Dear New Patient,

Thank you for choosing Foothills Urogynecology for your medical needs. Enclosed is your new patient packet, we ask that you complete this information and bring it in with you on the day of your appointment. We also ask that you bring your current insurance card(s), photo ID and a list of all medications (including over the counter and herbal) you are taking. A urine specimen will be needed at the time of your appointment.

As the patient, it's your responsibility to contact your insurance company's member services and inquire whether a referral, pre-authorization and a co-payment is required. Please keep in mind that we are a specialist, which may reflect a higher copayment.

If you would like to fax us referral information and patient medical record information fax to 303-282-0066.

We are located in the Harvard Park Medical Plaza (west building) at 850 East Harvard Ave, Suite 285 in Denver, CO. Please feel free to contact our office if you have any questions or concerns at (303) 282-0006.

We look forward to meeting you at your scheduled appointment.

Sincerely,

Dr. Terry S. Dunn, M.D. and Team

Foothills Urogynecology
Dr. Terry S. Dunn, M.D., F.A.C.O.G

850 East Harvard Ave., Ste. 285 | Denver, CO 80210
303.282.0006 | fax: 303.282.0066
www.urogyns.com

Foothills Urogynecology™
restoring comfort, confidence & dignity
850 East Harvard Ave Suite 285, Denver, CO 80210. (303) 282-0006 Fax (303) 282-0066

Patient Information *Please fill out completely* **Appointment Date:** ____/____/____

Last | First | M.I. | Nickname | Date of Birth

Social Security # | Marital Status | Gender

Address | City/State/Zip | Home Phone | Alt. Phone

Primary Language* | Ethnicity* | Race*

*As part of compliance with the HITECH Act, we are obligated to request this information; you are **not** required to provide it: ☐ Prefer not to say

Employment Information

Employer | Occupation | Business Phone | Extension

Street Address | City | State | Zip

Physician Information

Referring Physicians Name | Address | City/State/Zip | Phone

Primary Physicians Name | Address | City/State/Zip | Phone

How did you hear about our practice?

☐ Physician ☐ Internet: _____ ☐ Print ☐ TV ☐ Friend/Relative: _____
Where? Who?

Preferred Pharmacy Information

Pharmacy Name | Address | City/State/Zip | Phone

Insurance Information: *Please fill out completely regardless of us copying your insurance card(s)*

Please Note: If you have a Medicare Card along with other Insurance make sure you bring your Medicare card with you to your appointment.

Primary Medical Insurance _____ Effective Date ____/____/____
(space for secondary insurance information is provided on the next page)

ID# | Group#

Address | City/State/Zip | Phone

____/____/____

Policy Holder Name | Relationship | ID# | Insured Date of Birth | Insured SSN

Does your Insurance require a referral? ☐ Yes or ☐ No Co-Payment Amount (Specialist) $_____

Deductible ☐ Yes or ☐ No Amount $_____

Is your insurance a ☐ PPO or ☐ HMO plan?

Please continue to the next page →→ →→

Secondary Medical Insurance_____ Effective Date_____

ID# Group#

Address City/State/Zip Phone

Policy Holder Name Relationship ID# Insured Date of Birth Insured SSN

Does your Insurance require a referral? ☐ Yes or ☐ No Co-Payment Amount (Specialist) $_____

Deductible ☐ Yes or ☐ No Amount $_____

Is your insurance a ☐ PPO or ☐ HMO plan?

HIPAA Approved Contacts (anyone whom we may speak to regarding your healthcare in an emergency).

I.

Last First M.I. Relationship

Address City State Home Phone

II.

