Dear New Patient:

Thank you for selecting Meridian Women's Health as your medical provider. In order to provide the very best and most efficient care please complete the enclosed forms describing your health status and concerns. This will save you time and help us make your visit much more productive.

Please read all of the information enclosed in this new patient packet. It is essential that you bring all of the following items:

1. Picture Identification (i.e. drivers license)
2. Insurance card and co-pay (if applies)
3. Completed Patient Registration form (enclosed)
4. Completed Health Questionnaire (enclosed)

If you misplace the forms listed above they can be found on our website www.meridianwomenhealth.com. Valuable information, as well as our clinic policies can also be found on this website.

Due to the large volume of patients in our practice we require at least 24-hour notification of a cancellation. This enables us to offer your appointment time to another patient. Our office is available to take cancellation calls from 8:00am to 4:00pm Monday, Tuesday, Wednesday ,Thursday and Friday 8:00am-12:00pm. Please note that calls made to the answering service after hours will be considered less than a 24-hour notification.

For our patient's convenience, we collect all lab specimens in our office and they are sent to Northwest Hospital for processing and Cellnetix for pathology. If you have any questions regarding this policy please let the office know prior to your appointment.

Your health is our most important concern. If we have the most complete and accurate information we can provide the finest care and service to you. Thank you for your preparation, we look forward to meeting you in the near future.

Sincerely,

Dawn Frankwick, MD Patricia Rodrigues, MD Carol Salerno, MD Ali Lewis, MD Anita Tiwari, MD

MERIDIAN WOMEN'S HEALTH
10330 Meridian Avenue N. #200
Seattle, WA 98133
(206) 368-6644

PLEASE COMPLETE ALL SECTIONS - IN BLUE OR BLACK INK

PATIENT NAME:			**DATE:**
Last:	**First:**	**MI:**	
NAME YOU LIKE TO BE CALLED:			
MAIDEN NAME:			
Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Separated ☐ Divorced			
Address:	Apt#:	City:	State: Zip:
Home Phone:( )		Cell Phone: ( )	
Social Security #:		Text Message Reminders Yes ☐ No ☐	
Birthdate:	Age:	Primary Care Physician:	
Employer:			
Work Phone:( )			
Responsible Billing Party/Relationship to Patient: ☐ Self ☐ Partner/Spouse ☐ Child ☐ Parent			
(give address and phone if different than above)			
Spouse or Partner's Name/Parent's Name (if patient is a minor):			
Spouse, Partner or Parent's Phone: ( )			
Whom shall we call in an emergency? (Please give name, address, area code and phone number of someone not living with you)			
Relationship to You:			
Reason for visit:			

Primary Medical Insurance Carrier:	Member #:
Subscriber Name & DOB:	Group #:
Medicare Number:	
Secondary or Medicare Supplement Insurance Carrier:	Member #:
Subscriber Name & DOB:	Group #:

I have no insurance. I agree to pay today for services provided to me by Meridian Women's Health.

SIGNATURE: Date:

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for the balance due. I also authorize the doctor or insurance company to release any information required for this claim.

SIGNATURE: Date:

I acknowledge receipt of Northwest Hospital & Medical Center's Notice of Privacy Practices.

SIGNATURE: Date:

How did you hear about Meridian Women's Health?

Referred by Dr. _____ Other: _____

Thank you!
Our office continues to grow due to your referrals. We are pleased to care for your friends and family.

MERIDIAN
WOMEN'S HEALTH

Authorization to Leave Personal Health Information
By Alternate Means

Patient Name: _____ Date of Birth: _____

Patient Mailing Address: _____

_____

(Please check all that apply)

☐ May leave detailed message on voicemail at **home #**: _____

☐ May leave detailed message on voicemail at **work #**: _____

☐ May leave information with **spouse (name) and #**: _____

☐ May leave information with other **family member (name) and #**:_____

☐ May leave detailed message on **cellular phone #**: _____

☐ May leave detailed message at a **different phone #**: _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

_____

Patient or legally authorized individual signature Date

Health Care for Women by Women
10330 Meridian Ave N. Ste 200 Seattle, WA 98133 ***phone 206-368-6644*** *fax 206-368-6645*

MERIDIAN WOMEN'S HEALTH

NEW PATIENT HEALTH QUESTIONNAIRE

Name _____
(please print)

Date _____ Age: _____

Problems to discuss today _____

MEDICAL HISTORY

Circle any past medical problems:

