



Grand Rapids OB/GYN

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Welcome to Grand Rapids OB/GYN and 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 paperwork that must be filled out and sent back to us prior to making your first appointment- you may mail them, fax them to 616-247-3679, fill them out on-line, or email them to our Assistant Clinical Manager at amberl@grandrapidsobgyn.com.

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 participate with any Medicaid or Medicare plans (including or if your coverage changes to either while you are a patient with us).

You will be expected to pay any copays that are required by your insurance at the time of your 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 lab charges from a separate facility 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 20 – 60 minutes.

Patient Information

Name and gender on legal ID: _____

Date of Birth: _____

Name and gender you use (if different than on legal ID): _____

Age: _____

Address: _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

May we leave a message for you on any of these lines? If yes, which line _____

May we correspond with you via email? If yes, please list your email:

SSN# (required) _____

Spouse/Partner(s)/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 _____

Employer 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 _____

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

Insurance & Financial Policy

You will receive billing notices from 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 the 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 healthcare.

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 Grand Rapids OB/GYN and Center for Women's 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 _____

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 Grand Rapids OB/GYN and the Center for Women's Sexual Health are 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 Grand Rapids OB/GYN and the Center for Women's Sexual Health have not yet taken any action in reliance upon the consent.

Grand Rapids OB/GYN and the Center for Women's Sexual Health have 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 _____

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
<input type="radio"/> Breast Cancer		<input type="radio"/> Diabetes	
<input type="radio"/> Ovarian Cancer		<input type="radio"/> Heart Attack (Stroke, Bypass, Ect)	
<input type="radio"/> Uterine Cancer		<input type="radio"/> Fibromyalgia	
<input type="radio"/> Colon Cancer		<input type="radio"/> Depression	
<input type="radio"/> High Blood Pressure		<input type="radio"/> Endometriosis	
<input type="radio"/> PCOS (Polycystic Ovarian Syndrome)		<input type="radio"/> CPP (Chronic Pelvic Pain)	
<input type="radio"/> IC (Interstitial Cystitis)		<input type="radio"/> IBS (Irritable Bowel Syndrome)	

Please add any additional details about your selections below:

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? _____

Please list all pregnancies in order (please include miscarriages, premature, stillbirth, ectopic/tubal, and abortions)

Year	Any Complications	Weight of Baby	Delivery Type	Age

Gyn History:

Age at 1st period: _____

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

Average number of days from the start of one period to the start of the next period _____

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

Are you currently participating in any sexual activity? Yes No

Have you ever participated in sexual activity/genital touching with a partner? Yes No

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 using 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 STI screen _____ Results? _____

Date of last pap smear _____ Results? _____

Date of last mammogram _____ Results? _____

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? _____

Do you currently use any recreational drugs? Currently using 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 use this space to add any additional pertinent information you would like the provider to know regarding your visit with us today:

Bladder/Bowel Symptoms (Please answer all questions, even if you do not think you have an issue)

Bladder Symptoms

Do you lose urine when you:

Check all that apply:

- Cough/sneeze/laugh
- Lift/Dance/Exercise/Jump
- On the way to the bathroom
- When you have a strong urge to urinate
- Hear running water
- Directly after voiding
- Others: _____

Quantity of leakage (please circle)

Drops, splashes, or more

Couple times a month, weekly or daily

Do you use liners, pads or anything other types of protection?

_____ Brand/Type _____

How many times do you change pad or liner during a 24 hour period? _____

Check all that apply:

- Do you wet the bed?
- Feel unable to empty your bladder completely?
- Have burning/pain with urination?
- Feel like your bladder is falling out of you?
- Difficulty starting a stream of urine?
- Have pain with a full bladder?
- Strain/bare down to empty your bladder?
- Have a very strong/immediate urge to urinate?
- Urinate more than 7x a day?

Bowel Symptoms

Check all that apply:

- Strain to have a bowel movement?
- Have diarrhea often?
- Feel constipated often?
- Have pain with bowel movements?
- Leak gas by accident?
- Leak/Stain feces?
- Have a very strong urge to move your bowels?
- Include fiber in your diet?
- Take laxatives/enema regularly?

How often do you move your bowels? ____ x/day OR ____ x/week

Most common stool consistency: liquid soft firm pellets/hard other _____

Lifestyle

Recreation/Hobbies/Interests:

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:

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

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.

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

(If you *do not* have a history of or a current concern for mental health symptoms, please leave this section *blank*):

1) Have you ever been diagnosed with or treated for any of the following: (please circle all that apply)

- Depression
- Anxiety
- Dysthymia
- Seasonal affective disorder (SAD)
- Obsessive compulsive disorder (OCD)
- Bipolar disorder/ manic depression
- Psychosis
- Schizophrenia
- Post partum or perinatal mood disorder (PMD)
- Post traumatic stress disorder (PTSD)
- Autism spectrum disorder (ASD)

2) Are you currently seeing or have you previously seen a psychiatrist for treatment?

- If so, who? _____

3) Are you currently seeing a therapist or counselor?

- If so, who? _____

4) Have you ever been hospitalized for mental health concerns?

- If so, when and where? _____