Last First M.I. Relationship

Address City State Home Phone

PAYMENT TERMS AND AGREEMENTS

X_____
Initial Here

I, the undersigned, in consideration for services rendered to me by Foothills Urogynecology, understand and agree to the following :

1. Any co-payments are required to be paid on the day services are rendered.
2. Payment for charges is due on the date of service with the exception of insurance carriers for which Foothills Urogynecology is under contract to file directly. Cosmetic procedures must be paid in full two weeks prior to surgery.
3. My insurance coverage may not provide payment for all charges incurred in obtaining treatment from Foothills Urogynecology. I will be responsible for any co-payment, deductible, coinsurance, or service not covered by my insurance provider. If I do not have insurance coverage for services rendered by Foothills Urogynecology, I agree to pay all charges resulting from such services on the day of service.
   Please Note: If you have a Medicare Card along with other Insurance make sure you bring your Medicare card with you to your appointment.
4. As a patient it is my responsibility to verify with my insurance company that Foothills Urogynecology is a part of my provider network (HMO, PPO, etc.). I understand it is my responsibility to obtain visit referrals from my primary care physician (PCP) if my plan requires such.
5. I understand that I am responsible for notifying the office of any changes in insurance coverage, address or phone number(s). Failure to notify Foothills Urogynecology of these changes will make me responsible for claims not accepted by the insurance company.
6. **I understand that I am fully (100 %) responsible for my bill if I sought services provided by Foothills Urogynecology without receiving a proper authorized-referral from my primary care physician or my insurance company.**
   a. **Furthermore, I understand that it is my responsibility to obtain authorization/referrals as required by my insurance plan and to verify the receipt of such documents by Foothills Urogynecology prior to receiving care.**
   b. **I understand that it is my responsibility to verify eligibility, benefits and in or out of network-status.**
   c. **I understand that it is my sole responsibility to understand the terms and conditions of my insurance coverage.**
   d. **All HMO plans and Tri-Care Plans are managed by your primary care physician and require authorization from *your* primary care physician.**
7. I hereby authorize Foothills Urogynecology to file with my insurance carrier, and I assign payment of medical benefits to Foothills Urogynecology and in addition I authorize release of any and all medical records and information necessary to process any claim generated by services I receive from Foothills Urogynecology.

Please continue to the next page →→→→

8. I authorize the office and or its employees to release any and all medical records and information necessary for treatment, payment and operational purposes as indicated in Foothills Urogynecology's Notice of Privacy Practices.

9. Please note that we only use your Social Security Number for billing purposes only.

CONSENT FOR TREATMENT

_ **Initial Here**

1. I, the undersigned, voluntarily agree to the tests, procedures, and/or treatments which the physician has deemed necessary and which are administered to or performed on me under the direction of the physician or his/her designee.
2. I, the undersigned, acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure**.**

CONSENT TO RELEASE MEDICAL RECORDS

_ **Initial Here**

1. I understand that my insurance carrier, short and long term disability insurance may require copies of my medical records in order to process claims. I hereby agree to such release of my records.
2. I understand that in the course of its own business Foothills Urogynecology staff members will have access to my medical record. I hereby agree to such sharing of my personal health information.

CONSENT TO COMMUNICATE MEDICAL RESULTS

_ **Initial Here**

I authorize Foothills Urogynecology to discuss my medical condition (other than for purposes of treatment, payment or operations) with the following below named persons:

Last	First	M.I.	Relationship
Address	City	State	Home Phone
Last	First	M.I.	Relationship
Address	City	State	Home Phone

I have **read**, **understand** and **agree** to the terms, conditions, consents and disclosures in the above documents (Payment Terms and Agreements, Consent for Treatment, Consent to Release Medical Records, Consent to Communicate Medical Results) in their entirety.

Print Name

If other than patient, please indicate relationship and provide Power-of-Attorney.

SIGN HERE →→ _____

Signature of Patient or Authorized Representative

__/__/__

Date (mm/dd/yyyy)

Checklist :

☐ I have filled out all parts of this form.
☐ I have signed all applicable agreements.
☐ I have or will receive a referral and make proper arrangements with my Insurance Company and Primary Care Physician

Please Bring To Your Appointment:

☐ Driver's License and Insurance Card**(s)**
☐ This Form
☐ Medical History Questionnaire
- ☐ Any list of any questions or concerns that you would like to discuss with the provider.
- ☐ A current list of *all* of the medications, vitamins and supplements you take.
- ☐ A list of *all* allergies you suffer from (environmental and pharmaceutical) and associated reactions.

