

Dear Patient,

When you schedule your appointment at Seattle Women's, it is important to specify the type of care you are requesting so that we can allow the appropriate amount of time for your visit and ensure the services you receive are billed accurately to you and your insurance carrier.

Below is an explanation of the different categories of care as defined by insurance carriers. Not all types of care are reimbursed by insurance plans. Please check with your insurance carrier before your visit so that you are aware of your level of benefits.

**Preventive Care (also known as Routine, Annual, Yearly or Well-Woman Exam):** "Preventive" care includes a comprehensive history, a comprehensive examination and ordering of appropriate lab and diagnostic tests. **An appointment for "preventive" care does not include treatment for acute, recent or chronic problems.** Some examples of care not included in a preventive exam are: vaginal infections, abdominal pain, menstrual problems and perimenopausal or menopausal issues. In order to provide you with the best care possible, a separate appointment is required for treatment of acute, recent or chronic illness, such as, but not limited to the problems above.

We believe having your annual "preventive" care exam is important, however insurance coverage for this service varies considerably. Some plans cover "preventive" services at 100%, some cover only a certain amount per plan year and some do not provide any coverage. In that case, the patient is responsible for the entire balance including any laboratory charges. Please confirm your plan benefits for "preventive" care prior to your appointment. If you are scheduled for a "preventive" exam, our office will bill your insurance for "preventive" care. Once billed with a "preventive" diagnosis code, the service cannot be rebilled using any other diagnosis.

**Office Visit:** Evaluation and/or treatment of a specific problem or problems. If you have more than one problem, please let the receptionist know so that adequate time is allowed for your visit.

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When calling to schedule your appointment, please let our receptionist know the type of exam you are requesting, as this will affect the amount of time scheduled and how the service is billed. Please return this form to our office prior to your appointment. If you have questions prior to completion of this form, please let us know and one of our staff will be happy to assist you.

**I understand that I have requested a:**

Preventive Care Exam

Office Visit

I understand that it is my responsibility to check with my insurance company, prior to my appointment, regarding coverage of the above service. If the above service is not covered by my insurance, I am responsible for the bill, which may include any lab work done. I also understand that the service code and diagnosis cannot be changed after the original bill has been submitted.

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Patient Signature

Print Name

Date



Robin Kroll, MD, FACOG

Irene M. Piekarski, MD

Susan Vendeland, MN, ARNP

**Health & Gynecology Registration Form**

PATIENT: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_  
Last Name First Name M.I.

ADDRESS \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ MOBILE: \_\_\_\_\_

Please indicate whether it is OK to leave a detailed message on your voice mail at the above number(s): Yes  No

EMAIL ADDRESS (IF WE MAY USE IT TO CONTACT YOU): \_\_\_\_\_

We may occasionally contact you to ask if you would like to participate in a women's health research study in this office. If you would like to opt out of this opportunity, please check here:

REFERRED BY: \_\_\_\_\_ FAMILY DOCTOR: \_\_\_\_\_

**PATIENT INFORMATION**

MARITAL STATUS (CIRCLE ONE): Single Married Partnered Widowed Separated Divorced GENDER: M / F  
SOCIAL SECURITY #: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_  
ARE YOU A FULL TIME STUDENT?: Y / N IF YES: SCHOOL: \_\_\_\_\_

**SPOUSE INFORMATION**

SPOUSE'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_  
SPOUSE'S EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
WORK PHONE: \_\_\_\_\_

**PERSON RESPONSIBLE FOR BILL IF NOT THE PATIENT**

NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_ DAYTIME PHONE #: \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURANCE: \_\_\_\_\_ SECONDARY INS: \_\_\_\_\_  
SUBSCRIBER NAME: \_\_\_\_\_ SUBSCRIBER NAME: \_\_\_\_\_  
SUBSCRIBER DOB: \_\_\_\_\_ SUBSCRIBER DOB: \_\_\_\_\_  
GROUP #: \_\_\_\_\_ GROUP #: \_\_\_\_\_  
MEMBER #: \_\_\_\_\_ MEMBER #: \_\_\_\_\_  
PATIENT RELATION TO SUBSCRIBER: \_\_\_\_\_ PATIENT RELATIONSHIP TO SUBSCRIBER: \_\_\_\_\_  
SUBSCRIBER EMPLOYER: \_\_\_\_\_ SUBSCRIBER EMPLOYER: \_\_\_\_\_

