WOMEN'S SPECIALTY ASSOCIATES
Obstetrics and Gynecology

Dr. Richard Elsworth Dr. Carol Powers
Dr. Jennifer DeAnna

Welcome!

It is the policy of this practice that all obstetrical patients, new or established, receive prenatal care from all of our physicians during your pregnancy. These appointments will rotate through the physicians during the entire pregnancy. Our physicians rotate their "on-call" schedule daily at the hospital, which is why you will receive care from all of them.

Patients cannot choose which physician they want for an obstetrician, nor can they elect not to be seen by any particular physician.

The delivering physician within our group will be the physician who is "on-call" at the hospital. That will be the same physician you will schedule your post-partum appointment with, and in the case of a cesarean delivery, it will be the same physician you will schedule your post-op visits with.

Patients receiving gynecological care only can select whom they want for their gynecologist. Should that patient become pregnant again, they will begin the obstetrical rotation with all physicians.

I have read this information and understand the office policy.

Signature:_____

Printed Name:_____

Date:_____

→

3434 Regency Park Drive, Grand Blanc Michigan 48439 ~ Phone 810-694-9400 ~ Fax 810-694-9445

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The physicians of Women's Specialty Associates are also advocates for your unborn child.

During your pregnancy we may be performing random urine drug screenings at the time of your prenatal visits. If your drug screen indicates a positive result, we may find it necessary to withdraw from your care.

You will also be asked to comply with recommended routine obstetrical labs as well as vaginal exams at each obstetrical visit; failure to do so will call for your dismissal from the practice.

As a record of your consent to said testing, your signature is requested on this form to file into your permanent record.

In the even that you refuse to provide a signature of consent, we will cease to provide care to you, effective immediately.

Signature:_____

Printed Name:_____

Date:_____

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WOMENS SPECIALTY ASSOCIATES

NAME	AGE	DOB	HOME PHONE	CELL PHONE

ADDRESS	INSURANCE

SPOUSE	RACE	YOUR OCCUPATION	PEDIATRICIAN	DELIVERY AT GENESYS

PLEASE LIST ANY PAST PREGNANCIES, MISCARRIAGES OR ANYTHING PREGNANCY RELATED THAT WE SHOULD KNOW ABOUT.

YEAR OF DELIVERY	GENDER	INFANTS WEIGHT	TYPE OF DELIVERY	HOURS IN LABOR	DELIVERING PHYSICIAN	DELIVERING HOSPITAL	REMARKS AND GESTATIONAL AGE AT DELIVERY

FIRST DAY OF LAST MENSTRUAL PERIOD_____

WOMENS SPECIALTY ASSOCIATES
ANNUAL PATIENT INFORMATION FORM

PATIENT NAME_____ DATE OF BIRTH_____ AGE_____

SOCIAL SECURITY NUMBER_____ MARITAL STATUS_____

ADDRESS_____ APT_____ CITY_____ STATE_____ ZIP_____

HOME PHONE (___) _____ CELL PHONE (___) _____ Text appointment reminders? Yes___ No___

EMPLOYER_____ FAMILY DOCTOR_____ PHONE (___) _____

SPOUSES NAME_____ DATE OF BIRTH_____ PHONE NUMBER (___) _____

HEALTH INSURANCE_____ SUBSCRIBERS NAME_____ D.O.B_____

SUBSCRIBERS SOCIAL SECURITY NUMBER_____ SUBSCRIBERS EMPLOYER _____

EMERGENCY CONTACT NAME_____ PHONE (___) _____ RELATIONSHIP_____

PHARMACY NAME_____ PHONE NUMBER (___) _____

RACE: African American Asian Caucasian Hispanic Other_____ Refused

PRIVACY STATEMENT:

We protect our patient's information and the record that we have about their health and the services received in our office. We must have your written, signed consent in order to disclose your health information to your family doctor, insurance company (including disability claims) for the purposes of your treatment, the payment of your bills, appointment reminders, etc. I have received a copy of the Privacy Notice.

(HIPAA- 164.520 © Effective 04/14/2003) *To be filed and retained for a minimum of six (6) years.

