



DEBORAH D. WILSON, M.D.

Gynecology
Advanced Laproscopic Surgery

Dear Patient,

Our office has recently transitioned to electronic medical records. Your chart will be electronic from now on, and we need to update your information. Please complete all of the following information so that we may have an accurate record of your medical history.

Thank you. Deborah D Wilson, M.D.

Today's Date: _____

NAME: _____ **D.O.B:** _____

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

HAVE YOU HAD ANY RECENT GYNECOLOGICAL PROBLEMS? _____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? (PLEASE LIST THE DOSAGE AND HOW FREQUENTLY YOUR TAKE EACH ONE)

ARE YOU ALLERGIC TO ANY MEDICATIONS? (PLEASE LIST THE SPECIFIC REACTION)

PLEASE LIST ALL PAST & CURRENT MEDICAL CONDITIONS (DIABETES, HYPOTHYROIDISM, ETC.)

GYNECOLOGICAL HISTORY

DATE OF YOUR LAST PAP SMEAR _____

DATE OF YOUR LAST MAMMOGRAM _____

DATE OF YOUR LAST DEXA STUDY _____

DATE OF LAST MENSTRUAL PERIOD _____

HOW MANY DAYS IN BETWEEN YOUR PERIOD? _____

CAN YOU TELL YOUR PERIOD IS COMING? Y N IF SO, HOW? _____

DO YOU HAVE PAIN WITH YOUR PERIOD? Y N

DO YOU HAVE BLEEDING IN BETWEEN YOUR PERIODS? Y N

DO YOU HAVE A HISTORY OF ANY SEXUALLY TRANSMITTED DISEASES? Y N

(IF YES, PLEASE DESCRIBE) _____

WHAT ARE YOU PRESENTLY USING FOR BIRTH CONTROL? _____

WHAT HAVE YOU USED IN THE PAST FOR BIRTH CONTROL? _____

DO YOU HAVE AN IUD FOR BIRTH CONTROL? Y N PARAGAURD OR MIRENA

HOW OLD WERE YOU WHEN YOUR PERIOD FIRST STARTED? _____

ARE YOU MENOPAUSAL? Y N IF YES, WHEN DID YOU START? _____

HAVE YOU EVER HAD ANY PROBLEMS WITH INFERTILITY? Y N _____

ARE YOU SEXUALLY ACTIVE? Y N IF YES, WITH MALE FEMALE BOTH

HAVE YOU EVER HAD A PELVIC ULTRASOUND? Y N IF YES, WHAT WERE THE RESULTS? _____

HAVE YOU EVER HAD AN ENDOMETRIAL BIOPSY? Y N IF YES, WHAT WERE THE RESULTS? _____

HAVE YOU EVER HAD A COLPOSCOPY? Y N IF YES, WHAT WERE THE RESULTS? _____

HAVE YOU EVER HAD LASER TREATMENT OF THE VULVA/ VAGINA/ CERVIX? Y N WHY? _____

HAVE YOU EVER HAD A LOOP EXCISION OF THE CERVIX? Y N

HAVE YOU EVER HAD CRYOSURGERY? Y N

OBSTETRICAL HISTORY

HOW MANY TIMES HAVE YOU BEEN PREGNANT? _____

HOW MANY DELIVERIES HAVE YOU HAD? _____

WERE THEY VAGINAL DELIVERIES OR C-SECTION? _____

HOW MANY MISCARRIAGES HAVE YOU HAD? _____

HOW MANY TERMINATION OF PREGNANCIES HAVE YOU HAD? _____

HAVE YOU EVER HAD AN ECTOPIC PREGNANCY? Y N

IF YES, WAS THIS TREATED SURGICALLY OR WITH MEDICATION? _____

ARE YOU PLANNING A PREGNANCY IN THE FUTURE? Y N

SURGICAL HISTORY

DO YOU HAVE ANY MEDICAL PROBLEMS? Y N

IF YES, PLEASE DESCRIBE? _____

HAVE YOU HAD SURGERY OF ANY KIND? Y N (IF YES, PLEASE LIST BELOW)

