PEORIA WOMEN'S HEALTH
OBSTETRICS & GYNECOLOGY

Lindsey A. Ma, MD
5401 N. Knoxville Avenue, Suite 109
Peoria, Illinois 61614
Tamara L. Olt, MD

Date: ____________________

Name: ____ ____________________
First MI Last Maiden

Reason for Visit: ______________________________ Date of Birth: ______________ Age: ________

Primary Care Provider: ____

Personal Medical History (PLEASE CHECK ALL THAT APPLY):

- ☐ Diabetes, Type 1
- ☐ Diabetes, Type 2
- ☐ Gestational Diabetes
- ☐ Heart Disease
- ☐ Stroke
- ☐ Prior Blood Clot in legs or lungs
- ☐ Sickle Cell Disease/Trait
- ☐ Arthritis
- ☐ Blood Transfusion
- ☐ Seizures
- ☐ HIV/AIDS
- ☐ Frequent UTIs
- ☐ Kidney Disease
- ☐ Urinary Incontinence
- ☐ Asthma
- ☐ Lung Disease
- ☐ Skin Disease
- ☐ Chronic Yeast
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Breast Disease
- ☐ Thyroid Disease
- ☐ Intestinal Disease
- ☐ Bowel Disorder
- ☐ Stomach Problem
- ☐ HPV
- ☐ Migraine/Headaches
- ☐ Hepatitis
- ☐ Depression
- ☐ Anxiety
- ☐ Complications with Anesthesia
- ☐ STD: Please specify
- ☐ Herpes
- ☐ Mitral Valve Prolapse
- ☐ Cancer

Additional Illnesses: ____

Surgical History (PLEASE PROVIDE MONTH/YEAR FOR ALL THAT APPLY):

_______ /_______ Appendectomy
_______ /_______ Tonsilectomy
_______ /_______ Gallbladder
_______ /_______ Bladder
_______ /_______ Wisdom Teeth
_______ /_______ Orthopedic Surgery
_______ /_______ Brain Surgery
_______ /_______ Bowel
_______ /_______ Colonoscopy
_______ /_______ Lithotripsy
_______ /_______ Lung

Additional Surgeries: ____

Previous Gyne Surgical History (PLEASE PROVIDE MONTH/YEAR FOR ALL THAT APPLY):

_______ /_______ Colposcopy
_______ /_______ Cryotherapy
_______ /_______ Hysterectomy
_______ /_______ Cone Biopsy
_______ /_______ Removal of one or both ovaries
_______ /_______ Bilateral Tubal Ligation
_______ /_______ Breast Augmentation
_______ /_______ Cesarean Section
_______ /_______ Breast Biopsy (Left/Right)
_______ /_______ Ablation
_______ /_______ LEEP
_______ /_______ D&C
_______ /_______ Essure

Additional Surgeries: ____

Gynecology History (PLEASE COMPLETE ALL QUESTIONS THAT APPLY):

How old were you when you had your first menstrual period? ______________ Menopause? ______________

If you are currently having periods, what was the date of the first day of your last period? ______________

Do your periods occur regularly? ______________ How long do they typically last? ______________

How do you consider your menstrual flow? Heavy Moderate Light Cycle Length

How do you consider your menstrual pain? Severe Moderate Light

Are you currently sexually active? ______________

If yes, are you sexually active with Men, Women, or Both? ______________

If so, how many partners have you had in the past 12 months? ______________

Do you experience any pain or bleeding with intercourse? ______________

What is your current method(s) of contraception? ______________

Past method(s) of contraception? Any problems? ______________

Obstetric History (PLEASE COMPLETE ALL QUESTIONS THAT APPLY):

Total Pregnancies: ______________ Full Term Deliveries: ______________ Preterm Deliveries: ______________ Elective Abortions: ______________

Miscarriages: ______________ Ectopic Pregnancy: ______________ Multiple Births: ______________ Living Children: ______________

Delivery Date	Weeks Pregnant	Length of Labor	Birth Wt.	Sex	Type of Delivery	Name of Child	Complications

Family Medical History (PLEASE LIST MOTHER / FATHER / SISTER / BROTHER / MATERNAL OR FRATERNAL GRANDPARENTS):

______________ Ovarian Cancer ______________ Heart Disease ______________ Diabetes

______________ Uterine Cancer ______________ Stroke ______________ Osteoporosis/Fracture

______________ Breast Cancer ______________ Hypertension ______________ Blood Clotting Disorders

______________ Colon Cancer

Additional Diseases or Cancer Types: ______________

Social History:

Do you smoke?	Yes	No	# of cigarettes per day:	
Do you drink alcohol?	Yes	No	# of drinks:	Frequency:
Do you use recreational drugs?	Yes	No	Type:	Frequency:
Are you employed?	Yes	No	If yes, where?	
What is your marital status:				
Who do you live with:				
Do you exercise regularly?	Yes	No	Type of exercise:	Frequency:
Do you consume caffeine regularly?	Yes	No	# of drinks per day;	Coffee/Tea/Soda/Other:
Do you wear seat belts regularly?	Yes	No		

