Please complete the following forms and return them to our office. The information is confidential and will only be used to determine a suitable fit for you and our practice. We have two providers: Dr. Faye Ameredes DO and Mitzi Thompson WHCNP with combined experience of over 30 years. They work closely together as a team.

The paperwork can be returned by:

- mailing back to the above address or,
- dropped off at our office during business hours (found below) or,
- faxed to 541.677.3379

If you have any questions, please feel free to call our office at 541.677.4463.

We are located on the first floor of the Stewart Park Medical Building across the street from Sherm’s.

**Office Hours**
Monday - Thursday 9:00 am - 5:00 pm
(closed 12:00 pm - 1:30 pm for lunch)
Friday 9:00 am - 12:00 pm
PATIENT INFORMATION

Patient’s Name: _____________________________________________________________________________

□ Male  □ Female

Mailing Address: _______________________________________________________________________________________________
P.O. Box/Street City State Zip

Street Address: _______________________________________________________________________________________________
P.O. Box/Street City State Zip

Date of Birth: ____________________   SS#: _________________________________   Marital Status:
□ S □ MID □ W □ Other
Race: □ White □ Hispanic □ American Indian or Alaska Native □ Asian
□ Black or African American □ Native Hawaiian or Other Pacific Islander
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino   Preferred Language _____________________________________________________________________________

Email: _________________________________________________________________________________________________________

Home Phone: ___________________________________________ Message Contact: _________________________________

Phone: _________________________________________________

Emergency Contact: _____________________________________ Relationship: ______________________________________

Phone: _________________________________________________

RESPONSIBLE PARTY for the patient

Please check one: □ Self □ Spouse □ Parent □ Stepparent □ Legal Guardian
□ Power of Attorney □ In-law

Name: _____________________________________________   Responsible Party’s Phone: ________________________________

Mailing Address: _______________________________________________________________________________________________
P.O. Box/Street City State Zip

Employer: __________________________________________________________ Work Phone: ____________________________

Additional Guardian Information: ______________________________________ Cell Phone: _____________________________

OTHER RESPONSIBLE PARTY for the patient

Please check one: □ Self □ Spouse □ Parent □ Stepparent □ Legal Guardian
□ Power of Attorney □ In-law

Name: _____________________________________________   Responsible Party’s Phone: ________________________________

Mailing Address: _______________________________________________________________________________________________
P.O. Box/Street City State Zip

Employer: __________________________________________________________ Work Phone: ____________________________

Additional Guardian Information: ______________________________________ Cell Phone: _____________________________

PRIMARY INSURANCE for the patient

Please check one: □ Self □ Spouse □ Parent □ Stepparent □ Legal Guardian
□ Power of Attorney □ In-law

Insured/Employee’s Name: ______________________________________________________________________________________

Last                                                First                                              Middle Initial

Insurance Name: ___________________________________   Group Name/Employer: _________________________________

Group #: ______________________________  Policy ID#: __________________________________ Effective Date: ___________

Insured’s Date of Birth: ____________________________   Insured’s SS#: _________________________________
SECONDARY INSURANCE for the patient
Please check one: ❑ Self ❑ Spouse ❑ Parent ❑ Stepparent ❑ Legal Guardian
❑ Power of Attorney ❑ In-law

Insured/Employee’s Name: ____________________________________________________________

Last                                    First                                    Middle Initial

Insurance Name: ___________________________________   Group Name/Employer: ____________________________________

Group #: ______________________________  Policy ID#: ______________________________  Effective Date: _______________

Insured’s Date of Birth: ______________________________   Insured’s SS#: ______________________________

THIRD PARTY PAYOR
Please check one: ❑ Auto ❑ Worker’s Comp ❑ Home Owner’s Policy ❑ Other: ______________________________

Date of Injury: ____________________  Place of Injury: ______________________________  Claim #: _______________________

Insurance Company: __________________________________ Employer/Owner: _____________________________________

Insurance Phone: ____________________  Claim Representative: _________________________________

ADDITIONAL INFORMATION
Please provide a list of all the parties we may speak with or leave a message with regarding the patient’s medical care,
appointment scheduling, or payment information.