PLEASE LIST GYNECOLOGICAL SURGERY FIRST, AND PLEASE GIVE THE DATES OF YOUR SURGERY

HAVE YOU BEEN HOSPITALIZED FOR A NON-SURGICAL REASON? Y N

IF YES, PLEASE GIVE THE DATE AND REASON FOR YOUR HOSPITALIZATION. _____

FAMILY HISTORY

| FAMILY MEMBER | AGE | ALIVE | DECEASED | MEDICAL PROBLEMS | AGE AT DEATH | CAUSE OF DEATH |
|----------------------|-------|-------|----------|------------------|--------------|----------------|
| FATHER | _____ | _____ | _____ | _____ | _____ | _____ |
| MOTHER | _____ | _____ | _____ | _____ | _____ | _____ |
| CHILDREN | _____ | _____ | _____ | _____ | _____ | _____ |
| SIBLING(S) | _____ | _____ | _____ | _____ | _____ | _____ |
| ADOPTED | _____ | _____ | _____ | _____ | _____ | _____ |
| MATERNAL GRANDFATHER | _____ | _____ | _____ | _____ | _____ | _____ |
| MATERNAL GRANDMOTHER | _____ | _____ | _____ | _____ | _____ | _____ |
| PATERNAL GRANDFATHER | _____ | _____ | _____ | _____ | _____ | _____ |
| PATERNAL GRANDMOTHER | _____ | _____ | _____ | _____ | _____ | _____ |
| MATERNAL AUNT | _____ | _____ | _____ | _____ | _____ | _____ |

ANY FAMILY HISTORY OF BREAST, OVARIAN, UTERINE, CERVICAL, OR COLON CANCER IN YOUR FAMILY? Y N

ANY FAMILY HISTORY OF OSTEOPOROSIS? Y N

SOCIAL HISTORY

ARE YOU A SMOKER? Y N IF YES, HOW MANY PACKS PER DAY? _____

HAVE YOU SMOKED IN THE PAST? Y N HOW LONG DID YOU SMOKE? _____ WHEN DID YOU QUIT? _____

DO YOU USE RECREATIONAL DRUGS? Y N IF YES, WHAT KIND. _____

DO YOU EXERCISE? Y N WHAT KIND? _____ HOW OFTEN? _____

DO YOU DRINK ALCOHOL? Y N WHAT KIND? _____ HOW MUCH? _____

WHAT IS YOUR OCCUPATION? _____

ARE YOU EXPOSED TO ANY CHEMICALS OR HAZARDS AT WORK? Y N

WHAT IS YOUR MARITAL STATUS? SINGLE MARRIED WIDOWED DIVORCED SEPERATED

WHO LIVES WITH YOU AT HOME? _____

DO YOU HAVE ANY CONCERNS OVER EMOTIONAL AND OR PHYSICAL SPOUSAL ABUSE? Y N

REVIEW OF SYSTEMS

DO YOU HAVE ANY ABNORMALITIES OF:

IF YES, PLEASE EXPLAIN

| | | | |
|---|---|---|-------|
| SKIN | Y | N | _____ |
| ENDOCRINE SYSTEM (THYROID PROBLEMS, DIABETES) | Y | N | _____ |
| NERVOUS SYSTEM | Y | N | _____ |
| EYES | Y | N | _____ |
| RESPIRATORY SYSTEM | Y | N | _____ |
| ALLERGIES | Y | N | _____ |
| BLOOD | Y | N | _____ |
| URINARY SYSTEM | Y | N | _____ |
| EARS, NOSE, AND THROAT | Y | N | _____ |
| HEART OR VASCULAR SYSTEM | Y | N | _____ |
| DIGESTIVE SYSTEM | Y | N | _____ |
| MUSCLES OR JOINTS | Y | N | _____ |
| HAVE YOU HAD ANY PSYCHOLOGICAL PROBLEMS? | Y | N | _____ |

DEBORAH WILSON M.D.

.....ALEXANDRA KIDD M.D.

GYNECOLOGY
ADVANCED LAPROSCOPIC SURGERY

PATIENT NOTICE OF FINANCIAL POLICY

PATIENT NAME: _____

D.O.B: _____

Our office is committed to providing you with the best possible health care, and we will be happy to discuss our professional fees with you. Your clear understanding of our Financial policy is important to our professional relationship. Please ask if you have any questions about our fees, our Financial Policy or your financial responsibility.

All patients must complete our patient information forms before seeing the doctor and or nurse practitioner.

It is important that you understand that you are responsible for all charges that may occur during your visit. In addition to paying for any insurance co-payment at the time of your appointment, you may also be responsible for charges not covered by your insurance carrier. If your insurance carrier denies the medical claim submitted by our office in its entirety, or any part of the claim, the patient and/ or responsible party will be responsible for the bill per the insurance contract regulations. Your insurance and/ or responsible party is ultimately responsible for timely payment of the account. All **patient balances** are due within 30 days of notification.

Communication with our patients regarding our financial policy is essential. If you have any special needs or concerns regarding this policy, please bring them to our attention. We are here to help you and to provide you with the best service.