Co-Payment is due at time of service.

You have completed your Patient Demographic Form. Please continue to the next page to Complete your medical history questionnaire.

Foothills Urogynecology™
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850 East Harvard Ave Suite 285, Denver, CO 80210. (303) 282-0006 Fax (303) 282-0066

Comprehensive Health History & Symptom Questionnaire

Patient Questionnaire: *Please fill out completely* **Appointment Date:** ____/____/____

Name _____ Date of Birth (mm/dd/yy) ____/____/____ Age _____

Current Method of Birth Control: _____

Do you have a religious affiliation that would prevent you from having a blood transfusion if Medically necessary? _____

Do you have a history or current condition of bleeding/ clotting disorders? ☐ **Yes** ☐ **No**

Do you take blood-thinning medications (Coumadin, Warfarin, Lipitor, Plavix, etc.)? ☐ **Yes** ☐ **No**

Please briefly describe the reason(s) that you are being seen in our office :

_____

_____

_____

_____

_____

How long have you experienced this problem?

_____

_____

_____

Please list any previous tests or treatments for this condition:

_____

_____

_____

UROGYNECOLOGIC SYMPTOM QUESTIONNAIRE: Urinary Symptoms

*If you have **urinary incontinence** or **leakage** of urine please fill out the below information*

How long have you been experiencing this problem? _____

During an average day, I urinate_____times a day.

I usually urinate every_____hours during the day.

At night, I get up_____times to urinate.

If you have difficulty controlling your bladder, please answer the following:

I.	What amount of urine do you lose?	☐Small	☐Large	☐Both
II.	What position do you lose urine?	☐ Sitting	☐ Standing	☐ Lying Down
III.	Do you wear a pad all of the time?	☐NO		☐YES
	• If **YES** , how many pads per day? _____ o When you change your pads, are they:	☐Dry	☐Damp	☐Wet
IV.	Do you lose urine in spurts with laughing, sneezing or exertion?	☐NO		☐YES
V.	Do you have a sense of urgency before losing urine?	☐NO		☐YES
VI.	Do you experience urine leakage without knowing it?	☐NO		☐YES
VII.	Does the sound, sight, or feel of running water cause you to lose urine?	☐NO		☐YES
VIII.	Can you voluntarily stop the flow of urine?	☐NO		☐YES
IX.	Do you wet your bed at night?	☐NO		☐YES
X.	Do you lose urine as a constant drip?	☐NO		☐YES
XI.	Do you feel that you are able to empty your bladder completely when you sit down to urinate?	☐NO		☐YES
XII.	After urinating, you feel: ☐ Empty ☐ Still have the sensation to urinate			
XIII.	Is it difficult to get the urine stream started?	☐NO		☐YES
XIV.	Does your urine stream seem week or slow?	☐NO		☐YES
XV.	Do you feel as if your pelvic organs are falling down or can you feel a bulge at the opening of your vagina?	☐NO		☐YES
XVI.	Have you ever had blood in your urine?	☐NO		☐YES
XVII.	Do you have frequent urinary tract infections?	☐NO		☐YES

Please continue to the **BOWEL SYMPTOMS** section of this questionnaire on the next page →→

UROGYNECOLOGIC SYMPTOM QUESTIONNAIRE: Bowel Symptoms

*If you have **urinary or fecal incontinence** or **leakage** of urine please fill out the below information*

I move my bowels_____times/day and_____times/week.

I.	Do you experience:	☐Constipation	☐Diarrhea
II.	Do you experience loss of stool?	☐ NO	☐ YES
III.	Do you have blood in your stools?	☐NO	☐YES
IV.	Do you experience regular bowel movements?	☐ NO	☐ YES
V.	Do you experience difficulty emptying your rectum?	☐ NO	☐ YES
VI.	Do you have to "strain" during a regular bowel movement?	☐ NO	☐ YES
VII.	Do you feel pressure in your vaginal region?	☐ NO	☐ YES
VIII.	Do you experience Digital Defecation? (having to manually push stool out)	☐ NO	☐ YES
IX.	Do you have problems controlling gas?	☐ NO	☐ YES

Please list any other questions or concerns particularly related to urine or stool loss (not listed above)?