_______________________________________________________________________________________________________________

Name                                    Relationship                                    Phone

_______________________________________________________________________________________________________________

Name                                    Relationship                                    Phone

_______________________________________________________________________________________________________________

Name                                    Relationship                                    Phone

May we leave a message on your answering machine, if so at what phone number? ❑ Yes ❑ No
Phone number: ______________________________

May we contact you at work? ❑ Yes ❑ No

The undersigned patient or individual acting on the behalf of the patient agrees as follows:

1. Authority is granted to CMG Harmony Health For Women to render needed treatment to the above named patient.
2. I authorize CMG Harmony Health For Women to release needed treatment to the above named patient.
3. I authorize payment of medical benefits to CMG Harmony Health For Women for services rendered.
4. I understand that I am responsible for all charges incurred through CMG Harmony Health For Women.
5. Authorization Period: ❑ From __________________ to __________________ OR ❑ Lifetime

I request that payment under the medical insurance program be made to the provider named above on any bills for
services furnished me during the effective period of this authorization and I authorize the above named provider to
release to the Social Security Administration any information needed for this claim or any related Medicare claim. I further
permit a copy of this authorization to be used in place of the original. If this becomes necessary to effect Collection of my
account the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and court costs.

Signature: ____________________________________________________________   Date: ______________________

Signature: ____________________________________________________________   Date: ______________________
PAYMENT and INSURANCE POLICY

Welcome to our practice. We hope the following will answer any questions you have regarding our payment and insurance policy. If you have any questions please feel free to call our office.

Uninsured/Charity: If you have no insurance a $100 deposit is required at the time of service regardless of any financial assistance granted through the Centennial Medical Group Charity Policy. If you have any questions, please contact our office for an application.

Co-pays: The patient is responsible for any Co-pay for visits. Co-pays will be collected at the time of check in. For convenience we accept cash, check, Visa, MasterCard and Discover.

Insurance/Deductible Balance: The patient is responsible for any insurance deductible of balance and it will be collected at the time of check in for your appointment. For convenience we accept cash, check, Visa, MasterCard and Discover.

Insurance: As a courtesy, our office will bill the primary insurance company. It is the patient’s responsibility to provide us with accurate, current insurance information. Please bring current insurance cards to the appointment.

If the patient has secondary insurance coverage and provides us with the current valid information, we will bill secondary insurance after we have received response from primary insurance.

Coverage and Benefits: Please be aware, it is the patient’s responsibility to verify optimal coverage, benefits and limitations with their insurance company. Please call your insurance company if you have any questions regarding your coverage.

_________________________________________________________________________ _____________________________
Signature of Acceptance Date

2460 NW Stewart Parkway, Suite 104 • Roseburg, OR 97471 • Phone 541.677.4463 • Fax 541.677.3379
INDIVIDUAL DOCUMENT ACKNOWLEDGEMENT FORM

I, _______________________________ [Insert individual name] acknowledge that I received a copy of Mercy Medical Center’s Notice of Privacy Practices dated January 2017.

______________________ (Individual’s signature or initials)

(Sign here)

______________________ (Personal representative of individual if patient unable to sign)

Date

______________________ (Witness signature)

Individual (or personal representative of the individual) did not sign the acknowledgement for the following reason:

(Check (✓) one of the reasons below)

☐ Individual refused

☐ Individual refused, stating that he/she has already signed an acknowledgement

☐ Individual unable to sign because of medical condition

☐ There was not a personal representative of the individual available to sign

☐ Other: (explain) __________________________________________

Witness ___________________________ Date ________________

CMG A DIVISION OF MERCY MEDICAL CENTER

PATIENT LABEL

6900100 (4/17)
Consent / Authorization to Treat

Patient Full Name: _____________________________________________________________   Patient Date of Birth: ________________________

I agree my health information may be used to assist with my treatment, seek payment for health care services and products, and in routine practice operations, and I have received this office’s Notice of Privacy Practices. _____________

I agree Centennial Medical Group/Harmony Health for Women may furnish my insurance companies with all information they request concerning my treatment, including all of my personal health information. _____________

I understand there may be contact with a behavioral/mental health consultant and from time to time other persons may be observing or facilitating my care. Such persons may include but not limited to; students of the health profession, administrative or health care professionals in orientation or training. _____________

I assign to Centennial Medical Group/Harmony Health for Women all payments I become entitled to receive for services and products provided to me by Centennial Medical Group/Harmony Health for Women. _____________

I understand I must pay all co-payments, deductibles, and other charges not covered by insurance companies or other benefit programs. I understand that if these benefits stop for any reason, I must pay for all services and products provided. _____________

I agree to pay for services and products provided if for any reason insurance companies and other benefits plans do not pay. If I do not provide complete and correct insurance information, I may have to pay charges that would otherwise be covered by insurance. If my insurance requires a referral, and I do not have the necessary referral I will be responsible for paying for all services and products provided. If I file a Workers’ Compensation claim, I authorize Centennial Medical Group/Harmony Health for Women to release my personal health information, including information about my condition and treatments, to the Workers’ Compensation insurance company, my employer, and my lawyer. I understand I may request a copy of my own health information, propose changes or additions, and receive a list of non-treatment related disclosures of the information. _____________