I have read the financial policy for the office and understand that I am ultimately **responsible** for all charges on my account. It is my financial responsibility to remit payment for any charges not covered by my insurance plan(s) including, but not limited to co-insurance, co-payments and deductibles. I understand that **co-payments for office visits are due at the time of the service.**

I understand that **patient balances** are due within 30 days of notification. I understand that once my account is put into collections, **this office will discharge me as a patient and that I will be held responsible for any additional charges to collect any and all unpaid balances, including but not limited to collection agency fees, attorneys and any interest charged by the practice.**

As of September 1, 2008 if we need to make payment arrangements with you, an added annual interest rate of 24% yearly or 2% monthly will be added to the outstanding balance.
Please give 24 hours notice if you will be unable to keep your appointment,

missed appointments and appointments not cancelled with a 24 hours notice are subject to a Late Cancellation/No Show fee of \$35.00.

Three (3) No Shows will result in your being discharged from our Practice.

Patient Name – PLEASE print

Date

Patient Signature (REQUIRED)

Date

Signature

Relationship to Patient

All payments, including co-pays and co-insurance are due at the time the service is rendered. If you have an HMO or a plan that requires pre-authorization for services performed at our office, you must arrange to have the service authorized **BEFORE** your appointment. Please check your insurance coverage **BEFORE** your appointment if you are coming for a well woman visit. Thank you.

DATE: _____ E-MAIL ADDRESS: _____

PLEASE USE FULL LEGAL GIVEN NAME. DO NOT USE INITIALS OR NICKNAMES

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

D.O.B : _____ SOCIAL SECURITY # : _____

HOME ADDRESS: _____ APARTMENT #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE#: _____

MARITAL STATUS: _____ REFERRED BY: _____

EMPLOYER: _____ PHONE # : _____

EMPLOYMENT STATUS : FULL TIME PART TIME SELF EMPLOYED RETIRED NOT EMPLOYED STUDENT DISABLED

OCCUPATION: _____ OR SCHOOL NAME: _____

PRIMARY CARE PROVIDER: _____ PHONE # : _____

PRIMARY INSURANCE : _____ NAME OF INSURED: _____

CLAIMS ADDRESS: _____

ID/ POLICY # : _____ GROUP # : _____

SECONDARY INSURANCE: _____ NAME OF INSURED: _____

CLAIMS ADDRESS: _____

ID/ POLICY # : _____ GROUP # : _____

POLICY HOLDERS NAME: _____ D.O.B : _____

PHONE # : _____ SOCIAL SECURITY # : _____

EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT : _____ PHONE # : _____

ADDRESS: _____ RELATIONSHIP: _____

CONSENT TO TREAT

I, _____, HEREBY CONSENT TO MEDICAL CARE TO BE ADMINISTERED BY DEBORAH D WILSON, M.D. AND STAFF (A PHOTOCOPY OF THIS SIGNATURE IS ACCEPTABLE AS THE ORIGINAL)

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional fees rendered. I have read all of the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information

DATE: _____ REQUIRED PATIENT SIGNATURE: _____

DATE: _____ SIGNATURE: _____

PERSON LEGALLY AUTHORIZED TO CONSENT FOR THE PATIENT

RELATIONSHIP TO THE PATIENT: _____

DEBORAH D. WILSON, M.D.
ALEXANDRA KIDD, M.D.
PEGGY DECAROLIS WHCNP PAULA MAZZACANO WHCNP
ROBIN PARRY C-NP

IMPORTANT PATIENT INFORMATION

LABORATORY SPECIMEN COLLECTION AND PROCESSING

Dr. Wilson's office provides a laboratory drawing station for your convenience. This laboratory is a collection site only.

Please make sure you have given the front desk your most current insurance information, as your insurance carrier decides what laboratory processes your specimen.

Our technician will collect the specimen and forward it to the specified laboratory for processing. The processing Lab will bill your insurance carrier directly. Should you have any questions regarding your lab bill, please contact the appropriate lab-billing department, or the billing number that appears on your lab statement.

| | |
|------------------------|---------------|
| LAB CORP | 602-454--8000 |
| SONORA QUEST | 602-685-5050 |
| MEDICAL DIAGNOSTIC LAB | 877-269-0090 |

If you are unsure of your coverage, please call your insurance carrier and return at a later date for the specimen collection. **Dr. Wilson's billing department does not verify benefits for lab work**

WELL WOMEN VISITS:

Most insurance carriers provide for a yearly well-women visit. However, if you are not sure of your benefits, please contact your insurance carrier before your visit. A diagnosis code cannot be changed once we bill your insurance carrier.

