Welcome to Our Practice

At South Shore Women's Health we provide comprehensive Gynecologic and Obstetric services on Boston's South Shore. Our practice consists of seven Obstetrician Gynecologists, four Nurse Practitioners, and three Physician Assistants. We are affiliated with South Shore Hospital in Weymouth, Massachusetts.

We provide a full range of gynecologic care including routine exams, preconceptual counseling, pap smear evaluation, STD screening, birth control counseling, the evaluation of abnormal menstrual cycles, PMS treatment, and menopause care. It is also our privilege to provide obstetric care throughout pregnancy and birth.

Our philosophy is one of patient education and provider-patient teamwork to reach our common goal (your good health!) All patients may choose to see either a physician, a nurse practitioner, or a physician assistant as their primary provider. Please visit our web site at www.southshorewomenshealth.com for more information about our providers and our services.

Pre-registration
We have enclosed our patient registration and medical history forms. It would be greatly appreciated if you would take the time to complete them prior to your visit. You may either fax them to our office or bring them with you for your appointment.

Insurance
South Shore Women's Health participates with the following insurance plans. Please click on the individual plan name to obtain more information about general requirements. It is the responsibility of patients to know their individual benefits, so please consult your plan directly if you have questions regarding coverage of specific services.

As of January 1st, 2001, referrals are no longer required by plans for most Ob/Gyn services in Massachusetts. However "self-funded" plans and MassHealth may require referrals, and some services, such as infertility also still require referrals. Check with your insurance carrier for further information about their policies for referrals.

Insurance Plans

Aetna   Blue Shield   CIGNA   Fallon Community Plan   Network Health   MassHealth   First Health
Great West Health Care   Harvard Pilgrim Health Care   Humana/Choicecare   Medicare
Neighborhood Health Plan   Private Health Care System   Tufts Health Plan   Unicare   United Health Care
BMC Healthnet

We will request your co-payment during the registration process.

Appointments

Office visits are by appointment only. The scheduler may ask you about your illness or the reason for your visit in order to adequately schedule the physician's time. If you feel that you need to be seen on an urgent basis, you will be connected with our triage nurse.
As a new patient, *please arrive 15 minutes early* for your appointment so that we can process your information into our system. Be sure and bring your insurance card and a photo ID for identification purposes.

Cancellations

If you are unable to keep an appointment, please notify us at least 24 hours in advance. This will allow us to give your appointment slot to another patient. We will remind you of your appointment 24 – 48 hours in advance.

No Show – A missed appointment with no notice of cancellation

We understand that on occasion an appointment can be forgotten. It leaves your provider with an empty slot in their schedule and unable to see another patient. Both your time and your provider's time are valuable. With that in mind, please note that a continued pattern of not showing for appointments may result in your inability to pre-book future appointments.

Prior to your visit, if you have any questions regarding are policies or the enclosed forms please do not hesitate to call us for assistance.

90 Libbey Parkway, Suite #105
Weymouth, MA 02189
339-201-4120

689 Bedford Street
Whitman, MA 02382
781-447-4001

118 Long Pond Road, Suite 200
Plymouth, MA 02360
774-773-9976

PATIENT MEDICAL HISTORY FORM

Patient Name: ____ DOB: ____________________

Primary Care Physician: ______________________________ Phone #: (_____) ____________________

Reason for referral / appointment: ____

MENSTRUAL HISTORY (Complete even if post-menopausal or no longer having periods)

Age at first period: _____________

If your menstrual periods are regular; periods start every: _____________ days

If your menstrual periods are irregular; periods start every: _______ to _______ days (e.g., 12 to 60)

Duration of bleeding: _______ days

Does bleeding or spotting occur between periods? ☐ Yes ☐ No

Does bleeding or spotting occur after intercourse? ☐ Yes ☐ No

First day of last menstrual period ______________________ (Month / Day / Year) Menopause: ☐ Yes ☐ No

Do you have pain associated with periods? ☐ Yes ☐ No ☐ Occasionally

If yes, is the pain before? ☐ Yes ☐ No During? ☐ Yes ☐ No

PREGNANCY HISTORY (Please list ALL pregnancies) ☐ Never been pregnant

OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES

Year	Place of Delivery	Duration of Pregnancy	Hours of Labor	Type of Delivery	Complications Mother/Infant	Infant Sex	Infant Weight	Present Health of child

PREGNANCY RISK FACTORS: ***Fill out this Section only if you are pregnant or planning to become pregnant in the near future***

Have you or the baby's father or anyone in your families ever had any of the following:

Down Syndrome (Mongolism)? If yes, who? ______________________________

Other Chromosomal abnormality? If yes, specify and who? ______________________________

Neural tube defect (spina bifida, anencephaly)? If yes, specify and who? ______________________________