**IN CASE OF EMERGENCY, PERSON TO BE NOTIFIED (NOT AT SAME ADDRESS)**

NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

**ASSIGNMENT AND RELEASE:** I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN. I ALSO AUTHORIZE THE DOCTOR OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED FOR THIS CLAIM. I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



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**MEDICAL HISTORY FORM**

NAME \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
First MI Last

How would you like to be addressed? \_\_\_\_\_ Gender: Female  Male

Marital Status: Single  Partnered  Married  Widowed  Divorced  Separated

Reason for visit \_\_\_\_\_

**Medication (Drug)/Food Allergies**

Medication or Food	Reaction	Date first noted you had this allergy

**Primary Care MD/ARNP**

Name \_\_\_\_\_ Address \_\_\_\_\_ Telephone number \_\_\_\_\_

**Pharmacy**

Name \_\_\_\_\_ Address \_\_\_\_\_ Telephone number \_\_\_\_\_

**Other Health Care Providers** you have seen in the past year or see regularly (include naturopaths, etc.):

Name	Specialty	Address (include city, state, and zip)

**Medications you are taking or have taken in the past 3 months (include those you buy at the drug store):**

Medications and/or Vitamins	Dose (e.g. 10mg)	How often? (e.g. twice a day)	Start Date	Stop Date	Reason taken (e.g. cholesterol)	Who prescribed it for you?	Is it working for you?
							Yes <input type="checkbox"/> No <input type="checkbox"/>
							Yes <input type="checkbox"/> No <input type="checkbox"/>
							Yes <input type="checkbox"/> No <input type="checkbox"/>

**SURGICAL HISTORY (including Cosmetic Surgery)**

Surgery type	Date(s)	Where was it done (Hospital/City)?	Surgeon

**PERSONAL HEALTH HABITS**

Do you use any tobacco products? YES  NO  How much per day? \_\_\_\_\_ Year started \_\_\_\_\_ Year quit \_\_\_\_\_

Do drink alcohol? YES  NO  Average number of drinks per week \_\_\_\_\_

Do you exercise regularly? YES  NO  How many hours per week: Aerobic exercise \_\_\_\_\_ Weight Training \_\_\_\_\_

Dietary Restrictions (e.g. vegan)? \_\_\_\_\_

**SCREENING**

If age 50, Colonoscopy (View of bowels) Date \_\_\_\_\_ Where? \_\_\_\_\_ Was it normal? YES  NO

Any Polyps removed? YES  NO  When is your next colonoscopy due? (year) \_\_\_\_\_

DEXA (Bone Scan) Date \_\_\_\_\_ Where? \_\_\_\_\_

Results: NORMAL  OSTEOPENIA  OSTEOPOROSIS  Next DEXA Scan due (year) \_\_\_\_\_

Lipids (Cholesterol): Date \_\_\_\_\_ Diabetes testing (fasting blood sugar): Date \_\_\_\_\_ Normal? YES  NO

**PERSONAL AND FAMILY MEDICAL HISTORY**

Condition	SELF	SELF		FAMILY	Office Use Only
	When?	Date First Diagnosed	Date Resolved	Family Member	
<b>Dermatological</b>	<b>None <input type="checkbox"/></b>				
Rashes	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Change in a mole	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
<b>Neurological</b>	<b>None <input type="checkbox"/></b>				
Migraines / Headaches	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Depression	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Anxiety	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Psychiatric Care	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Epilepsy/Seizures	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
<b>Cardiovascular</b>	<b>None <input type="checkbox"/></b>				
Blood Clots / Pulmonary Embolism	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Heart Murmur	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Irregular Heart Rate/Palpitations	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Chest Pain	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Shortness of Breath	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
High Blood Pressure	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Elevated Cholesterol	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
<b>Pulmonary</b>	<b>None <input type="checkbox"/></b>				
Asthma / Lung Disease	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Persistent Cough	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
<b>Gastrointestinal</b>	<b>None <input type="checkbox"/></b>				
Ulcers	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Hepatitis / Liver Problems	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Gall Bladder Disease	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/>	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Bowel Problems _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/>	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Blood in Stools	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
<b>Urinary Tract</b>	<b>None <input type="checkbox"/></b>				
Bladder / Kidney Infection	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Kidney Disease _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Leaking Urine	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Painful urination <input type="checkbox"/> Frequency <input type="checkbox"/>	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Blood in Urine	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
<b>Musculoskeletal</b>	<b>None <input type="checkbox"/></b>				
Osteoporosis <input type="checkbox"/> Osteopenia <input type="checkbox"/>	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Osteoarthritis	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Rheumatoid Arthritis	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
<b>Ear, Nose, Throat</b>	<b>None <input type="checkbox"/></b>				
Eye problems	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Nose / Sinus issues	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Seasonal Allergies	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Contact Lens	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
<b>Reproductive</b>	<b>None <input type="checkbox"/></b>				
Vaginal Discharge/Odor	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Vaginal Dryness	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Painful Intercourse	Now <input type="checkbox"/> In the past <input type="checkbox"/>				