High blood pressure	Diabetes	Heart murmur	Angina	Heart attack
Tuberculosis	Asthma	Pneumonia	Bronchitis	Thyroid disease
Sickle cell trait	Anemia	Glaucoma	Cancer	Osteoporosis
Kidney infections	Depression	Headache	Arthritis	Seizures
Indigestion	Hepatitis	Diverticulosis	Ulcers	

Any other significant medical problems: _____

_____

Previous surgeries (include dates) _____

_____

Current Medications/Vitamins/Over the counter meds or herbs _____

_____

Allergies to medications _____

_____

Date of last cholesterol screening _____ Date of last Colonoscopy _____

History of blood transfusion? _____ Date of HPV Vaccination_____Series complete: Y N

Date of Tdap Vaccination _____

GYNECOLOGICAL HISTORY

of pregnancies _____ # of children _____

First day of last period _____ Period occurs every _____ days Regular? ____ Period lasts _____ days

Age at 1st period _____ Age at menopause _____ Date of last pap smear _____

Method of birth control currently used _____ Date of last mammogram _____

If menopausal, are you on hormone replacement? _____ Hormones used _____

Are you sexually active? _____ New sexual partner? _____

Do you wish to be checked for sexually transmitted diseases? _____ Do you feel safe at home? _____

Circle GYN problems you have had in the past:	Endometriosis	Infertility	Fibroids	Genital warts
	Gonorrhea	Chlamydia	Breast problems	Herpes
	Ovarian cysts	Abnormal Pap	Pelvic Inflammatory Disease	

PATIENT SOCIAL HISTORY

Marital Status: Single ___ Married ___ Separated ___ Divorced ___ Widowed ___ Partner ___

Current Occupation _____

Spouse (name, age, medical problems) _____

Children (names, ages, medical problems) _____

_____

Use of Alcohol: Drinks/week _____ Quit when _____ Have you ever felt the need to cut down? _____

Use of Caffeine, Cups per Day: Coffee _____ Soda _____ Tea _____

Use of Tobacco: Never _____ Previously, but quit _____ Current Packs/Day _____

Use of Drugs: Never _____ Previously, but quit _____ Type / Frequency _____

Exercise: Never _____ Rarely _____ Weekly _____ Daily _____ Type of Exercise _____

FAMILY MEDICAL HISTORY:

Do you know of any blood relative who has or had: (indicate relationship)

Breast Cancer	_____	Bleeding Tendency	_____
Ovarian Cancer	_____	Heart Disease	_____
Colon Cancer	_____	High Blood Pressure	_____
Diabetes	_____	Mental Illness	_____
Osteoporosis	_____	TB	_____

ADDITIONAL QUESTIONS ON BACK OF FORM

HEALTH QUESTIONNAIRE (Continued)

NAME _____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING:

CONSTITUTIONAL SYMPTOMS

Unexplained weight gain or loss	yes	no
Fever or chills	yes	no
Night sweats/Hot flashes	yes	no
Fatigue	yes	no

HEMATOLOGIC/LYMPHATIC

Bleeding or bruising tendency	yes	no
Anemia	yes	no

EYES

Blurred or double vision	yes	no

EARS/NOSE/MOUTH/THROAT

Chronic sinus problem or rhinitis	yes	no
Hay fever	yes	no

CARDIOVASCULAR

Chest pain or angina	yes	no
Irregular heart rate	yes	no
High blood pressure	yes	no

RESPIRATORY

Shortness of breath	yes	no
Asthma or wheezing	yes	no

GASTROINTESTINAL

Loss of appetite	yes	no
Change in bowel movements	yes	no
Nausea or vomiting	yes	no
Frequent diarrhea	yes	no
Painful bowel movements or constipation	yes	no
Rectal bleeding or blood in stool	yes	no
Abdominal pain	yes	no

GENITOURINARY

Frequent urination	yes	no
Painful urination	yes	no
Blood in urine	yes	no
Urination at night (> 1/night)?	yes	no
Urinary incontinence	yes	no
Sexual difficulty	yes	no
Infertility	yes	no
Pain with periods	yes	no
Irregular periods	yes	no

MUSCULOSKELETAL

Joint pain	yes	no
Back pain	yes	no

INTEGUMENTARY (skin, breast)

Rash or itching	yes	no
Breast pain	yes	no
Breast lump	yes	no
Breast discharge	yes	no

NEUROLOGICAL

Frequent or recurring headaches	yes	no
Light headed or dizzy	yes	no
Convulsions or seizures	yes	no
Numbness or tingling sensations	yes	no

OTHER

Nervousness	yes	no
Depression/Anxiety/Panic	yes	no
Insomnia	yes	no
Current emotional or physical abuse	yes	no

Other concerns:

_____

_____

_____

_____

Physician's Initials: _____

Date: _____