Hemophilia or other coagulation abnormality? If yes, specify and who? ______________________________

Muscular Dystrophy? If yes, who? ______________________________

Cystic Fibrosis? If yes, who? ______________________________

Patient Name: ______________________________ **DOB:** ______________________

BIRTH CONTROL HISTORY
What birth control method(s) do you currently use? ______________________________
What birth control method(s) have you used in the past? ______________________________

SEXUAL HISTORY
Have you ever had a sexual partner? ☐ Yes ☐ No Age you became sexually active? ____________

HEALTH HISTORY

☐ Liver Disease (including hepatitis)
☐ Epilepsy
☐ Blood Transfusions
☐ Thyroid disease
☐ Asthma
☐ Emphysema
☐ Bronchitis
☐ HIV +
☐ Eating Disorder
☐ Other: ______________________________

CURRENT MEDICATIONS (Please list ALL medications. Please use back of form if more room is needed.)

Medication	Dose	Frequency	Prescribed By

Pharmacy Information:
Name: ______________________ **Address:** ______________________________

Phone: ______________________________

OVER THE COUNTER MEDICATIONS / VITAMINS / SUPPLEMENTS – Please List ALL

Name	Dose	Frequency	Taken for

ALLERGIES: Please list ALL known allergies -or- ☐ None

Allergy	Reaction / Symptoms

Patient Name: ____ **DOB:** ____________________________

SOCIAL HISTORY:

Do you smoke: ☐ Yes ☐ No Packs per day: _______ / cigarettes per day: _______ How many years: _______
Drink alcohol: ☐ Yes ☐ No Wine (glasses/day): _____ Beer (bottles/day): _____ Hard Liquor (oz. /day): _____
Use street drugs: ☐ Yes ☐ No Type: _______________ Amount: _______________ How often: _____________
Exercise: ☐ Yes ☐ No Type: ______________________________ How often: ____________________________

Your occupation: ____ Employer: ____________________________________

Marital Status: ☐ Married ☐ Single ☐ Widow ☐ Divorced ☐ Separated

Do you feel threatened or unsafe in your current relationship? ____

Do you have a history of: Emotional abuse: ☐ Yes ☐ No Sexual abuse: ☐ Yes ☐ No
Physical abuse: ☐ Yes ☐ No Verbal abuse: ☐ Yes ☐ No

FAMILY HISTORY Please check all that apply

☐ Diabetes
☐ High Blood Pressure
☐ High Cholesterol
☐ Heart Disease

☐ Breast Cancer
☐ Ovarian Cancer
☐ Endometrial Cancer
☐ Colon Cancer

☐ Bleeding Disorder
☐ Osteoporosis
☐ Thyroid Disease
☐ Genetic Disorder

Other: ____

If "yes" to any, please list affected relatives and which disease applies:

____

OTHER SYMPTOMS Please check all that apply and list the year

☐ None

Have you recently experienced:

☐ Weight Loss
☐ Hair Growth
☐ Hair Loss
☐ Change in exercise tolerance

☐ Weight Gain
☐ Change in engergy
☐ Change in urinary function
☐ Hot Flushes / Flashing

☐ Breast Discharge
☐ Other: _______________
____
____

Patient Name: ______________________ **DOB:** ______________________

PAST OBSTETRICAL / GYNECOLOGICAL SURGERIES **Please check all that apply**

YEAR

☐ D&C ____________
☐ Hysteroscopy ____________
☐ Infertility Surgery ____________
☐ Tuboplasty ____________
☐ Tubal Ligation ____________
☐ Laparoscopy ____________
☐ Hysterectomy ____________
Abdominal or Vaginal
☐ Myomectomy ____________

YEAR

☐ Ovarian Surgery ____________
☐ L cyst(s) removed ovarian ____________
☐ R cyst(s) removed ovarian ____________
☐ L ovary removed ____________
☐ R ovary removed ____________
☐ Vaginal or bladder repair ____________
for: Prolapsed or incontenence
☐ Cesarean Section ____________
☐ Other (Specify): ______________________

PAST SURGICAL HISTORY **(Not OB/GYN)**

Please list all surgeries and the year performed ☐ **NONE**

Surgery:	Year

PAST SMEAR / MAMMOGRAM HISTORY

Date of last PAP smear? ______________ Date of last Annual Wellness Exam: ______________
Have you ever had an abnormal PAP smear? ☐ Yes ☐ No
Have you ever had treatment for an abnormal pap smear? ☐ Yes ☐ No
If yes, what type(s) of treatment have you had?
Check all that apply:
Cryotherapy ☐ Yes ☐ No
Colposcopy ☐ Yes ☐ No
Cone Biopsy ☐ Yes ☐ No
Loop Excision (LEEP) ☐ Yes ☐ No