Routine Health Screening History (PLEASE PROVIDE MONTH/YEAR FOR ALL THAT APPLY):

Month / Year	Test			
_______ /_______	Lipids Testing	Normal	Abnormal	________________
_______ /_______	Thyroid Testing	Normal	Abnormal	________________
_______ /_______	Other Blood Work	Normal	Abnormal	________________
_______ /_______	Most Recent Pap Smear	Normal	Abnormal	LSIL HSIL ASCUS ASCUS-H AGUS Unknown
_______ /_______	Previous Abnormal Pap Smear		Abnormal	LSIL HSIL ASCUS ASCUS-H AGUS Unknown
_______ /_______	Gonorrhea / Chlamydia	Negative	Positive	________________
_______ /_______	RPR (Syphilis) Testing	Negative	Positive	________________
_______ /_______	HSV (Herpes) Culture	Negative	Positive	________________
_______ /_______	HSV (Herpes) Blood Testing	Negative	Positive	________________
_______ /_______	HIV Testing	Negative	Positive	________________
_______ /_______	Mammogram	Normal	Abnormal	________________
_______ /_______	Bone Density	Normal	Abnormal	________________
_______ /_______	Colonoscopy	Normal	Abnormal	________________

Additional Health Screening: ____

Immunization History (PLEASE PROVIDE ALL THAT APPLY):

_______ /_______ Flu Vaccine　　_______ /_______ HPV Vaccine

_______ /_______ Pneumonia Vaccine　　_______ /_______ Zoster Vaccine

Additional Immunizations: ____

Please list all medications and dosages that you are currently taking (prescription, supplements, and over-the-counter):

____

____

Please list all medical allergies and symptoms (medicine, latex, etc.):

____

____

Please list all other allergies and symptoms (environmental, food, etc.):

____

PEORIA WOMEN'S HEALTH

PATIENT INFORMATION

Patient Name ____
Last First MI Maiden Name

Address ____
Street City State Zip

Home Phone (_____)____________________ Cell (_____) ____________________

Date of Birth ________ /________/________ SS# ________ /________/________

Place of Employment ______________________________ Work # (_____)______________

REFERRING/FAMILY PHYSICIAN

Name ____ Phone # ______________

SPOUSE/PARENT INFORMATION

Name ______________________________ DOB _____ /_____ /_____ SS# _____ /_____ /_____

EMERGENCY CONTACT

Name ______________________ Relationship ______________ Phone # (_____)______________

INSURANCE INFORMATION

PRIMARY

Ins. Co. ______________________ Group # ______________ Policy # ______________

Insured: ❑ Self ❑ Spouse ❑ Other ______________ (List relationship)

Insured Name: ______________________ DOB _____ /_____ /_____

SECONDARY

Ins. Co. ______________________ Group # ______________ Policy # ______________

Insured: ❑ Self ❑ Spouse ❑ Other ______________ (List relationship)

Insured Name: ______________________ DOB _____ /_____ /_____

I authorize payment of benefits, as determined by the company directly to Peoria Women's Health. I understand that I may still be responsible for any amounts not paid by my insurance company in the event that the charges made are applied to my deductible, copay or are not reasonable or customary.

Signature ☒ ______________________________________ Date: ______________

I authorize any insurance company, organization, employer, hospital, physician or pharmacist to release any information requested with regard to processing my claim. I certify that information I furnish is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Signature ☒ ______________________________________ Date: ______________

Peoria Women's Health

Patient Privacy and Confidentiality Statement

In order to ensure patient privacy and confidentiality, our office will not release information to friends or family members without written consent. Please list any family members or other persons, if any, who we may inform about your general medical condition, diagnosis and appointments.

NAME	RELATIONSHIP	PHONE NUMBER

Please print the phone number, if any, where you would like to receive calls/texts about your appointments, pap smear results, biopsy results, lab results or other health care information.

____

Can appointment reminders or messages asking you to call our office be left on your voicemail? YES NO

Can we contact you at your place of employment to inform you of test results, appointments or other health care information? YES NO

Please list an address where you would like correspondence from our office to be sent if other that your home address.

____

Patient Name: ________________________ Date of Birth: __________

Patient Signature: ________________________ Date: __________

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OBSTETRICS & GYNECOLOGY

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Tamara L. Olt, MD

Telephone (309) 692-2805 • Fax (309) 692-1913

RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

I, ______________________________, hereby acknowledge receipt of the Notice of Privacy Practices. The notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her Privacy Practices that are described in the Notice. I also understand that a copy of a Revised Notice will be provided to me or made available.

Signed:____ Date ________________

If you are not the patient, please specify your relationship to the patient__________________

Place in Patient's File

Peoria Women's Health
Obstetrics & Gynecology
5401 N. Knoxville Ave. Suite 109
Peoria, IL 61614
(309) 692-2805

FINANCIAL POLICY

We know that choosing a physician is a very important decision and we thank you for choosing our office. Please take a minute to carefully read this overview of some of our financial policies.