_____

_____

_____

_____

_____

INDIVIDUAL INCONTINENCE IMPACT QUESTIONNAIRE

*Please complete the following questionnaire if **applicable** to **your** situation*

If you have difficulty controlling your bladder, please answer the following:

My bladder control problem affects my… ***(Please place a check after each appropriate statement)***

I. Ability to do household chores (washing dishes, cleaning house, etc.)

☐ Not at all ☐ Rarely ☐ Frequently ☐ All of the time ☐ Not applicable

II. Ability to socialize and interact with friends and colleagues.

☐ Not at all ☐ Rarely ☐ Frequently ☐ All of the time ☐ Not applicable

III. Quality and quantity of sleep.

☐ Not at all ☐ Rarely ☐ Frequently ☐ All of the time ☐ Not applicable

IV. Performance of routine exercise or participation in sports (walking, jogging etc.).

☐ Not at all ☐ Rarely ☐ Frequently ☐ All of the time ☐ Not applicable

V. Personal and intimate relationships (including hugging and sexual intercourse).

☐ Not at all ☐ Rarely ☐ Frequently ☐ All of the time ☐ Not applicable

VI. Ability to participate in entertainment activities.

☐ Not at all ☐ Rarely ☐ Frequently ☐ All of the time ☐ Not applicable

VII. Ability to perform my job.

☐ Not at all ☐ Rarely ☐ Frequently ☐ All of the time ☐ Not applicable

VIII. Ability to wear the clothes I want.

☐ Not at all ☐ Rarely ☐ Frequently ☐ All of the time ☐ Not applicable

IX. Ability to go places I want to go.

☐ Not at all ☐ Rarely ☐ Frequently ☐ All of the time ☐ Not applicable

Please list an activity (not listed above) which is particularly affected by your urine loss:

_____

_____

_____

_____

_____

PATIENT INTAKE FORM

We realize that seemingly small issues can have a profound impact on your overall quality of life, and we are committed to offering specialized services that help our patients feel their very best. We have recently added a new procedure, Geneveve™, which treats a very common condition called vaginal laxity – a natural outcome of aging, genetics, lifestyle or vaginal childbirth. While women may or may not be adversely impacted by this condition, we would like to give you the opportunity to determine if this may be affecting you. We recognize patients can be hesitant to bring up personal or intimate issues but want to assure you we welcome your questions and are happy to talk about this further with you.

HAVE YOU EVER EXPERIENCED THE FOLLOWING?

Passing air from the vagina	Yes	No
Urine leakage especially when coughing, sneezing, jumping, etc.	Yes	No
Tampons slipping	Yes	No
Feeling of looseness during intercourse	Yes	No
Reduced sensation during intercourse	Yes	No
Feeling that the vaginal area is not as firm or tight as it once was	Yes	No
A general sense of looseness in the vaginal area	Yes	No

HOW WOULD YOU RATE YOUR CURRENT LEVEL OF VAGINAL LAXITY/LOOSENESS? CIRCLE ONE

1 - Very Loose 2 - Moderately Loose 3 - Slightly 4 - Neither Loose nor Tight

Loose 5 - Slightly Tight 6 - Moderately

Tight 7 - Very Tight

Has this changed over time?	Yes	No

HAS A FEELING OF LOOSENESS AFFECTED YOUR:

Overall sexual enjoyment	Yes	No
Mental sexual arousal	Yes	No
Physical sexual arousal	Yes	No
Ability to have orgasms	Yes	No
Feelings of closeness /connection with your partner	Yes	No
Communication with your partner	Yes	No
Self-confidence	Yes	No
Sexual self-image	Yes	No
Interest in having sex	Yes	No
Mental engagement during sex Other (please explain):	Yes	No