I understand this office participates in the DCIPA Community Health Record Database. This means Centennial Medical Group/Harmony Health for Women will enter my health information, including chart notes, prescription records, operatory notes, radiographs and scans, lab results, and other health information in a secure shared database accessible only to other participating community healthcare providers. My other medical providers participating in the shared database do the same thing, permitting all participating providers ready access to up to date information regarding my condition and care. Participating in this shared database allows my healthcare providers to provide me better care with less hassle. By signing below, I agree Centennial Medical Group/Harmony Health for Women may upload my health information onto the database, view all of my personal health information on the database, and share my personal health information with other participating providers through the database. I understand that, with certain expectations, if I refuse to permit my health information to be included in this shared database, Centennial Medical Group/Harmony Health for Women may refuse to treat me. _____________

I authorize Centennial Medical Group/Harmony Health for Women to render medical products and services, including diagnosis and treatment, laboratory testing, x-rays and scans, and other medical services as deemed necessary by my physician. _____________

I agree Centennial Medical Group/Harmony Health for Women may from time to time take photographs of me and keep them with my medical records. I agree that all my medical providers may use these photographs for identification purposes, to prevent fraud, and to assist with my medical care. _____________

Patient Signature: ______________________________________________________________________________ Date: _____________________

Other Signature or Legal Guardian: _____________________________________________________________
GYNECOLOGY PATIENT QUESTIONNAIRE

Name: ___________________________ Date of Birth: ___________ Today’s Date: ___________

Name of your Primary Care Provider: __________________________

Pharmacy you choose for prescriptions: __________________________

Briefly describe reason for visit: 1. __________________________

2. __________________________

3. __________________________

Have you recently had any of the following? Check Yes or No.

- Vaginal itching □ Yes □ No
- Vaginal burning □ Yes □ No
- Abnormal vaginal discharge □ Yes □ No
- Abnormal vaginal bleeding □ Yes □ No
- Pelvic Pain □ Yes □ No
- Abdominal bloating □ Yes □ No
- Urinary urgency □ Yes □ No
- Poor appetite □ Yes □ No
- Hot Flashes □ Yes □ No
- Night sweats □ Yes □ No
- Early morning awakening □ Yes □ No
- Vaginal dryness □ Yes □ No
- Bleeding after menopause □ Yes □ No
- Bleeding after intercourse □ Yes □ No
- Weight gain or loss □ Yes □ No
- Urinary leakage/wetting □ Yes □ No

Pain:

Are you in pain today? □ Yes □ No If yes, Location: __________________________ Cause: __________________________

Do you have chronic pain? □ Yes □ No If yes, Location: __________________________ Cause: __________________________

Do you use any of the following: (Check which applies)

- Tobacco: □ Current □ Previous □ Never Type: __________________________ Amount: __________________________
- Caffeine: □ Current □ Previous □ Never Type: __________________________ Amount: __________________________
- Alcohol: □ Current □ Previous □ Never Type: __________________________ Amount: __________________________
- Illegal Drugs □ Current □ Previous □ Never Type: __________________________ Amount: __________________________
- Exercise: □ Current □ Previous □ Never Type: __________________________ Amount: __________________________
- Seatbelt use: □ 100% □ 75% □ 50% □ 25% □ 0%

Date of Last Pap Smear: __________________________ Was it Normal? □ Yes □ No

Have you ever had an abnormal pap? □ Yes □ No If yes explain: __________________________

Have you completed the Gardasil vaccine series? □ Yes □ No

Date of Last Mammogram: __________________________ Was it Normal? □ Yes □ No

The first day of your last menstrual period: __________________________ or Hysterectomy or Menopause

Number of days from 1st day of period until 1st day of next period: __________________________

Usual number of days of flow (including spotting): __________________________

Flow is usually (please check): □ Light □ Moderate □ Heavy

Pain from cramping is (please check): □ Mild □ Moderate □ Severe

What do you do to prevent becoming pregnant?