Signature_____ Date_____

Please list the family member or persons, if any, whom we may inform about your general medical condition and diagnosis.

_____ _____

_____ _____

Can we leave a confidential message about your care on your answering machine/voice mail? _____

Do you have an authorized power of attorney? Yes___ No___ Do you have an advanced directive? Yes___ No___

Would you be interested in information about advanced directives? Yes___

→ **FINANCIAL RESPONSIBILITY:** I authorize the release of medical information to insurance carriers concerning my illness and treatment and I hereby assign to the doctor all payment for medical services rendered to me or my dependent. I understand that I am responsible for any amount not covered by insurance and that I will pay any co-pays on the date of service unless other arrangements are made.

RESPONSIBLE PARTY SIGNATURE_____ DATE _____

→ **MEDICARE AUTHORIZATION:** I request that payment of authorized Medicare benefits be made to Women's Specialty Associates on my behalf. I authorize the holder of my medical information to release to the HCFA and their agents any information needed to determine these benefits for related services. I understand that HCFA is the government Medicare agency.

_____ _____ _____

Medicare Beneficiary Signature Date Medicare Number

PATIENT QUESTIONNAIRE

NAME_____

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

HAVE YOU HAD ANY PROBLEMS WITH YOUR MENSTRUAL CYCLES?	YES___	NO___
IRREGULAR BLEEDING?	YES ___	NO___
CRAMPS WITH YOUR PERIOD?	YES___	NO___
ABNORMAL VAGINAL DISCHARGE?	YES___	NO___
PELVIC/ ABDOMINAL PAIN?	YES___	NO___
BREASTS?	YES___	NO___
CHANGE IN BOWEL HABITS?	YES___	NO___
ANY URINARY PROBLEMS, BURNING OR FREQUENCY?	YES___	NO___
PHYSICAL/ MENTAL/ SEXUAL ABUSE?	YES___	NO___
IN THE LAST YEAR, HAVE YOU HAD ANY MEDICAL PROBLEMS?	YES___	NO___
SEXUAL PROBLEMS?	YES___	NO___
DENTAL PROBLEMS?	YES___	NO___
SURGERIES?	YES___	NO___
CHANGE IN FAMILY HISTORY?	YES___	NO___
PLANS TO ATTEMPT PREGNANCY THIS YEAR?	YES___	NO___

PLEASE LIST ALL ALLERGIES:

_____

_____

PLEASE LIST ALL MEDICATIONS (PRESCRIPTION OR OVER-THE-COUNTER) THAT YOU TAKE ON A REGULAR BASIS:

_____

_____

DO YOU SMOKE?	YES___	NO___	(HOW MUCH?_____)
DO YOU DRINK ALCOHOL?	YES___	NO___	(HOW MUCH?_____)
DO YOU DRINK CAFFEINE?	YES___	NO___	(HOW MUCH?_____)
DO YOU USE MARIJUANA, COCAINE OR ANY OTHER STREET DRUGS?	YES___	NO___	
DO YOU DO SELF BREAST EXAMS?	YES___	NO___	
DO YOU EXERCISE ON A REGULAR BASIS?	YES___	NO___	(WHAT TYPE?_____)

ANY OTHER PROBLEMS YOU WOULD LIKE TO DISCUSS? _____

_____

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REPRODUCTIVE GENETIC HISTORY QUESTIONNAIRE

NAME: _____

MEDICAL HISTORY

YES	NO	DO YOU...	COMMENTS
☐	☐	1. Have diabetes?	
☐	☐	2. Have seizures or epilepsy?	
☐	☐	3. Have kidney disease?	
☐	☐	4. You or your husband/partner have a history of cancer treatment?	
☐	☐	5. Have any skin disorders including moles, acne, light or dark patches of skin?	
☐	☐	6. Have rheumatoid arthritis or systemic lupus erythematosus (SLE)?	
☐	☐	7. Have a history of being on a special diet as a baby or a small child?	
☐	☐	8. Know the results of routine prenatal blood tests for Rubella (German measles) susceptibility and if yes, check accordingly ☐ Immune ☐ Susceptible (not-immune)	
☐	☐	9. Have any other medical condition not mentioned?	