INFORMATION REGARDING INSURANCE COVERAGE

You must be informed of and understand the details of your health insurance coverage and fulfill any associated requirements (pre-certification, obtaining referrals, providing information regarding pre-existing conditions, etc). It is also your responsibility to provide our office with all required information regarding your health insurance coverage. It is important that you promptly notify us if there are nay changes to your insurance information. If any complications arise during the billing process, you have an obligation to promptly provide assistance and information to our billing staff and if you fail to timely provide any information or assistance then we have the right to not submit the claim to your insurance company and you will be fully responsible for the balance.

UNINSURED PATIENTS

If you do not have current health insurance coverage, the entire payment for any services performed shall be paid at the time of service.

NON-PARTICIPATING PROVIDER OR NON-COVERED BENEFITS

If we do not participate with your health insurance carrier, or if the services provided are not covered under your particular health plan, then you are responsible for paying for all services at the time of service. If you would like us to do so, we can (upon your request and full payment) provide a statement for your records and/or reimbursement purposes.

PARTICIPATING PROVEDER AND COVERED BENEFITS

If we participate with your health insurance carrier and the services sought are covered services we will directly bill your health insurance carrier. Under your plan, you may be responsible for paying certain amounts (co-payments, deductibles, and fees for non covered services), which are due at the time of service.

TYPES OF PAYMENT

OUR OFFICE ACCEPTS CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AND AMERICAN EXPRESS. If your check is dishonored you will be required to pay an additional fee of $35.00, which shall be due and owing immediately.

COLLECTION OF OUTSTANDING BALANCES

All outstanding balances shall be due within 30 days. All past due balances are due in their entirety prior to or at the time of your visit. Balances that are 30+ days old will be assessed a finance charge that will accrue monthly until paid. Balances that remain outstanding for a period of 90 days or more may be referred to a collection agency or attorney's office. If your account is referred to a collection agency, you will be responsible for paying a collection charge equal to 40% of your outstanding balance, which is in addition to your outstanding balance. If your account is referred to an outside attorney, you will be responsible for paying all reasonable attorneys' fees and court costs, which are in addition to your outstanding balance. To avoid all of this please pay your bill in a timely manner it is as simple as that.

MISSED APPOINTMENTS

It is important that you appear for all scheduled appointments. As a courtesy, we usually call to confirm your appointment a day or two before the scheduled appointment. If speaking to you is not possible for any reason, we will attempt to leave a reminder message with a family member or on a voicemail. Failure to cancel your appointment within 24 hours deprives other patients of an opportunity to visit our office. A fee of $25 may be charged if you fail to appear for scheduled appointments. This policy is aimed at minimizing the waiting time and ensuring availability of prompt medical care. We recognize that there may be circumstances, which may not permit you to gives 24 hour notice and such circumstance are exceptional and shall be considered on a case-by-case basis.

RELEASE OF MEDICAL RECORDS

Medical records created by our office shall only be released pursuant to your express written authorization in accordance with HIPAA or other controlling laws. In accordance with Illinois Law, we can charge:

Annual adjustment of copying fees as required under 735 ILCS 5/8-2006

Fee	**Base**	**2013**
Handling charge	$20.00	$25.99
Copy pages 1 through 25	$0.75	$0.97
Copy pages 26 through 50	$0.50	$0.65
Copy pages in excess of 50	$0.25	$0.32
Copies made from microfiche or microfilm	$1.25	$1.62

Electronic Records (Source: Public Act 95-480)

- Records retrieved from scanning, digital imaging, electronic information or other digital format does not qualify as microfiche or microfilm retrieval for purposes of calculating charges.
- For electronic records, retrieved from a scanning, digital imaging, electronic information or other digital format in a electronic document, a charge of 50% of the per page charge for paper copies listed above. This per page charge includes the cost of each CD Rom, DVD, or other storage media.

Records already maintained in an electronic or digital format shall be provided in an electronic format when so requested. If the records system does not allow for the creation or transmission of an electronic or digital record, then the facility or practitioner shall inform the requester in writing of the reason the records cannot be provided electronically.

MISCELLANEOUS FEES

FMLA Paperwork: The first time completing these for patients will be complimentary, each time there after there will be a $10 fee assessed and must be paid at time of visit or request.
Other services such as family conferences, producing narrative reports, personal letters, etc.) may produce additional fees. Our physicians also perform newborn circumcisions . Most insurance carriers provide benefits for this service and what is not covered by your insurance provider then is your responsibility. In order to process this in a timely matter we will need you to contact us with his

policy information within 30 days of his birth otherwise we will not be able to process it through to the insurance.

By signing below, patient or responsible party acknowledges that he/she has read and understands the Financial Policy of Peoria Women's Health and agrees to be bound by the terms and conditions set forth therein.

____

Signature of Patient Or Responsible Party

____

Print Name of Patient or Responsible Party

____

Date