OTHER PAST GYNECOLOGICAL HISTORY **Please check all that apply** **or** ☐ **None**

Year Treated

Venereal Warts ☐ Yes ☐ No ____________
Herpes – Genital ☐ Yes ☐ No ____________
Syphilis ☐ Yes ☐ No ____________
Pelvic Inflammatory disease ☐ Yes ☐ No ____________

Year Treated

Endometriosis ☐ Yes ☐ No ____________
Chlamydia ☐ Yes ☐ No ____________
Gonorrhea ☐ Yes ☐ No ____________
Vaginal Infections ☐ Yes ☐ No ____________

Other: ______________________

Patient Name: ______________________________ **DOB:** ____________________

PERSONAL MEDICAL HISTORY **Please check all that apply** ☐ **None**

☐ Arthritis ☐ High Blood Pressure ☐ Kidney Disease
☐ Diabetes ☐ Heart Disease ☐ Gallstones

OTHER SCREENING EXAMINATIONS:

Date of last Colonoscopy: ____________________ Performed by: ________________________

Date of last Bone Density Scan (DEXA): __________________ Location: ____________________

ADDITIONAL COMMENTS / CONCERNS: Please list any additional comments, concerns or questions you would like to be addressed by your provider.

____

____

____

____

____

____

____

Patient Signature: ______________________________________ **Date:** ______________

STAFF REVIEW:

Comments:

____

____

____

Nurse Signature: ____ **Date:** ____________

SOUTH SHORE WOMEN'S HEALTH
Obstetrics • Gynecology • Midwifery

PATIENT REGISTRATION

Name: ______________________________ Maiden Name: __________ DOB: __________
Last First MI

Mailing Address: ______________________________ Marital Status: ______ SS#: ________
Street Town State Zip

Cell Phone: ______________ Home Phone: ______________ Email: ______________

Employer: ______________________________ Occupation: ______________

Address: ______________________________ Work Phone #: ______________
Street Town State Zip

Primary Care Physician/Referring Physician: ______________________________

Preferred Pharmacy Name/Address: ______________________________ Phone #: ______________

Race

____ American Indian or Alaska Native
____ Asia
____ More than one race
____ Other Pacific Islander
____ White
____ Black or African American
____ Native Hawaiian
____ Other

Ethnicity

____ Hispanic or Latino
____ Not Hispanic or Latino

Primary Language: ______________

Insurance Information

Insurance Coverage: Yes ____ No ____

Name of Insurance: ______________________________

Type of Plan: HMO ____ PPO ____ Other ____

Company Name if Group Policy: ______________________________

Subscriber: ______________________________

Subscriber Date of Birth: ______________________________

Subscriber Soc. Sec. #: ______________________________

Relationship: Self ____ Spouse ____ Child ____ Other ____

Policy Number: ____________ Member Number: ____________

Group Number: ______________________________

If MassHealth: Recipient ID Number: ______________________________

Managed Care Org: ______________________________

If you have a second insurance, indicate below:

Name of Insurance: ______________________________

Subscriber: ______________________________

Subscriber Date of Birth: ______________________________

Relationship: Self ____ Spouse ____ Child ____ Other ____

Policy Number: ____________ Member Number: ____________

Group Number: ______________________________

Guarantor (Person who has financial responsibility) Same as Subscriber? Yes ____ No ____

Name: ______________________________

Address: ______________________________ Relationship: __________ Home Phone #: ______________

Employer: ______________________________ Employer Phone#: ______________

Name of nearest relative not living with you

Name: ______________________________ Relationship: ______________

Address: ______________________________ Home Phone #: ______________

Medical Information and Payment Authorization

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor group indicated on the claim. I understand I am financially responsible for any balance not covered by my carrier. A copy of this signature is as valid as the original.

Signature: ______________________________ Date: ______________

How did you hear about our office?

☐ Friend/Family ☐ Referral ☐ Health Fair ☐ Newspaper ☐ Magazine ☐ Website ☐ Other ______________

Which newspaper / magazine? ______________

ACKNOWLEDGEMENT / RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form I acknowledge the receipt / reading of South Shore Women's Health, PC, Notice of Privacy Practices (Reception Room plaque or brochure) which provides me with detailed information about how South Shore Women's Health, PC may use and disclose my protected health information for the purposes of treatment, payment and health care operations.

In addition, by signing below, I understand that I hereby authorize the Practice to disclose my medical information so that the Practice may treat, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations.

Patient's Signature:____ Date:__________________

Patient's Name:____ DOB:_________________
(Printed Name)

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY, FRIENDS AND / OR OTHER REPRESENTATIVES

NAME	RELATIONSHIP	TELEPHONE #

Patient's Signature:____Date:_________________