Condition	SELF	SELF		FAMILY	Office Use Only
	When?	Date First Diagnosed	Date Resolved	Family Member	
Ovarian Cyst	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Bleeding after Intercourse	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Decreased Sex Drive	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Sexually Transmitted Disease: Genital Warts <input type="checkbox"/> Herpes <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/>	Now <input type="checkbox"/> In the past <input type="checkbox"/> Were you treated? YES <input type="checkbox"/> NO <input type="checkbox"/>				
<b>Cancer:</b> _____	<b>None</b> <input type="checkbox"/>				
Cancer, OTHER: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
<b>Other:</b> _____	<b>None</b> <input type="checkbox"/>				
Diabetes Mellitus	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Anemia/Blood Disorder	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Unusual Fatigue	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Thyroid Disease	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Injuries/Accidents: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Other Problems: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				

### PAP SMEAR AND CERVICAL HISTORY

Date of last PAP Smear \_\_\_\_\_ Where was it done? \_\_\_\_\_

Have you had a hysterectomy? YES  NO  Date of Hysterectomy: \_\_\_\_\_ Reason: \_\_\_\_\_

If so, do you have a cervix? YES  NO

Were your ovaries removed? YES  NO  UNKNOWN  ONE REMOVED: LEFT  RIGHT

Ever had an ABNORMAL PAP? YES  NO  DATE(S): \_\_\_\_\_

Ever had a COLPOSCOPY (examining your cervix with a microscope-like instrument)? YES  NO  DATE(S) \_\_\_\_\_

Ever had any procedure on your cervix? (Like LEEP, Cryosurgery (freezing), Laser, Cone, etc.?) YES  NO  DATE(S) \_\_\_\_\_

### MAMMOGRAM/BREAST HISTORY

Ever had a Mammogram? YES  NO  Date of last Mammogram: \_\_\_\_\_

Where have you had your mammograms? \_\_\_\_\_ Results were: Normal  Abnormal

Ever had an ABNORMAL Mammogram? YES  NO  DATE(S): \_\_\_\_\_

Ever had any procedure done on your breast(s)? YES  NO  Date: \_\_\_\_\_

What procedure? \_\_\_\_\_

Ever had a breast ultrasound or MRI? YES  NO  Where? \_\_\_\_\_

Do you have breast implants? YES  NO  Type: Saline  Silicone  When? \_\_\_\_\_

### IMMUNIZATIONS (Adults without risk factors)

Do you get a flu shot yearly? YES  NO  Date of last tetanus shot \_\_\_\_\_ (recommended every 10 years)

Have you had a Measles/Mumps/Rubella vaccine? YES  NO  Have you had a varicella vaccine (or had chicken pox)? YES  NO

If age 65 or over, have you had a pneumococcal vaccine? YES  NO

Ever been tested for Tb? YES  NO  Was it positive? YES  NO  BCG Vaccine YES  NO

Have you had the series of vaccines for HPV (Human Papilloma Virus)? YES  NO

I've had: All three vaccines  The first one only  Two vaccines

### SEXUALITY

Have you EVER been sexually active? YES  NO  If yes, age at first sexual activity \_\_\_\_\_

Are you currently sexually active? YES  NO  If yes, do you partner with a: MALE  OR FEMALE  OR BOTH

Number of partners since becoming sexually active 1-2  3-5  > 5

Has anyone forced you into having sex? YES  NO  If yes, are you currently in a safe relationship? YES  NO

Would you like more information on sexual issues? YES  NO

### BIRTH CONTROL

Are you currently using ANY form of birth control? YES  NO

If so, what? List all: Condoms  Mirena IUS  ParaGard IUD  Nuvaring  DepoProvera (shots)  Patch  Diaphragm  Pills

Name of pills: \_\_\_\_\_ Vasectomy  Withdrawal of penis before ejaculation  Other : \_\_\_\_\_

Is this method working for you? YES  NO  If not, why not? \_\_\_\_\_

What have you used in the past?

