Seashore
WOMEN'S HEALTH
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#:	Email:
Current Address:		
City:	State:	Zip:
Cell Phone:	Home 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:**

Seashore
WOMEN'S HEALTH
Nadine Antonelli, MD
1500 Medical Center Drive Wilmington, NC 28401
Phone: 910.833.7199 Fax: 910.833.7203 info@seashorewomenshealth.com

PATIENT MEDICAL HISTORY FORM

Name_____ Date of Birth____/____/____

Single_____ Married_____ Partnered_____ Separated_____ Divorced_____ Widowed_____

How did you hear about us?_____

Name of your Primary Care Physician_____

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 and the dosage you are currently taking, including over-the-counter medications, vitamins and herbal remedies (please list on additional paper if necessary):

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

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)	Child's Name/Age

Seashore
WOMEN'S HEALTH
Nadine Antonelli, MD
1500 Medical Center Drive Wilmington, NC 28401
Phone: 910.833.7199 Fax: 910.833.7203 info@seashorewomenshealth.com

Gyn History:

Age of first period _____ Periods are: □Regular Flow is □Light
Age of last period _____ □Irregular □Light to moderate
Cycle length: every _____days □Painful □Moderate to heavy
Lasting_____ day's □Not bothersome □Very heavy

Date of Last Menstrual Period_____

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 □Nexplanon □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

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

Date of GARDASIL vaccination_____ □Never received

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	
□Colon Cancer		□Thyroid Disease	
□Pancreatic Cancer		□Blood Clots	
□Melanoma		□Genetic Mutations	

Seashore
WOMEN'S HEALTH
Nadine Antonelli, MD
1500 Medical Center Drive Wilmington, NC 28401
Phone: 910.833.7199 Fax: 910.833.7203 info@seashorewomenshealth.com

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	Unintentional weight loss	Y/ N	Frequent urination
Y/ N	Abnormal weight gain.	Y/N	Burning with urination
Y/ N	Unexplained fever	Y/N	Incontinence
Y/ N	Unusual fatigue	Y/ N	Urinary urgency
Y/ N	Vision problems (excluding glasses)	Y/ N	Bladder infection
Y/ N	Sinus problems	Y/ N	Stomach pains / indigestion
Y/ N	Hearing loss / ringing in ears	Y/ N	Abnormal vaginal discharge
Y/ N	Headache	Y/ N	Irregular vaginal bleeding
Y/ N	Chest pain	Y/ N	Pelvic pain
Y/ N	Palpitations	Y/ N	Painful intercourse
Y/ N	Shortness of breath	Y/ N	Breast lumps
Y/ N	Dizziness	Y/ N	Back pain
Y/ N	Swelling in legs	Y/ N	Joint/muscle pain
Y/ N	Chronic cough	Y/ N	Muscle weakness
Y/ N	Diarrhea	Y/ N	Depression
Y/ N	Constipation	Y/ N	Anxiety
Y/ N	Bloating	Y/ N	Insomnia
Y/ N	Nausea / vomiting		
Y/ N	Blood in stools	_____	None of the above
Y/ N	Heartburn/reflux		

Any additional information that you think we should know about:

_____

_____

_____

_____

_____

_____

_____

_____

Seashore
WOMEN'S HEALTH
Nadine Antonelli, MD
1500 Medical Center Drive Wilmington, NC 28401
Phone: 910.833.7199 Fax: 910.833.7203 info@seashorewomenshealth.com

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 consent and state my preference to have Seashore Women's Health communicate with me by mail, telephone, email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing.

   I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party. _____ (Initial)

   Home Phone: _____

   Cell Phone/SMS Messaging: _____

   E-mail: _____

   Mailing 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: _____

   1. Name: _____ **2**. Name: _____

      Phone Number: _____ Phone Number: _____

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: _____

Seashore
WOMEN'S HEALTH
Nadine Antonelli, MD
1500 Medical Center Drive Wilmington, NC 28401
Phone: 910.833.7199 Fax: 910.833.7203 info@seashorewomenshealth.com

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 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 $50 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 $25.00, 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**

Seashore
WOMEN'S HEALTH
Nadine Antonelli, MD
1500 Medical Center Drive Wilmington, NC 28401
Phone: 910.833.7199 Fax: 910.833.7203 info@seashorewomenshealth.com

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 voicemail and we will call you to reschedule your appointment.
3. If you miss an appointment without contacting our office, a fee of $50 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 10 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 10 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:**_____