FAMILY HISTORY

YES	NO		COMMENTS
☐	☐	10. Are you 34 years or older?	
☐	☐	11. Is your husband/partner 55 years or older?	
☐	☐	12. Are you and your husband/partner blood relatives?	
☐	☐	13. Are you or your husband/partner of ☐ Jewish ☐ African American ☐ Mediterranean descent?	
☐	☐	14. Have you had a stillbirth or miscarriage?	

Do you or your husband/partner...

☐	☐	15. Have any birth defects, handicapping condition, or disorder that might be hereditary?	
☐	☐	16. Have any previous children with birth defects, handicaps or a genetic disease?	
☐	☐	17. Have any children who died? (other than an accident)	
☐	☐	18. Have any relative who have had a stillborn infant or multiple miscarriages?	

☐ ☐ 19. Have a brother, sister or parent with a handicap, birth defect or a genetic disease? _____

☐ ☐ 20. Have uncles, cousins, nieces, nephews, grandparents, or grandchildren with birth defects or genetic disease? _____

☐ ☐ 21. Know of any family member with mental retardation (even mild) or learning disabilities? _____

SOME EXAMPLES OF BIRTH DEFECTS AND GENETIC DISEASE THAT MIGHT BE IN YOUR FAMILY

(Please check any of the following that apply)

☐ Anencephaly (open skull)	☐ Down syndrome (mongolism)	☐ Mental illness
☐ Epilepsy or seizures	☐ Heart defect	☐ Mental retardation
☐ Hemophilia (bleeding tendency)	☐ Deafness	☐ Muscular dystrophy
☐ Hydrocephalus (water on the brain)	☐ Cystic fibrosis	☐ Neurofibromatosis
☐ Kidney disease	☐ Cleft lip/ palate	☐ Short stature (under 5ft)
☐ Limb disease	☐ Chromosome abnormality	☐ Skin disease
☐ Blindness or eye problem	☐ Cerebral palsy	☐ Spina bifida (open spine)
☐ Bone disorder	☐ Malformations or birth defects	☐ Tay-Sachs disease
☐ Neurologic or degenerative disorder	☐ Skeletal problems	☐ Urinary tract abnormality

☐ Other _____

MEDICATION/DRUG EXPOSURES

YES NO

☐ ☐ 22. Do you take any prescription drugs or over-the-counter medications?

Have you taken any medications since your last period?

(Please check any of the following that apply)

☐ Accutane or other dermatologic acne medications	☐ Diet pills	☐ Antibiotics
☐ Female hormones	☐ Male hormones	☐ Anticoagulants (blood thinners)
☐ Multi-vitamins	☐ Steroids	☐ Anti-thyroid drugs
☐ Tranquilizers	☐ Vitamin A	☐ Chemotherapeutic drugs
☐ Other high does vitamins	☐ Other _____	

YES NO

☐ ☐ 23. Have you had any illness or infection recently or do you have any chronic disease not mentioned? _____

☐ ☐ 24. Have you had frequent or high fevers? Take hot whirlpool baths or sit in saunas? _____

☐ ☐ 25. Have you recently had x-rays or surgery or are you planning to do so soon?

☐ ☐ 26. Are you exposed to anesthetic gases, lead, other heavy metals or radiation in your occupation?

☐ ☐ 27. Are you exposed to pesticides or potentially toxic chemicals at home or elsewhere?

☐ ☐ 28. Do you drink more than one glass of alcohol per week?

☐ ☐ 29. Do you have a house hold cat or clean a cat litter box?

☐ ☐ 30. Do you eat very raw meat?