List all: Condoms  Mirena IUS  ParaGard IUD  Nuvaring  DepoProvera (shots)  Patch  Diaphragm

Pills  Name of pills: \_\_\_\_\_ Vasectomy  Withdrawal of penis before ejaculation  Other : \_\_\_\_\_

Why did you stop using this method? \_\_\_\_\_

Would you like information about birth control? YES  NO

### OBSTETRIC

Have you ever been pregnant (including miscarriages and abortions)? YES  NO  How many times total? \_\_\_\_\_

Number of miscarriages: \_\_\_\_\_ Number of abortions \_\_\_\_\_

Number of tubal pregnancies \_\_\_\_\_ Had a molar pregnancy? YES  NO

Number of multiple pregnancies (twins, triplets, etc.) \_\_\_\_\_

Number of vaginal deliveries \_\_\_\_\_ DATE(S) \_\_\_\_\_

Number of C-Section deliveries \_\_\_\_\_ DATE(S) \_\_\_\_\_

Did you deliver any of your babies early (less than 37 weeks gestation)? YES  NO  How many weeks early? \_\_\_\_\_

Complications during any pregnancy or delivery \_\_\_\_\_

Are you planning a pregnancy? YES  NO  When? \_\_\_\_\_

Have you ever had fertility treatments to help you become pregnant? YES  NO  DATE(S) \_\_\_\_\_

Are you currently breastfeeding? YES  NO

### MENSTRUAL/MENOPAUSE

How old were you when you had your first period? \_\_\_\_\_

First day of your last menstrual period (date): \_\_\_\_\_

Is your usual flow: HEAVY  MEDIUM  LIGHT  How many days does your period last? \_\_\_\_\_

How many days between periods (1<sup>ST</sup> day to 1<sup>ST</sup> day)? \_\_\_\_\_

Do you bleed/spot between your periods? YES  NO  If so, how much and how often? \_\_\_\_\_

Do you skip periods? YES  NO

Do you have cramps/pain? YES  NO  List any other menstrual symptoms you have: \_\_\_\_\_

Did your mother take DES? YES  NO  DON'T KNOW

Have you reached menopause? YES  NO  WHAT YEAR? \_\_\_\_\_

Have you had any bleeding since menopause? YES  NO  If so, when? \_\_\_\_\_

Did a health care provider evaluate the bleeding? YES  NO

Are you taking Hormone Therapy? YES  NO  What? \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by MD/ARNP \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by CRC (if applicable) \_\_\_\_\_ Date \_\_\_\_\_

### Map and Directions

#### From North or South via I-5

1. Take I-5 to the 45th Street exit
2. Turn East onto NE 45th Street
3. Continue on NE 45th Street past the University of Washington and down the hill
4. Turn left at the stoplight and continue on NE 45th Street past University Village to the 5-way intersection. There are two left turn lanes - choose the one on the right
5. Take a soft left onto NE 45th Place (in front of Baskin Robins)
6. Take an immediate left into one of the two parking lots at the Lakeview Medical Dental Building. We are on the ground floor in Suite #100.

#### From the East via 520

1. Take the Montlake Blvd North exit.
2. Merge onto Montlake Blvd. E.
3. Follow Montlake Blvd. as it curves to the east, merge onto NE 45th Street.
4. Continue on NE 45th Street past University Village to the 5-way intersection. There are two left turn lanes – choose the one on the right.
5. Take a soft left onto NE 45th Place (in front of Baskin Robbins).
6. Take an immediate left into one of the two parking lots at the Lakeview Medical Dental Building. We are on the ground floor in Suite #100.

#### Via Seattle Metro Transit

1. Plan your trip at <http://metro.kingcounty.gov/>
2. Bus routes 25, 65, and 75 all have stops within one block of our building.

