Stephanie Taylor MD PhD
A Woman's Wellspring
26365 Carmel Rancho Blvd. Suite F
Carmel, CA 93923-8744
TELEPHONE 831-622-1995, FAX 831-622-1999

NAME: _____ AGE_____

DATE: _____

OCCUPATION: _____

New Patient History

Drug Allergies_____

Circle reason for today's visit Annual Exam Menopause Consultation Menstrual Problem Pain Discharge Possible Pregnancy Birth Control
Other:_____

Your Medical History (List all illnesses, and the year of onset)

_____

_____

_____

Your Surgical History (List all surgeries and year performed)

_____

_____

_____

Current Medications including contraceptives

Med_____ Dose_____ Med_____ Dose_____
Med_____ Dose_____ Med_____ Dose_____
Med_____ Dose_____ Med_____ Dose_____
Med_____ Dose_____ Med_____ Dose_____

Menstrual History

Started Age _____ regular _____irregular _____ other_____
First day of last period or date of onset of menopause_____
Average days between periods_____ Average days of bleeding_____ Heavy?_____
Any bleeding between periods?_____ Any bleeding after intercourse?_____
Any Pain with Intercourse?_____ Time with present Partner _____
What vaginal infections or STDs were treated in the past?_____
Date of last Pap smear_____ Any abnormal Pap smears?_____
Treatment for abnormal pap smears (please circle)? LEEP Freezing Cervix Cervical biopsies

OB History

Male or Female Year Born Months of Preg Labor duration Birth Weight Complications

Menopause History

Age at Menopause_____ Ever on Hormone Replacement? _____

Reason for HRT: Hot Flashes Night Sweats Insomnia Vaginal Dryness Other_____

List hormone therapy and duration_____

Family History	List relative	Age at Diagnosis	Current Status
Breast Cancer			
Colon Cancer			
Ovarian Cancer			
Heart Disease			
High BP			
Diabetes			
Thyroid disease			
Osteoporosis			

Social History

Alcohol Never Social Daily Current Use#_____/week

Tobacco Never Quit Current Smoker Number cigarettes/ day_____

Age at starting smoking_____ Age at quitting smoking_____

Regular Exercise? _____

Are you? Single Married Divorced Separated Caregiver Have Pets?

Screening History

Blood Work	Date_____	Results_____	Due_____
Pap/HPV	Date_____	Results_____	Due_____
Mammogram	Date_____	Results_____	Due_____
Bone Density	Date_____	Results_____	Due_____
Colonoscopy	Date_____	Results_____	Due_____
Other	Date_____	Results_____	Due_____

Symptom Review-circle all that apply or write in

General	Weight Gain Weight Loss Poor Sleep Fatigue
HEENT	Snoring Sleep Apnea Allergies Loss of Hearing Visual Changes
Heart	Chest Pain Heart Trouble Palpitations
Lungs	Cough Short of Breath Asthma
Digestion	Abdominal Pain Nausea Vomiting Constipation Diarrhea Bloating Heartburn/reflux Food intolerance
Urination	Frequent urination Urinary Urgency Loss of Urine Kidney Stones
Gynecology	Pelvic Pain Hot Flashes Night Sweats Vaginal dryness Pain with intercourse Vaginal discharge Pelvic Pain No Desire
Muscle/Joints	Muscle Pain Joint Pain Back Pain Neck Pain
Neurology	Migraines Memory changes Anxiety depression
Other	Chemically Sensitive Hair Loss Hot/Cold intolerance Excess Hair

STEPHANIE TAYLOR, M.D., Ph.D
PATIENT INFORMATION SHEET

Patient Name:_____ **Date:**_____
First M.I. Last

Mailing Address:_____ **City:**_____ **State:**____ **Zip Code:**_____

Street Address (if different from mailing):_____

Home Phone:_____ **Cell Phone:**_____ **Work Phone:**_____

Date of Birth:_____ **Marital Status:**_____

Email Address:_____

Employer:_____
Name Address City, State, Zip Code

Primary Care Physician:_____
Name Address City, State, Zip Code

Emergency Contact:_____
Name Home Phone Cell Phone

What Pharmacy do you use?:_____
Name Address City

HOW DID YOU HEAR ABOUT US?_____

INSURANCE INFORMATION

PLEASE COMPLETE THE FOLLOWING INFORMATION BELOW AND PRESENT YOUR INSURANCE CARD(S) TO THE RECEPTIONIST (TO BE ATTACHED TO YOUR LAB ORDER)

SELF-PAY: (circle one) ***Non Provider*** ***No Insurance***

Primary Insurance:_____ **Insured's Name:**_____ **DOB:**_____

Insured's address (if different from above):_____

Relationship to Insured (please circle one): ***Self*** ***Spouse*** ***Child*** ***Other*** **Insured's SSN#:**_____

Insured's Employer:_____
Name Address City, State, Zip Code

Physician charges will be due at time of service.
You are responsible to contact your insurance prior to services to determine if services provided are covered.
I consent to treatment for the care of the above patient. I authorize the release of all medical records to the referring and family physicians and to insurance carriers as needed to process a claim. I allow fax transmittal of medical records if necessary. I understand that I am financially responsible for all charges.

Patients Signature:_____ **Print Name:**_____

Stephanie Taylor, M.D. Ph.D.
26365 Carmel Rancho Blvd., Ste. F
Carmel, CA 93923

Office Hours:
Monday - Thursday 8:00 am - 4:30 pm
Closed for lunch 12:30 pm - 1:30 pm

Financial Policy

PLEASE READ, COMPLETE AND SIGN IN THE AREA BELOW.

Dr. Taylor is not contracted with any insurance. She will be an out of network provider. If you have insurance we will give you a Superbill upon request that has all the information you need to file a claim with your insurance company. You can call your insurance company or log on to their website for specific instructions on filing a claim for out-of-network services. Medicare, MediCal or Tricare cannot be billed.
Medicare and Tricare patients: Dr. Taylor does not have a UPIN number, therefore, you **cannot** submit for reimbursement. **Medicare recommends patients who send bills to Medicare after signing the Private Contract, be discharged from care.** _____
initial here

Payment is due at the time of service. We accept cash, check, Visa, MasterCard or Discover as means of payment. There is a **$25.00** charge for any returned checks.

There is a **$75.00** fee for cancellation of appointments with less than 24 hour notice and **$75.00** for any missed appointments._____
initial here

Current insurance cards must be presented at each visit to be attached to your lab order.
I have elected to see Dr Taylor and have been informed that she is not a provider with my insurance plan. I will pay for services at the time they are rendered.
I have read, understood, and agreed to the above financial policy for payment of professional fees. I am ultimately responsible for all professional fees, as well as knowing my insurance policy coverage and limitations.

_____

Patient Signature Print Name Date

Acknowledgement of Receipt of Notice

Stephanie Taylor, M.D., Ph.D.
26365 Carmel Rancho Blvd., Ste F
Carmel, CA 93923
Tel: (831) 622-1995
FAX: (831) 622-1999
www.womanswellspring.com

Karla-Privacy officer

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: _____.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: _____

For Office Use Only:

- ☐ Signed form received by: _____
- ☐ Acknowledgment refused:

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____