

How did you hear about us?_____

**Medical History** Have you ever had any of the following?

| | | | |
|---|---|---|---|
| ☐Anemia | ☐Heart Disease/Attack | ☐High Blood Pressure | ☐Stroke |
| ☐High Cholesterol | ☐Mitral Valve Prolapse | ☐Bleeding Problems | ☐Chicken Pox |
| ☐Liver Disease/Hepatitis | ☐Gall Bladder Disease | ☐Arthritis | ☐Diabetes |
| ☐Kidney Infections | ☐Bladder Infections | ☐Blood Clots in Lungs/Legs | ☐Migraines |
| ☐Genetic Condition | ☐Pelvic Infections | ☐Drug or Alcohol Problem | ☐Cancer |
| ☐Epilepsy/Seizures | ☐Depression/Anxiety | ☐Blood Transfusion | ☐Asthma |
| ☐Sickle Cell Disease | ☐Tuberculosis | ☐Thyroid Problem | ☐Pneumonia |

List all medications you are currently taking, including over-the-counter medications, vitamins and herbal remedies:
_____ _____ _____ _____
_____ _____ _____ _____

List any allergies to medications: _____ No Known Allergies

**Surgical History** Please list all surgeries with dates:
_____
_____

**Obstetrical History**
Please list all pregnancies in order, including miscarriages, premature births, stillbirths, ectopics (tubal), and abortions:

| Year | M/F | Weight | Type of Delivery | Length of Pregnancy | Problems (e.g., preterm labor, diabetes, high blood pressure) | Name/Age |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**Gyn History**
Age of first period _____
Age of last period _____
Cycle length: every _____days
Lasting_____ day's
Date of Last Menstrual Period_____

Periods are: ☐Regular ☐Irregular ☐Painful ☐Not really bothersome

Flow is ☐Light ☐Light to moderate ☐Moderate to heavy ☐Very heavy

Are you sexually active? ☐Yes ☐No ☐virginal
☐same sex ☐opposite sex ☐both

Method of Birth Control:

| | | | | |
|---|---|---|---|---|
| ☐condoms | ☐vaginal ring | ☐tubal/Essure | ☐partner with vasectomy | ☐pills |
| ☐patch | ☐IUD | ☐natural family planning | ☐other | ☐none |

Have you ever had any of the following STDs?

| | | | | |
|---|---|---|---|---|
| ☐Chlamydia | ☐Gonorrhea | ☐Herpes | ☐HPV | ☐Hepatitis C |
| ☐Syphilis | ☐Trichomonas | ☐HIV | ☐Hepatitis B | ☐Never had any |

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Have you ever had any of the following?
☐Fibrocystic breasts ☐Ovarian cysts ☐Uterine fibroids ☐Endometriosis

Date of last pap smear_____ normal / abnormal

Have you ever needed any of the following for an abnormal pap?
☐Colposcopy ☐Cryosurgery ☐LEEP/Laser/Conization ☐No

Date of last mammogram _____ ☐Norma l ☐Abnormal ☐Never had one

Date of last bone density _____ ☐Normal ☐Osteopenia ☐Osteoporosis ☐Never had one

Date of last colonoscopy_____ / Never had one

**Family History**
Please list any close relatives with a history of the following:

| | Relative/Age at Diagnosis | | Relative |
|---|---|---|---|
| ☐Breast cancer | | ☐High blood pressure | |
| ☐Ovarian cancer | | ☐Diabetes | |
| ☐Uterine cancer | | ☐Heart Disease (heart attack, stroke, bypass surgery) | |
| ☐Colon cancer | | ☐Thyroid Disease | |

**Social History**

| | | | | | | |
|---|---|---|---|---|---|---|
| Alcohol use | ☐Yes | ☐No | if yes, _____drink(s) per day/week/month | | | |
| Tobacco use | ☐Yes | ☐No | if yes, _____ pack(s) per day for _____ years | | | |
| Street drug use | ☐Yes | ☐No | Type and frequency_____ | | | |
| Exercise | ☐Yes | ☐No | Type and frequency_____ | | | |
| Caffeine | ☐Yes | ☐No | If yes, _____ caffeinated drinks (coffee, tea, soda) per day/week | | | |
| Sexual Abuse | ☐Yes | ☐No | if yes, are you safe now? | Yes / No | Counseling? | Yes / No |
| Physical Abuse | ☐Yes | ☐No | if yes, are you safe now? | Yes / No | Counseling? | Yes / No |
| Emotional Abuse | ☐Yes | ☐No | if yes, are you safe now? | Yes / No | Counseling? | Yes / No |