☐ ☐ 31. Do you smoke? How many packs of cigarettes per day? _____

☐ ☐ 32. Do you use any other drugs or medications not previously listed? _____

☐ ☐ 33. Do you have any other questions or concerns regarding your ability to have a healthy baby? _____

HEREDITARY CANCER RISK SCREENING FORM

Patient Name_____ Date of Birth_____ Cell Phone Number _____
Email Address_____ Insurance Co._____ Reason for Visit_____
May we contact you by phone / email and leave a message? YES___ NO___

INSTRUCTIONS:

- Please circle Y for items that apply to YOU and / or YOUR FAMILY
- Please list cancers for YOU and the following family members ON BOTH SIDES OF YOUR FAMILY
  MOTHER / FATHER / SISTER / BROTHER / CHILDREN / AUNT / UNCLE / GRANDPARENT / NIECE / NEPHEW / COUSIN / GREAT GRANDPARENT

		BREAST AND OVARIAN CANCER	SELF	WHICH FAMILY MEMBER(S) MOTHER'S SIDE	WHICH FAMILY MEMBER(S) FATHER'S SIDE	AGE AT DIAGNOSIS	STILL LIVING?
(Y)	N	*EXAMPLE: Ovarian cancer at any age*			*Grandmother*	*62*	*No*
Y	N	Ovarian cancer at any age					
Y	N	Breast cancer diagnosed under age 50?					
Y	N	Three breast cancers on the same side of the family at any age					
Y	N	Male breast cancer at any age					
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family					
Y	N	Pancreatic cancer at any age					
Y	N	Invasive Prostate cancer at any age (Gleason Score 7 or more)					

		COLON AND UTERINE CANCER	SELF	WHICH FAMILY MEMBER(S) MOTHER'S SIDE	WHICH FAMILY MEMBER(S) FATHER'S SIDE	AGE AT DIAGNOSIS	STILL LIVING?
Y	N	Endometrial (uterine) cancer under age 50?					
Y	N	Colorectal cancer at under age 50?					
Y	N	Two or more of the following cancers on the same side of the family, ONE diagnosed under age 50: stomach, colorectal, uterine/endometrial, ovarian, small bowel, brain, kidney/urinary tract, ureter or renal pelvis					
Y	N	Three or more of the following cancers on the same side of the family at any age: stomach, colorectal, uterine/endometrial, ovarian, small bowel, brain, kidney/urinary tract, ureter or renal pelvis					
Y	N	10 or more colon polyps in yourself or family member?					

Have YOU or a FAMILY MEMBER ever been tested for hereditary cancer risk? (BRCA or Lynch Syndrome Testing)
If Yes, please explain in the space below:

Is there any other cancer in YOU or YOUR FAMILY that is not listed above? Please explain (list relationship, site and age of diagnosis):

_____

_____

Patient Signature_____ Today's Date_____

FOR OFFICE USE ONLY

- ☐ Patient is appropriate for genetic testing (at least one YES above): YES / NO
- ☐ Patient offered genetic testing today: YES / NO
- ☐ Patient submitted sample for genetic testing today: YES / NO
- ☐ Appointment for Test Results Consult is scheduled on: _____
- ☐ Healthcare Provider's Signature: _____
- ☐ If patient DECLINED genetic testing, Patient Signature: _____
  Patient Signature and Date

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Our goal as your physician is to provide you with professional, high quality and effective care. In order for us to achieve timely consultations and enhanced quality of care, we need to work closely with your primary care physician and any other specialist.

Do you have a primary care physician? ☐ Yes ☐No

If yes, who is your primary care physician?

Name: _____
FIRST *LAST*

Address: _____

_____

Would you authorize us to provide your primary care physician with our medical recommendations and care you have been receiving in our office? ☐ Yes ☐No

If no, please explain why: _____

_____

I have read and understand the information provided in regards to My Medical Neighborhood. I have been counseled on the importance of continuity of care between myself (the patient), my primary care physician and the specialist(s).

