CENTER FOR WOMEN'S SEXUAL HEALTH

Dr Stephen C Dalm
Nisha McKenzie PA-C
Erin Walker PA-C
5060 Cascade Rd SE Ste C
Grand Rapids, MI 49546
Phone (616) 591-9100 Fax (616) 247-3679

Welcome to the Center for Women's Sexual Health- The office of Dr. Stephen C Dalm and Physician Assistants Nisha McKenzie and Erin Walker, as well as Physical Therapist Lily Dawson.

Thank you for choosing our office! We look forward to having you as a patient. Enclosed you will find the paperwork that must be filled out and brought along with you to your first appointment. If you take any medications, please list them along with their dosages, or feel free to bring them with you to the appointment. Due to federal regulations, you must be able to provide your current insurance card at every appointment, along with a photo ID. Without these cards we will not be able to see you or you may be responsible for payment at the time of service. If you do not have a picture ID, or if your driver's license does not show your current address, you must also bring along a utility bill showing your current address. If you are under the age of 18, your parent or guardian must provide these items. Please call with any insurance questions. We do not accept any Medicaid or Medicare plans (or if your coverage changes to either if you are a new patient to us).
You will be expected to pay any copays that are required by your insurance at the time of the appointment. It is your responsibility to know and understand your insurance, including deductibles and copays. Please take the time to learn about your coverage prior to your visit, as office visits and labs may apply.

Please contact us at least 24 hours prior to your appointment time if it will not work for you, or a no show fee of $75.00 may apply.

We use Mercy Health St Mary's Hospital and Grand Valley Surgical Center for surgeries. If you have any questions, feel free to call 1-616-591-9100.

Your appointment is scheduled for _____

Please plan for your first appointment to be approximately 1 hour.

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Patient Information

Name: _____ Date of Birth:_____ Age:_____
Address: _____
Home Phone (___) _____ Work Phone (___) _____ Cell Phone (___)_____
May we correspond with you via email? If yes, _____
(When doing so, please place your name in the subject line of each email)
SSN# (required) _____ Spouse/Guardian's name (if applicable)_____
Driver's License #_____
Race: _____ (Circle) Hispanic Non-Hispanic

Circle all that apply:

Married Widowed Separated Partnered
Single Remarried Divorced Polyamorous

Referring Physician: _____

Primary Care Physician:_____

Emergency Contacts:
Name:_____ Relationship: _____ Phone#: _____
Name: _____ Relationship: _____ Phone#: _____
Employment Status (Circle): Employed Unemployed Retired Self-Employed Student
Employer _____ Occupation _____
Address _____
Responsible Party (If patient is a minor):
Name:_____ Date of Birth _____ Relationship_____
Address _____
Primary Phone: _____ Secondary Phone: _____

Authorization:
I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process any insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Signature _____ Date _____

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Who may we thank for referring you to our office? _____

Insurance & Financial Policy

You may receive billing notices from our partnering company, Grand Rapids OB/GYN. You will not be billed from both companies. We make every effort to address and code such things that are typically covered by most commercial insurance plans. However, given the nature of many topics discussed, some insurance companies may deny coverage, and therefore decline payment. These decisions are, unfortunately, out of our control. *If a claim is denied for any reason, you will be required to make the payment within 30 days*. Denied claims will **not** be resubmitted unless it is deemed absolutely necessary. If you are seen for future visits for the same issue, payment will be requested at time of service. We are hopeful that this will change in the near future, and that insurance companies will realize that female sexual health is just as important as male sexual health, and more so, that it is important to a woman's overall health. We appreciate your trust in our care and your help in trying to make important changes in the ever shifting landscape of health care.

In the unfortunate event that your account is turned over to our Collection Agency a 30% fee will be billed to your account.

By signing below, I hereby agree to and understand the financial policy for the Women's Center for Sexual Health.

Signature _____ Date: _____

Insurance Information:

(If you have a secondary insurance, please notify the front desk upon arrival)

Type: _____

Contract #: _____

Name of insured: _____ SSN#_____ DOB _____

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The following consent is required by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) Protected Health Information or PHI is any information that is unique to you. It includes any personal information about you and your health care. I authorize the use and disclosure of my PHI for purposes of treatment, payment, and daily healthcare operations which include but are not limited to: the coordination of healthcare services between providers of such services; services with insurance companies regarding payment, reimbursement, premiums, eligibility, coverage, and utilization review; third party collectors and consumer reporting agencies. I have been offered a copy of the Notice of Privacy Practices. I understand that I may review the office's Notice at any time. I understand the Notice may change and that I may request a revised Notice. I understand that I may request restrictions be placed on disclosure of my PHI, but that The Center for Women's Sexual Health is not obligated to comply with my requests, unless they agree to my restrictions in writing. I understand that I have a right to revoke the consent, in writing, to the extent that The Center for Women's Sexual Health has not yet taken any action in reliance upon the consent.

The Center for Women's Sexual health has always protected your personal information and we will continue to do so. If for any reason you are not willing or able to sign the consent, then we will be unable to enter into a physician/patient relationship with you.