Do you believe you may be currently pregnant? __________________________
GYNECOLOGY PATIENT QUESTIONNAIRE

**Medical History:** Have you ever had any of the following? Please check Yes or No.

- Total number of pregnancies: __________
- Number born to term: __________
- Number of preterm: __________
- Number of miscarriages: __________
- Number of ectopics: __________
- Number of abortions: __________

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia/Blood disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Stones</td>
<td></td>
<td></td>
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<tr>
<td>Hyperthyroidism</td>
<td></td>
<td></td>
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<tr>
<td>High Blood Pressure</td>
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<tr>
<td>COPD</td>
<td></td>
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<tr>
<td>GERD (Reflux)</td>
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<tr>
<td>Heart Disease</td>
<td></td>
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<tr>
<td>Blood clot in leg or lung</td>
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<tr>
<td>Bacterial Vaginosis</td>
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<tr>
<td>Syphilis</td>
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<tr>
<td>Genital warts</td>
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<tr>
<td>Sleep Apnea</td>
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<tr>
<td>Cancer</td>
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<td></td>
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<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes, what treatment used? ____________________________

If yes, please list type and stage: ____________________________

**Surgical History:** Check which applies, list other surgeries, the reason for the surgery, and the year they occurred.

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Reason</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hysterectomy</td>
<td></td>
<td></td>
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<tr>
<td>Ovaries Removed</td>
<td></td>
<td></td>
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<tr>
<td>Bladder Suspension</td>
<td></td>
<td></td>
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<tr>
<td>Tubal Ligation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appendectomy (removal of appendix)</td>
<td></td>
<td></td>
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<tr>
<td>Cholecystectomy (removal of gallbladder)</td>
<td></td>
<td></td>
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<tr>
<td>Laparoscopy</td>
<td></td>
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<tr>
<td>Surgery:</td>
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<td>Surgery:</td>
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<tr>
<td>Surgery:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Have you had any of the following in the last month?** Check Yes or No

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast pain</td>
<td></td>
<td></td>
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<tr>
<td>Breast Lumps</td>
<td></td>
<td></td>
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<tr>
<td>Nipple discharge</td>
<td></td>
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<tr>
<td>Chest pain</td>
<td></td>
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<tr>
<td>Edema</td>
<td></td>
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<tr>
<td>Irregular heartbeat</td>
<td></td>
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<tr>
<td>Wheezing</td>
<td></td>
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<tr>
<td>Coughing</td>
<td></td>
<td></td>
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<tr>
<td>Shortness of breath</td>
<td></td>
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<tr>
<td>Nausea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vomiting</td>
<td></td>
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<tr>
<td>Abdominal pain</td>
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<tr>
<td>Heartburn</td>
<td></td>
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<tr>
<td>Constipation</td>
<td></td>
<td></td>
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<tr>
<td>Diarrhea</td>
<td></td>
<td></td>
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<tr>
<td>Unable to empty bladder</td>
<td></td>
<td></td>
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<tr>
<td>Painful urination</td>
<td></td>
<td></td>
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<tr>
<td>Urinary Frequency</td>
<td></td>
<td></td>
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<tr>
<td>Skin rash</td>
<td></td>
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<tr>
<td>Skin itching</td>
<td></td>
<td></td>
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<tr>
<td>Boils</td>
<td></td>
<td></td>
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<tr>
<td>Severe Depression</td>
<td></td>
<td></td>
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<tr>
<td>Severe Anxiety</td>
<td></td>
<td></td>
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<tr>
<td>Plans for Suicide</td>
<td></td>
<td></td>
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<tr>
<td>Dizzy Spells</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue (chronic)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
GYNECOLOGY PATIENT QUESTIONNAIRE

Family History: Please indicate the relationship of any family member who had any of the following: (example: Paternal Grandmother, Maternal Grandfather, Mother, Sister, Uncle, etc.)

Heart disease
Diabetes
High blood pressure
Stroke
Thyroid disease
Epilepsy
Asthma
Arthritis
Mood disorders or mental illness
Tuberculosis
Endometriosis
Osteoporosis
Breast Cancer
Lung Cancer
Ovarian Cancer
Other Cancer (list type)

Please list all Medications and Supplements: (pills, patches, inhaler, vitamins, herbs, and implants)

1. __________________________ Dosage: __________ How often: __________ Reason:
2. __________________________ Dosage: __________ How often: __________ Reason:
3. __________________________ Dosage: __________ How often: __________ Reason:
4. __________________________ Dosage: __________ How often: __________ Reason:
5. __________________________ Dosage: __________ How often: __________ Reason:
6. __________________________ Dosage: __________ How often: __________ Reason:
7. __________________________ Dosage: __________ How often: __________ Reason:
8. __________________________ Dosage: __________ How often: __________ Reason:
9. __________________________ Dosage: __________ How often: __________ Reason:
10. __________________________ Dosage: __________ How often: __________ Reason:

Medication Allergies:

1. __________________________ Effect:
2. __________________________ Effect:
3. __________________________ Effect:
4. __________________________ Effect:
5. __________________________ Effect:
6. __________________________ Effect:
7. __________________________ Effect:

Comments:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________