



# Edward T. Wolanski, M.D., P.C.

Edward T. Wolanski, MD ♦ Donna Vinal, CNM, PhD

600 Peter Jefferson Parkway, Suite 300 ♦ Charlottesville, VA 22911 ♦ (434)293-9800

<b>REGISTRATION FORM</b>		<i>(PLEASE PRINT)</i>		<b>Chart #</b>		<b>TODAY'S DATE:</b>		
Last Name:			First Name:			MI:		
DOB: / /		Age:	Marital Status (circle one) Single / Married / Divorced / Separated / Widowed					
Street Address:			P.O. Box:		Email Address:			
City:		State:	Zip Code:		SSN#:			
Cell Phone:		Home Phone:		Work Phone:				
Occupation:			Employer:					
How were you referred to us? <input type="checkbox"/> Dr. <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Ad								
<b>INSURANCE INFORMATION</b>		<i>(Please give your insurance card and photo ID to the receptionist)</i>						
Primary Insurance:		Subscriber's Name:			Subscriber's DOB / /			
Secondary Insurance:								
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other								
<b>PHARMACY INFO PLEASE ALLOW 24 - 48 HOURS FOR PRESCRIPTION REFILLS TO BE CALLED INTO YOUR PHARMACY</b>								
Preferred Pharmacy:			Location:					
<b>CASE OF EMERGENCY</b>								
Name of local friend or relative (not living at same address):								
Home phone #:		Work Phone #:		Relationship to Patient:				
<b>AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION</b>								
It is the policy of Dr. Wolanski's and Donna Vinal's office to make confirmation phone calls for certain appointments, because of HIPAA, it is necessary for us to get your authorization on certain items. I authorize your staff to call my (preferred number) _____ and leave a message on my answering machine regarding appointments. I authorize the staff to speak with and release ALL medical information to the following individual (s):								
Name:		Relationship to patient:		I AUTHORIZE THE STAFF TO LEAVE A MESSAGE ON MY VOICEMAIL AT MY WORK NUMBER. <table border="1"><tr><td>YES</td><td>NO</td></tr></table>			YES	NO
YES	NO							
<i>I acknowledge that I have reviewed and / or been offered a copy of Notice of Privacy Practices. I understand that I may request and review a copy of these Practices at any time from the office staff. I certify that I have insurance with the above company and assign benefits to Edward T. Wolanski MD, PC. I authorize this practice to release information necessary to secure benefits and payment. I authorize use of the signature on all claims.</i>								
Patient / Guardian Signature: _____						Date: _____		

**FINANCIAL POLICY****Chart #****Date:**

As a courtesy to our patients, we file claims to most insurance companies. Please be aware that some or perhaps all of the services rendered may or may not be covered. Benefits are determined by you and your insurance company. Please be aware of your benefits. If your insurance company denies payment, you will be billed and payment is due upon receipt of statement.

We cannot file your insurance unless an active card is presented or on file. Your insurance must be current and verifiable at the time of service. Payment assignment must be made to this office. Co pays, deductibles and non-covered services fees are due at the time of service. A fee (approx. \$10) may be assessed if copay is billed to patient. Full payment is due at time of service if insurance payments are sent to the patient.

If referral or preauthorization for services is required, you are responsible for confirming this prior to receiving services. If referral/preauthorization is not obtained, services may be rescheduled or you may be responsible for payment in full.

Please be aware that attending scheduled appointments is important. A fee will be assessed after the 3rd (third) "No Show" or cancellation within less than 24 hour notice.

Should it be necessary to utilize an outside collection means for a past due account, you are responsible for all costs including attorney, court and collection fees (30%). A \$35 fee will be assessed on all returned checks. Financial non-compliance is grounds for discharge from the practice

**I have read the above and understand the Financial Policies of Edward T. Wolanski, MD, PC. I have completed this form to the best of my ability and will not hold the practice responsible for my errors or omissions.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**DEEMED CONSENT**

I voluntarily consent to medical care in this practice. No promises have been made as to the results of the examinations or treatments. I authorize the release of pertinent medical information to other providers involved in my care.