Please list any persons whom you authorize us to discuss or release medical information and /or test results with:

(Authorizations will remain in effect until removed) Date of Authorization

_____

_____

_____

Signature _____ Date _____

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Today's Date ___/___/___

Name_____ Date of Birth ___/___/____

Do you have any medication allergies? Y N

If yes, please list:

_____

_____

Please list any close relatives with a history of the following medical conditions:

	Relative		Relative
○ Breast Cancer		○ Diabetes	
○ Ovarian Cancer		○ Heart Attack (Stroke, Bypass, Ect)	
○ Uterine Cancer		○ Fibromyalgia	
○ Colon Cancer		○ Depression	
○ High Blood Pressure		○ Endometriosis	
○ PCOS (Polycystic Ovarian Syndrome)		○ CPP (Chronic Pelvic Pain)	
○ IC (Interstitial Cystitis)		○ IBS (Irritable Bowel Syndrome)	

Please add any additional details about your selections below:

_____

_____

_____

_____

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Have you ever been diagnosed with any of the following illnesses? Circle all that apply.

Anemia	Blood Clots	Chicken Pox	High Blood Pressure	Stroke	Bleeding Issues
Bladder Infection	Pelvic Infection	Migraines	Depression	Anxiety	Drug/Alcohol Abuse
Diabetes	Thyroid Problem	Genetic Condition	Cancer	Blood Transfusion	Sickle Cell
Fibrocystic Breasts	Endometriosis	Ovarian Cysts	Uterine Fibroids	Abnormal Pap	Osteoporosis

Date Diagnosed: _____

Type (if applicable): _____

Added Details:

_____

_____

_____

OB History - Are you currently pregnant? _____

Year of Birth	M or F	Weight of Baby	Delivery Type	Complications	Age

Gyn History:

Age at 1st period: _____

Are you still menstruating? _____ If no, at what age was your last period? _____

Cycle length _____ # of days your period lasts for _____

Are your periods … (Circle all that apply):

Regular or Irregular Painful/ Bothersome or Not Bothersome

Light Light to Moderate Moderate to Heavy Very Heavy

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Are you currently sexually active? Yes No Have never been sexually active

Are you sexually attracted to: Men Women Both Other: _____

If applicable, what pronouns do you use? She/Her He/Him They/Them Other: _____

Number of Lifetime sexual partners? _____

Are you currently on birth control? _____ What Kind? _____

Have you ever been diagnosed with a Sexually Transmitted Infection? _____
If you answered yes to the above question, please list all infections that you have been diagnosed with in your lifetime:

_____
_____

Date of last pap smear _____ Were results normal or abnormal? _____

Date of last mammogram _____ Were results normal or abnormal?_____

Please list all surgeries & the year they were performed:

_____
_____
_____

Have you ever had any of the following vaccinations? If yes, please list the date of last injection.

- TDap (Tetanus) _____
- Gardasil (HPV) Series _____
- Flu Shot _____

Do you currently smoke cigarettes? _____ How many per day? _____
Are you a former smoker? _____ When did you quit? _____
Do you chew tobacco? _____ Do you use E-Cigarettes? _____

Do you currently drink alcohol? _____ # of drinks per week? _____

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Do you currently use any recreational drugs? Never used Used in the past but not anymore

Check all that apply:

- Marijuana
- Amphetamines
- Heroin
- Barbiturates
- Opiates
- Cocaine
- Others: _____

Do you currently exercise? _____
How often & what type?
_____
_____

Do you have a history of physical, sexual or emotional abuse? _____
If yes, are you safe now? _____
Did you attend counseling for the abuse? _____
Please list all medications you are currently taking, including supplements, vitamins & herbs:
_____
_____
_____
_____

Please add here any additional pertinent information you would like the provider to know regarding your visit with us today:
_____
_____
_____
_____
_____
_____
_____
_____
_____

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Pelvic Pain History (If you have no issues with pelvic pain, you may skip this section.)

Please describe your pain (use a separate sheet of paper if needed):

_____

_____

_____

What do you think is causing your pain?

_____

_____

Is there an event you associate with the onset of your pain? If so, what?

_____

_____

How long have you had this pain? : ___ months ____ years

Please check all instances below that relate to or cause your pelvic pain:

- o **Pain with start of cycle**
- o **Pain at ovulation (mid cycle)**
- o **Pain (not cramps) before period**
- o **Pain in groin when lifting**
- o **Deep pain during intercourse**
- o **Pain lasting hours or days after intercourse**
- o **Pain when bladder is full**
- o **Other muscle or joint pain: _____**
- o **Pain just after period is over**
- o **Burning or vaginal pain after intercourse**
- o **Pain with urination**
- o **Back pain**
- o **Pain when sitting**

Coping: How do you cope with your pain?

_____

_____

Who are the people you talk to concerning your pain, or during stressful times?
(Example: Doctor, friend, church group, spouse, etc.)

_____

_____

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What types of treatments have you tried in the past for your pain? What type of providers have you already seen? Check all that apply.

- o **Acupuncture**
- o **Anti-Seizure Medications**
- o **Antidepressants**
- o **Biofeedback**
- o **Botox injections**
- o **Contraceptive Pills/Ring/Patches**
- o **Danazol (Danocrine)**
- o **Depo-provera**
- o **Herbal Medicine**
- o **Homeopathic Medicine**
- o **Lupron, Synarel, Zoladex**
- o **Massage**
- o **Meditation**
- o **Narcotics**
- o **Nerve Blocks**
- o **Physical Therapy**
- o **Surgery**
- o **Skin Magnets**
- o **TENS unit**
- o **Trigger point injections**
- o **Nutrition/Diet Changes**
- o **Gynecologist**
- o **Family Practitioner**
- o **Neurologist/Neurosurgeon**
- o **Psychiatrist**
- o **Rheumatologist**
- o **Urologist**
- o **Uro-gynecologist**
- o **Other Provider: _____**

What physicians or health care providers have evaluated or treated you for your chronic pelvic pain?

Physician/Provider Name Specialty City/State/ Phone number

_____

_____

_____