_____

DO YOU THINK SOME DEGREE OF LOOSENESS HAS AFFECTED YOUR PARTNER'S EXPERIENCE?	Yes	No

GYNECOLOGIC HISTORY

Please complete the following questionnaire

First day of last period_____ Number of days between periods _____
Current method of birth control_____ **past** methods of birth control _____
Age at first period _____
How many days does your period usually last? _____
Do you have bleeding or spotting between periods? _____
Date of last Pap smear?_____ Normal? ☐ YES ☐ NO
History of Abnormal Pap? ☐ YES ☐ NO:_____ (RESULT)
Date of last Mammogram?_____ Normal? ☐ YES ☐ NO: _____ (RESULT)
Have you had a DEXA scan (bone density test)? ☐ YES ☐ NO
Have you had a colonoscopy? ☐ YES ☐ NO If so, when? _____

Please check if you have had or currently have any of the following infections

☐ Yeast ☐ Trichomonas ☐ Chlamydia ☐ Gonorrhea

☐ Herpes ☐ HPV ☐ HIV ☐ MRSA ☐ Other:_____

SEXUAL HISTORY

Are you sexually active? ☐ NO ☐ Yes

If yes , is sex: ☐ Satisfactory ☐ Uncomfortable ☐ Wish to Discuss

OBSTETRICAL HISTORY

Number of pregnancies:_____ Miscarriages:_____ Abortions:_____ Live Births: _____
# # #

Did you have an episiotomy? _____

Did you have Gestational Diabetes? _____

Did you have Pre-eclampsia/Toxemia during pregnancy? _____

Weight of Baby	Type of Delivery

SOCIAL HISTORY *please complete this section entirely and honestly*

Tobacco: ☐ No ☐ Yes Current Use: ☐ No ☐ Yes for how long? _____

How frequently/How many cigarettes per day? _____

Alcohol: ☐ No ☐ Yes how many ounces per week? _____

Caffeinated beverages: ☐ No ☐ Yes Type, frequency and amount: _____

Street drugs: ☐ No ☐ Yes Type, frequency and amount: _____

Have you ever sought treatment for addiction (street drugs or prescriptions): ☐ No ☐ Yes
If yes, for what and when? _____

Have you ever had a Pain Management Contract with any healthcare providers? ☐ No ☐ Yes

Do you do any type of exercise? If **yes,** what type(s) _____

SURGERIES AND HOSPITALIZATIONS

List any surgeries and serious illnesses, which required hospitalization (excluding pregnancy).

Surgery/Hospitalization	Date:

MEDICATIONS

List all medications you currently take, with dosage and frequency, including over-the-counter-drug.

You may use My Medicine List and print a copy: mml.nlm.nih.gov if you do not want to handwrite this list.

Medication	Dosage	How Often Taken?

Herbal Supplements/Vitamins

List all supplements you are currently taking.

Supplement Name	Dosage	How Often Taken?

DRUG ALLERGIES INCULDING LATEX, IV DYE, IODINE OR ADHESIVES

*List **all** drugs you are allergic to and the allergic reaction to each drug.*

Medication/Product	Reaction

PAST/PRESENT MEDICAL HISTORY: PATIENT ONLY

Please note if** you **have been diagnosed with any of the following conditions. In the "Please Explain" column, please indicate when you had this condition.