Patient signature: _____ Date: _____

Parent/guardian signature: _____ Date: _____

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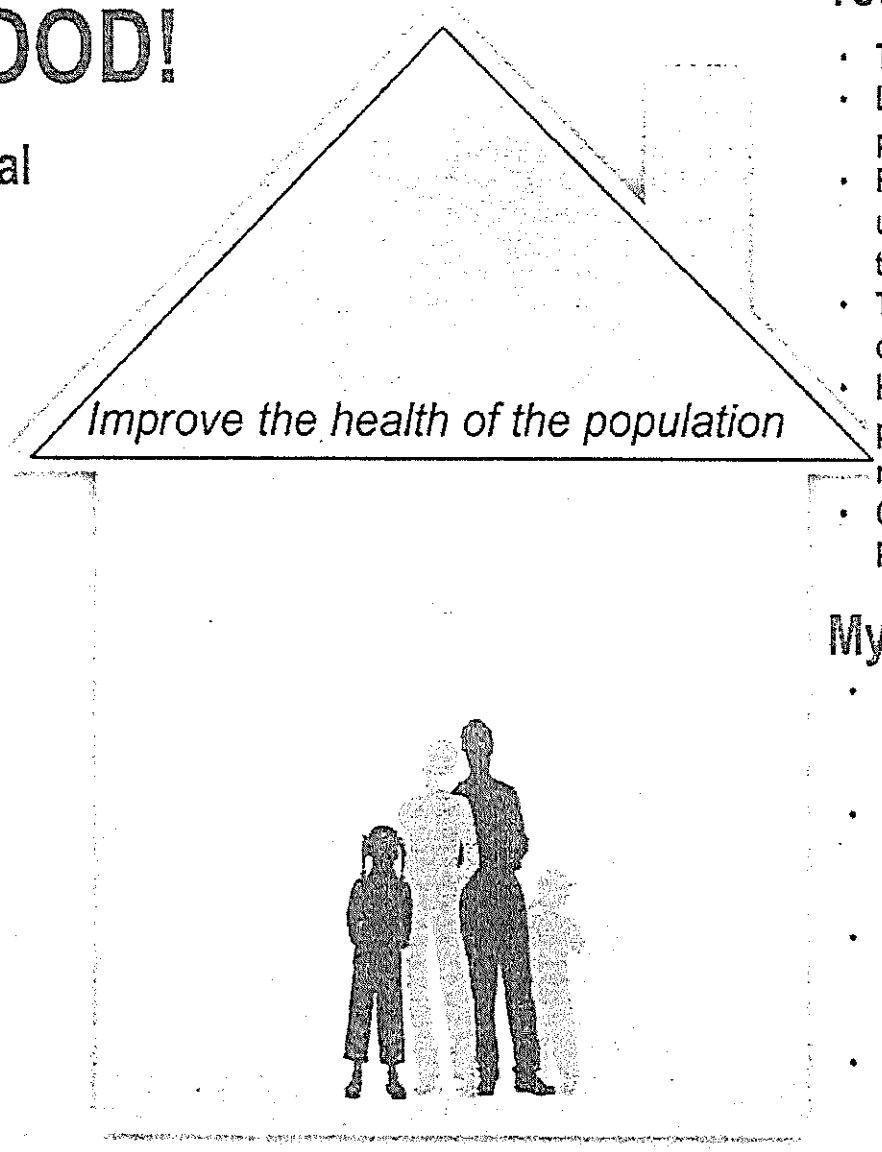
WE ARE PART OF YOUR MEDICAL NEIGHBORHOOD!

Patient Centered Medical Neighborhood

A Patient Centered Medical Home (PCMH) is a team approach to providing comprehensive healthcare to patients in a high quality and cost effective manner.

The Medical Neighborhood is an expansion of the PCMH model connecting primary care physicians, specialty practices, hospitals, and other community health services to work together more efficiently in meeting the specific needs of each patient.



Your Role As the Patient...

- Take part in planning your care
- Learn about wellness and how to prevent diseases
- Follow the care plan that is agreed upon and receive the recommended treatment
- Tell us any prescribed or over the counter medications you are taking
- Have all other physicians who take part in your care send us a report regarding your visit to them
- Continue to see your Primary Care Physician for preventive services

My Role As the Physician...

- Provide you with care that meets your needs and fits with your goals and values
- Work closely with your Primary Care Physician and other Specialists to provide coordinated care
- Ensure efficient flow of information, including timely consultations, referrals and test results
- Support enhanced access and patient-centered, high quality care

GENESYS PHO