If a referral is needed, it is the patient's responsibility to contact her primary care physician to obtain the referral. **This may take 1-2 weeks to process.**

TEST RESULTS:

You will be contacted with all test results. Please contact our office if you have not received your results within 14-21 days.

DEBORAH WILSON, M.D.
*******ALEXANDRA KIDD, M.D.**
PEGGY DECAROLIS WHCNP PAULA MAZZACANO WHCNP
ROBIN PARRY C-NP
ADVANCED LAPAROSCOPIC SURGERY
GYNECOLOGY

WWW.DRWILSONOBYGYN.COM

8997 E. DESERT COVE 1ST Floor Scottsdale, Arizona 85260 480-860-4791

Dear Patient:

Dr. Deborah Wilson and her staff would like to welcome you to our practice and take an opportunity to introduce you to the aesthetic services available at our office.

We offer *LightSheer (Laser Hair Removal)*~ LightSheer treatments are safe, non-invasive long term solutions to unwanted hair on all body parts and any skin type. Say Good-bye to messy creams and temporary solutions in an hour or less, you will begin to see smoother, sleeker skin. You can even resume your regular activities immediately following treatment .

IPL Photo Rejuvenation ~ Scientifically proven “pulsed light” technology to rejuvenate the skin. Decreasing redness, brown spots and fine lines while shrinking pores. Treats medical conditions such as rosacea, telangiectasias and melasma. IPL can be applied to any part of the body.

Microdermabrasion ~ The revolutionary way to re-texturize your skin, and add luminosity and clear out those pores. Microdermabrasion introduces small “crystals” delivered pressure to slough off dead cells and stimulate new cell growth.

Peels~ This treatment is an excellent deep cleanser. It dissolves oil by penetrating and cleaning out clogged pores. It diminishes blackheads and pimples. It also prevents skin blemishes from forming. The skin will immediately feel smoother, softer, and will appear more evenly pigmented.

Sclerotherapy/Laser Vein Treatment~ Non surgical treatment for varicose vein and spider veins. With the sclerotherapy technique, we use a fine needle to inject a small amount of a solution into the affected vein. The sclerosant solution causes the vein to seal up and disappear. With the laser vein treatment, the laser throws heat into the vessel collapsing it onto its self and *the vein disappearing*.

Restylane~ Restylane is made in Sweden, a nation known for health, nature and beauty. Since 1996, more than a million people have been successfully treated in more than 60 countries worldwide. It is a safe and natural cosmetic dermal filler that restores volume and fullness to the skin wrinkles and folds. Restylane is also different than traditional collagen because it delivers a longer-lasting effect with virtually no risk of animal based disease transmission or allergic reaction.

Feel free to call “Skintique” to schedule a complimentary consultation at 480-860-9383 or 480-860-4791.

Our “Skintique” office is located at 10752 N. 89th Place Suite 102.

DEBORAH WILSON M.D. ALEXANDRA KIDD M.D.

**PEGGY DECAROLIS WHCNP, PAULA MAZZACANO WHCNP
ROBIN PARRY C-NP**

NOTICE OF PRIVACY PRACTICE

To our Patients: This notice describes how health information about you, as a patient of this practice may be used and disclosed, how you may obtain access to your Health Insurance Portability and Accountability Act of 1996 (**HIPAA**).

Our commitment to your Privacy:

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, however, we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances.

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement officials.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To Correctional institutions or law enforcement officials if you are in inmate or under the custody of law enforcement officials.
8. For Workers Compensation and similar programs.

Your Rights Regarding your Health Information:

1. Communications, you request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for the treatment, payment, or health care operations.

Notice of Privacy Practices

Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing *to Deborah Wilson, M.D. 8997 E. Desert Cove, First floor, Scottsdale, Arizona 85260.*
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to *Deborah Wilson, M.D. 8997 E. Desert Cove Avenue, First Floor Scottsdale, Arizona 85260*
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact *Deborah Wilson, M.D. 8997 E. Desert Cove Avenue, First Floor Scottsdale, Arizona 85260*
6. Right to file a complaint. If you believe your privacy rights have been violated you may file a complaint with our Practice Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the Office of Deborah Wilson, M.D. at 480-860-4791 and to speak to the Office Manager.

I hereby acknowledge that I have been provided and have reviewed the *Notice of Privacy Practice.*

Signature: _____

Date: _____

Please Print Name: _____

Source: Advocacy Resource Center of the American Medical Association, October 1999