Virginia law requires health care providers to notify you that Hepatitis B and C and HIV testing be done if a healthcare worker is exposed to your blood or body fluids. This notice is to advise you that this is in effect at this facility. As a health care provider under Virginia Acts Assembly, Section 32.1-45.1, whenever a health care worker associated with Edward T. Wolanski, MD, PC, is directly exposed to body fluids of a patient in a manner which, according to the CDC guidelines, may transmit HIV, Hepatitis B or C, this practice will proceed to test both the patient and health care worker who was exposed.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**MEDICARE AUTHORIZATION (if applicable)**

I request payment of authorized Medicare benefits to me made to Edward T. Wolanski, MD, PC for services rendered by this practice. I authorize release of my information to HCFA and its agents, information required to determine benefits. If I have other insurance, my signature authorizes release of information to that insurance company. In Medicare assigned cases, the practice agrees to accept Medicare's determination as payment in full, noting the patients' responsibilities for deductibles, co insurance and non covered services.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

*Thank you for your time completing this form!!*



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## HEALTH QUESTIONNAIRE

<b>Chart #</b>		<b>Today's Date:</b>	
Patient's Last Name: _____		Patient's First Name: _____	
Date of Birth: _____		Primary Physician: _____	
Reason For Visit Today: _____			
Current Method of Contraception (including Vasectomy or Tubal Ligation): _____			
<b>Current Meds Prescribed by Our Office:</b>		<b>Other Meds Currently Taking:</b>	
<b>Surgery/Hospitalization History:</b>		<b>Current Medical Conditions:</b>	
<b>Allergies:</b>		<b>Adverse Reactions:</b>	
<b>Provider notes:</b>			
<b>OBSTETRICAL HISTORY</b>			
How many times have you been pregnant? _____		How many children do you have? _____	
Any Miscarriages? YES NO How many? _____		Have you had any abortions? YES NO How many? _____	
<b>Have you had any of the following complications during pregnancy, delivery or post delivery care:</b>			
High Blood Pressure	YES NO	Diabetes	YES NO
Infection	YES NO	Bleeding	YES NO
Cesarean Section	YES NO	Anemia	YES NO
		Pre-Term Labor	YES NO
		Post Partum/Depression	YES NO
		Other:	
<b>Provider Notes:</b>			
<b>GYNECOLOGICAL HISTORY</b>			
Date of your last normal period?		At what age did you begin your periods?	
How often do your periods occur?		How long do your periods last?	
Are you sexually active?	YES NO	Date of your last mammogram. _____	
Do you perform self breast exams?	YES NO	Any history of abnormal mammograms?	YES NO
Do you have any vaginal itching?	YES NO	Any history of abnormal Pap Smears:	YES NO
Do you have any abnormal discharge?	YES NO	Date of your last Pap Smear: _____	
<b>Provider Notes:</b>			
<b>REVIEW OF SYSTEMS (Please circle any that apply))</b>			
Fatigue	YES NO	Migraines	YES NO
Dizziness	YES NO	Intestinal Problems	YES NO
Blurred/Double Vision	YES NO	Varicose Veins	YES NO
Chest Pain	YES NO	Phlebitis	YES NO
Chronic Cough	YES NO	Edema (swelling)	YES NO
Breathing Problems	YES NO	Blood Transfusion(date)	YES NO
Indigestion/GERD	YES NO	Reaction to transfusion	YES NO
Weight loss/gain (amt?)	YES NO	Poor Appetite	YES NO
Breast Tenderness	YES NO	Other: List	
Pelvic Pain or Pressure	YES NO		
		Food intolerance	YES NO
		Eating Disorder(name)	YES NO
		Urinary Stress Incontinence	YES NO
		Burning w/Urination	YES NO
		Blood in Urine	YES NO
		Anxiety/Nervousness	YES NO
		Insomnia	YES NO
		Breast Lump	YES NO
		Unusual Vag. Discharge	YES NO
		Irregular Bleeding	YES NO
<b>Provider Notes:</b>			