**Review of Systems** Do you currently have any of the following?

Y/ N Generally healthy
Y/ N Recent weight gain or loss of 25 lbs.
Y/ N Fever
Y/ N Fatigue
Y/ N Vision problems (excluding glasses)
Y/ N Sinus problems
Y/ N Hearing loss / ringing in ears
Y/ N Headache
Y/ N Chest pain
Y/ N Palpitations
Y/ N Shortness of breath
Y/ N Dizziness
Y/ N Swelling
Y/ N Chronic cough
Y/ N Diarrhea
Y/ N Constipation
Y/ N Bloating
Y/ N Nausea
Y/ N Blood in stools
Y/ N Heartburn/reflux

Y/ N Frequent urination
Y/N Burning with urination
Y/N Incontinence
Y/ N Urgency
Y/ N Bladder infection
Y/ N Stomach pains
Y/ N Vaginal discharge
Y/ N Irregular vaginal bleeding
Y/ N Pelvic pain
Y/ N Painful intercourse
Y/ N Breast lumps
Y/ N Back pain
Y/ N Joint/muscle pain
Y/ N Muscle weakness
Y/ N Depression/anxiety
Y/ N Insomnia

_____ None of the above

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## Patient acknowledgement of receipt of HIPPA NOTICE

1) I acknowledge that I have reviewed or have been offered a copy of Seashore Women's Health Privacy Practices, effective 11/1/2014. _____ (Initial)

2) I acknowledge that I have been offered the option to request to receive communications of my personal health information by alternative means or at alternative locations, as long as this request is reasonable. _____(Initial)

3) I would like Seashore Women's Health to use the following addresses and telephone numbers for appointment reminders or other office communications. Office communications may include, but are not limited to, billing matters, laboratory results, pathology results and imaging results. _____ (Initial)

   Phone:_____ E-mail_____

   Physical address: _____

4) Please list all persons with whom the patient will allow Seashore Women's Health to discuss or to leave messages regarding billing or medical information, including Patient Representative

   Not applicable/None: _____

   Name: _____

   Phone: _____

   Name: _____

   Phone: _____

**A current NOTICE OF PRIVACY PRACTICES for Seashore Women's Health is also available in the waiting area.**

**Name (print)**_____ **Date:**_____

**Signature of Patient or Patient Representative:** _____

**Relationship to Patient:**_____

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## Payment Policy

Thank you for choosing Seashore Women's Health, PLLC as your provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

**1. Insurance.** We participate in most insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**2. Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

**3. Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurance carrier. You must pay for these services in full at the time of visit.

**4. Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

**5. Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

**6. Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

**7. Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis. **Please be aware that should your account be referred to a collection agency, the percentage charged by the collection agency to our practice will be added to the total amount of your bill.**

**8. Missed appointments.** There is a $25 no-show/late-cancellation fee. All appointments must be canceled 24 hours prior to your appointment (or by 12 PM on Friday for a Monday appointment), to avoid charges for a no-show or late cancellation. After hour messages regarding cancellations maybe left at (910) 833-7199. Insurance will not cover charges for no-show/late-cancellation fees**.**

**9. Copies of Medical Records and Insurance/Disability Forms.** Our office will gladly make copies of medical records for you. The fee for this service is $15.00 per set. If you need our office to complete any disability forms or forms for your insurance company or other parties, we will be glad to do so for a fee of $15.00, payable in advance.

**I have read and understand the payment policy and agree to abide by its guidelines:**

_____ _____

**Signature of patient or responsible party** **Date**

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## Appointment Cancellation / Late Policy

**Please note our cancellation / late policy as outlined below. We ask your cooperation should you need to reschedule your appointment or if you are going to be late for your scheduled appointment.**

If you need to reschedule your appointment:

1. We require a **24-hour notice** in the event that you need to reschedule your appointment. This will make the appointment time available to someone else. Our scheduling number is 910-833-7199.
2. If the office is closed, please leave a message on our answering machine and we will call you to reschedule your appointment.
3. If you miss an appointment without contacting our office, a fee of $25 will be charged to you for a missed appointment.
4. If you accumulate a total of three (3) missed appointments, you may not be rescheduled for future appointments and you may be discharged from the practice.

If you are going to be late for your appointment:

1. If you are less than 15 minutes late for your scheduled appointment, you will be seen as soon as possible. Your office visit may need to be shortened in length or you may have to wait a bit longer to be seen.
2. If you are more than 15 minutes late to your scheduled appointment, your appointment may need to be rescheduled.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have.

Thank you,

Seashore Women's Health, PLLC

**I acknowledge that I have read and understand the policy outlined above and, that I will be subject to the policy as outlined above.**

**Patient Signature:**_____ **Date:**_____