RETURN VISIT INFORMATION UPDATE FORM: Please answer the questions accurately and in detail. It is very important that we are aware of any new developments in your medical status as well as that of your family.

1. What is the reason for your visit today? ____________________________________________

2. Do you have any specific gynecologic concerns or complaints? ____________________________

3. Has anything changed for you since you were last seen in this office? ____________________________

4. What medications are you currently taking? Please include hormones, including over the counter preparations, birth control, or any other gynecologic medications. Please list the dosage and how frequently you take your medication.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
<th>How long have you taken this drug?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1._________</td>
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5. Are you allergic to any medications? ________________________________________________

6. Have you been diagnosed with any new medical conditions since you were last seen in this office? ____________________________

7. Have you been hospitalized or had any surgery since your last visit? ____________________________

GYNECOLOGIC PROFILE:

8. When was the 1st day of your LMP? ________________________________________________

9. What was the date of your last mammogram? ____________________________________________

10. What was the date of your last bone density DEXA screen? ____________________________

11. What was the date of your last pelvic ultrasound, CT scan or MRI? ____________________________

12. Are you experiencing any abnormal bleeding? ____________________________________________

13. Are you having pelvic pain? _______________________________________________________

14. Have there been any changes in your personal situation (marriage, divorce, etc.)? ____________________________

15. Are you sexually active?_________ Is your Partner male ___________ Or Female ___________

16. Have there been any changes in your family medical history (new diagnosis of cancer, blood clotting disorders etc.)? ____________________________

Rev. 07/2014
## REVIEW OF SYSTEMS: CHECK ALL THAT APPLY

### UROLOGY
- Difficulty Urinating
- Blood in Urine
- Frequent Urination
- Urinary Incontinence
- Urinating throughout the night
- Urinary Urgency

### HEMATOLOGY
- Fatigue
- Loss of Appetite
- Varicose Veins
- Easy Bruising

### ALLERGY
- Runny Nose
- Itchy Eyes
- Ear Fullness
- Sinus Congestion

### RESPIRATORY
- Shortness of Breath
- Chest Pain
- Wheezing
- Cough

### OPTHALMOLOGY
- Diminished Vision
- Eye Irritation
- Drainage from Eyes
- Blurring of Vision
- Seasonal Eye Symptoms
- Dander Related Eye Symptoms
- Loss of Vision

### NEUROLOGY
- Headache
- Tingling/Numbness
- Seizures
- Insomnia
- Memory Loss
- Dizziness
- Gait Abnormality

### CONSTITUTIONAL
- Weight Gain
- Loss of Appetite
- Fever
- Weakness
- Weight Loss
- Night Sweats
- Insomnia
- Bloating
- Fatigue
- Headache

### EARS, NOSE, THROAT
- Cold
- Cough
- Hearing Loss
- Ringing in Ears
- Sinuses
- Sore Throat

### CARDIOLOGY
- Chest Pain
- Palpitations
- Leg Swelling
- Dizziness
- Shortness of Breath
- Varicose Veins

### GASTROENTEROLOGY
- Nausea
- Heartburn
- Vomiting
- Difficulty Swallowing
- Abdominal Pain
- Diarrhea
- Constipation
- Blood in Stool

### DERMATOLOGY
- Rash
- Moles
- Lumps
- Dry or Sensitive Skin
- Hives

### MUSCULOSKELETAL
- Joint Swelling
- Joint Pain
- Leg Cramps
- Joint Stiffness

### PSYCHOLOGY
- High Stress Level
- Depression
- Sleep Disturbances
- Eating Disorder
- Mental or Physical Abuse
- Anxiety

### FEMALE REPRODUCTIVE
- Heavy periods
- Painful intercourse
- Sexually Active
- Frequent Yeast Infections
- Pelvic Pain
- Contraception
- Painful Periods
- Night Sweats
- Insomnia
- Bleeding Between Periods
- Moodiness
- Loss of Urine
- Absence of Period
- Abnormal
- Spotting/Bleeding
- Lack of Sexual Desire
- Abnormal Vaginal Discharge
- Hot Flashes
ASSIGNMENT OF RIGHTS AND BENEFITS

<table>
<thead>
<tr>
<th>Date</th>
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I, ________________________________, understand that services rendered to me by Deborah D. Wilson, MD and Associates are my financial responsibility and that the provider will bill my insurance company, __________________________ as a courtesy. I authorize my insurance company to pay my benefits directly to Deborah D. Wilson, MD and Associates and I understand that I will be fully responsible for any outstanding balance on my account.

This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by __________________________.

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Deborah D. Wilson, MD and Associates. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

_____________________________ _____________________________
Signature of Patient or Guardian Witness Date
SURGERY CANCELLATION POLICY

Date Patient

In the event you need to have surgery, we need you to please read and sign this policy.

In order for us to maintain our efficiency in the Operating Room, as well as giving full consideration to the hospital staff and anesthesia staffing, it has become necessary for us to implement a cancellation policy.

If you need to cancel your surgery, we ask that you do so in a timely manner:

- Cancellations within two (2) weeks of surgery will be charged a $300.00 fee
- Cancellations within seventy-two (72) hours will be charged a $500.00 fee

We understand that sometimes it may be necessary to reschedule a surgical procedure, due to child illness, unforeseen death, etc., therefore we will allow for a one-time reschedule and forgo the cancellation fee if done in a timely manner. Any additional reschedules will be charged $150.00, plus the cancellation fee.

This policy will be effective May 1, 2008, please understand the time consideration involved in the surgical scheduling process.

We thank you in advance for your co-operation.

Sincerely,
Deborah D. Wilson, MD

Signature of Patient or Guardian ________________________
Printed Name _______________________________________
Date ________________
RELEASE OF INFORMATION

In case of an Emergency who would you authorize us to speak with and release records to:

☐ I __________________________________________ give express written consent to the physicians and staff of this practice to disclose any information pertaining to my health and medical records _________________________________.

(specify full name and relationship)

Signature of Patient or Guardian __________________ Printed Name __________________ Date ____________

— OR —

☐ I decline release of any information regarding my medical health:

Signature of Patient or Guardian __________________ Printed Name __________________ Date ____________

Rev. 03/2015