Condition/ Disorder/ Disease	YES	NO	Please Explain
Allergies, Immune & Infectious Problems (hay fever, seasonal allergies, HIV, Lupus etc…)	☐	☐	
Blood & Lymph Node (Anemia, Blood Clot/Transfusion, bleeding disorder)	☐	☐	
Bones/ Joints and Muscles (Arthritis, etc…)	☐	☐	
Cancer (What type of Cancer?)	☐	☐	Please explain and indicate treatment (chemo, radiation, other):
Gynecological Cancers (ovarian, uterine, endometrial)	☐	☐	
Cardiovascular (heart problems, chest pains, high blood pressure, stroke, pacemaker, heart surgery, heart disease, high cholesterol)	☐	☐	
Constitutional (chronic cough, fever, weight loss, poor appetite)	☐	☐	
Ear/ Nose/ Throat (hearing loss, sinus, sore throat, frequent bloody noses)	☐	☐	
Endocrine (diabetes, thyroid or pituitary problems etc…)	☐	☐	
Eyes (eye disease, glaucoma, cataract, lazy eye, retina problems)	☐	☐	
Gastro-Intestinal (heartburn, acid reflux, diarrhea, vomiting, ulcer, IBD, Crohn's Disease, IBS etc…)	☐	☐	
Genito-Urinary (urinary problems, blood in urine etc…)	☐	☐	
Hematologic (blood disorders, leukemia, easy bleeding/bruising, take aspirin etc…)	☐	☐	
Lungs and Respiratory (asthma, tuberculosis, shortness of breath, wheezing, coughing **or** problems with anesthesia)	☐	☐	
Musculoskeletal (muscle aches, joint pain, swollen joints, artificial joint, arthritis etc…)	☐	☐	
Neurological (numbness, weakness, paralysis, headaches, spasm, seizures, Fibromyalgia, MS etc…)	☐	☐	
Psychiatric (depression, anxiety etc…)	☐	☐	
Skin (skin rashes, excessive dryness, used Accutane, skin cancer/disease etc…)	☐	☐	
Infectious Disease (Hepatitis B or C, HIV or AIDS, Tuberculosis, etc.)	☐	☐	
Anything Else We Should Know About:			

FAMILY MEDICAL HISTORY

(Please specify *Maternal or Fraternal*)

*Please note **any blood-relatives** that have had any of the following conditions*

Condition/ Disorder/ Disease:	YES	NO	Please Explain
Breast Disease	☐	☐	
Cardiovascular (heart problems, high blood pressure, stroke, pacemaker, heart surgery, heart disease)	☐	☐	
Diabetes	☐	☐	
Gynecological Cancers (ovarian, uterine, endometrial)	☐	☐	
Hepatitis B or C, HIV or AIDS, Tuberculosis etc…	☐	☐	
Other:			
Other:			

I have **completed all parts of this form** and understand that it is my responsibility to provide an accurate medical history and disclose all information relevant to my health; and that accuracy of such information is crucial to my care at Foothills Urogynecology.

Print Name

If other than patient, please indicate relationship and provide Power-of-Attorney at appointment.

SIGN HERE →→ _____

Signature of Patient or Authorized Representative

__/__/__

Date (mm/dd/yyyy)

Checklist :

☐ I have filled out all parts of this form.

Please Bring To Your Appointment:

☐ Drivers License and Insurance Card**(s)**

☐ Patient Demographic Form

☐ **Completed** Medical History Questionnaire, as well as:

- ☐ Any list of any questions or concerns that you would like to discuss with the provider.
- ☐ A current list of *all* of the medications, vitamins and supplements you take.
- ☐ A list of *all* allergies you suffer from (environmental and pharmaceutical) and associated reactions.

Co-Payment is due at time of service.

This is the last page of your New Patient Packet.

Thank you for completing, we look forward to serving your healthcare needs.

Please bring this **entire** packet to your appointment.

If you have any questions, please call us at (303) 282-0006.

Foothills Urogynecology™

restoring comfort, confidence & dignity

_____

Today's Date

I understand that I am fully responsible for my bill if I sought services provided by Foothills Urogynecology without receiving a proper authorized referral from my primary care physician or my insurance company. Furthermore, I understand that is my responsibility to obtain authorization / referrals as required by my insurance, and to verify the receipt of such documents by Foothills Urogynecology prior to receiving care.

I understand that it is my responsibility to verify eligibility, benefits, and in or out of network status.

I understand that is my sole responsibility to understand the terms and conditions of my insurance coverage.

All HMO plans and Tricare Plans are managed by your primary care physician and require authorization from *your* primary care physician.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need.

_____ _____

Printed Name Signature

_____

Date of birth