**Name:** \_\_\_\_\_ **Chart #** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PAST MEDICAL HISTORY: Please circle any that apply to you now or in the past**

Asthma	YES	NO	Kidney Stones	YES	NO	Hepatitis (A/B/C)	YES	NO
Blood Transfusion	YES	NO	Lung Disease/Cancer	YES	NO	Herpes	YES	NO
Bowel Problems	YES	NO	Thyroid Disease	YES	NO	HPV	YES	NO
Gallbladder Disease	YES	NO	Lupus	YES	NO	Syphilis/Gonorrhea	YES	NO
Fibromyalgia	YES	NO	Migraines	YES	NO	Substance Abuse	YES	NO
Depression	YES	NO	Mitral Valve Prolapse	YES	NO	Ulcers	YES	NO
Human Immunodeficiency Virus	YES	NO	Chlamydia	YES	NO	Skin Cancer	YES	NO
High Cholesterol	YES	NO						

**Provider Notes:** \_\_\_\_\_

**FAMILY HISTORY:** Have you or anyone in your family had(Use MGM for maternal grandmother, PGF for paternal grandfather, etc.)

	<i>OTHER FAMILY MEMBER</i>		<i>Self</i>		<i>OTHER FAMILY MEMBER</i>		
	<i>Self</i>	<i>MEMBER</i>	<i>Self</i>	<i>MEMBER</i>	<i>Self</i>	<i>MEMBER</i>	
Alzheimer's							Have you ever had a colonoscopy? YES    NO Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>  Date of your last one? _____ Was told to follow-up in yrs. ____
Birth Defects							
Blood Clot History							
Breast Cancer							
Colon Cancer							
Ovarian Cancer							
Heart Disease							

**Provider Notes:** \_\_\_\_\_

**SOCIAL HISTORY**

Do you smoke cigarettes?	YES	NO	Do you exercise?	YES	NO	
How many packs per day? _____ /How long? _____			How many times per _____ Week? _____ Month? _____			
Do you drink alcohol?	YES	NO	How many? _____	Seat Belt Use	YES	NO

**Provider Notes:** \_\_\_\_\_

**Please do not fill below out, until you return next year !!!!!**

**RETURN PATIENT HEALTH UPDATE      UPDATE FOR NEXT YEAR (return visit) Date: \_\_\_\_/\_\_\_\_/\_\_\_\_**

Reason for your visit today?	Date of last period?
Date of your last Mammogram? _____ Date of last PAP? _____	Surgery/Hospitalization since last visit?    YES    NO
Medications <b>CHANGES</b> since last visit?    YES    NO	Any <b>CHANGES</b> to Illness History?    YES    NO
List Changes: _____	List Changes: _____
To the best of my knowledge, the questions on this form have been answered. <b>Patient's Signature:</b> _____	
I have read and reviewed the information provided by the Patient/Guardian above. <b>Provider Signature:</b> _____	

**Provider Notes:** \_\_\_\_\_

**RETURN PATIENT HEALTH UPDATE      UPDATE FOR 2nd YEAR (return visit) Date: \_\_\_\_/\_\_\_\_/\_\_\_\_**

Reason for your visit today?	Date of last period?
Date of your last Mammogram? _____ Date of last PAP? _____	Surgery/Hospitalization since last visit?    YES    NO
Medications <b>CHANGES</b> since last visit?    YES    NO	Any <b>CHANGES</b> to Illness History?    YES    NO
List Changes: _____	List Changes: _____
To the best of my knowledge, the questions on this form have been answered. <b>Patient's Signature:</b> _____	
I have read and reviewed the information provided by the Patient/Guardian above. <b>Provider Signature:</b> _____	

**Provider Notes:** \_\_\_\_\_