



Welcome and thank you for choosing to become a patient of our practice. We will work diligently to ensure that you receive the best care available. We would like to take this opportunity to familiarize you with our office policies:

**Please bring the following items to your first visit:**

- Insurance card(s), picture ID and payment for co-pay or self-pay services
- **All medications you are currently taking in the bottles**
- The name, address, phone/fax number of your previous doctor(s) to obtain medical records
- All NEW PATIENT paperwork, health history and required signatures

**Reminders:**

- ***It is your responsibility to review and understand your health insurance coverage and benefits.*** This includes co-pays, the referral policy and approved outpatient facilities.
- If you are required to select a Primary Care Provider (PCP), please do so **PRIOR** to your appointment or you may be asked to reschedule.
- ***For your convenience, we provide on-site lab services through VIM and Quest Diagnostics. If your insurance has specific requirements, it is your responsibility to notify us prior to your labs being drawn.***
- New patients will only be allowed to reschedule or cancel their initial appointment twice, while providing no less than 24-hour notice. Failure to contact the office will result in dismissal from the practice and no further appointments will be scheduled.
- Payment for co-pays, non-covered or self-pay services are due in full at the time services are rendered, unless prior arrangements have been made with the billing office.
- To ensure patient care is not interrupted during the day, all calls for the Providers will be directed to the nurses.
- We provide same day and walk-in appointments for our established patients.
- In compliance with HIPAA laws, no information will be given to anyone, including family, without prior written consent.

**Our goal is to provide you with the most efficient and up to date healthcare available. We are always open to suggestions. We look forward to seeing you!**

Sincerely,

Dr. Mary Bell Vaughn and Vineville Internal Medicine Staff

[www.vinevilleinternalmedicine.com](http://www.vinevilleinternalmedicine.com)  

Be sure to like us on Facebook AND Instagram @vinevilleinternalmedicine

Your appointment is scheduled for ____ / ____ / ____ at ____ :			
<b>3448 Vineville Avenue, MACON, GA 31204</b>			
<b>Bldg A - Blue</b>	<b>Bldg B - Green</b>	<b>Bldg C - Purple</b>	<b>Acute Care Clinic-Bldg D - Yellow</b>
( ) Erin Caves, NP	( ) Briana Birdsong, MD	( ) Mary Bell Vaughn, MD	( ) Daryl Remick, MD
( ) Jarrett Mitchell, NP	( ) Kristen Selph, NP	( ) Catie Dennis, NP	( ) Catie Dennis, NP
( ) Katie Aldridge, NP	( ) Shandora Hayman- Jones, NP	( ) Sarah Mitchum, NP	
( ) Melissa Butts, NP	( ) Shannon Ethridge, NP	( ) Cherrice Clay-Austin, NP	
<b>1024 Keith Drive, PERRY, 31069</b>			
( ) Kim Johnson, NP	( ) Gina Wiley, NP	( ) H.Franklin Smisson, MD	
<b>147 James Street, GRAY, GA 31032</b>			
( ) Jen Woodall, NP	( ) Kayla Whitley, NP		
<b>506 Osgian Blvd, WARNER ROBINS, GA 31088</b>			
( ) Ashley Dykes, NP	( ) Krista Keen, NP	( ) Briana Birdsong, MD	
<b>504 Osgian Blvd, WARNER ROBINS, GA 31088</b>			
( ) Tammy Hughes, NP	( ) Haylee Martin, NP		
<b>164 N. Lee Street, Suite 164, FORSYTH, GA 31029</b>			
( ) Shandora Hayman- Jones, NP	( ) Katie Aldridge, NP		



Thank you for choosing Vineville Internal Medicine (VIM) for your healthcare needs. We are committed to providing quality and affordable healthcare to you and your family. We strive to provide easy access to our Providers by offering an acute care clinic, multiple locations, telemedicine appointments, availability for same day visits and walk-ins for our established patients.

### **General Practice Policies**

#### **Telephone Calls:                   \*\*\* If you have a medical emergency, please call 911\*\*\***

- We have a great team of live operators to facilitate appointments and communications. But, due to heavy call volumes, some calls will be transferred to a voice mail box that is monitored continuously throughout the day. All calls received before 4pm will be returned within the same business day.
- To schedule an appointment, you may call us directly at 478-405-0045, Option #3, or use the Patient Portal Healow App.

#### **Medication Refills:**

- All prescription refills and renewals should be initiated through your pharmacy.
- We request 24-48 hours to process all prescription refill requests.
- Some refill requests may require an appointment for evaluation prior to being filled. You may call us directly at 478-405-0045, Option #1, or use the Patient Portal Healow App.

#### **Missed Appointments:**

- Our system is set to call and/or text reminders of your scheduled appointments.
- It is your responsibility to ensure your preferred method of contact and phone information is up to date in our system.
- Although we understand emergency situations may arise, we request 24-hour advance notice to cancel or reschedule your appointment. Canceling an appointment less than 24 hours (one business day) in advance will incur a "no show" fee of \$25.00 for a regular office visit and \$50.00 for a physical appointment.
- ***Three (3) late cancellations or "no show" appointments in one year may result in your dismissal from our practice.***

#### **Minor Patients:**

- Patients under the age of 18 will not be seen without a parent/guardian present or without a signed consent form. For all services rendered to minor patients, we will look to the adult accompanying the patient for payment.

#### **Patient Portal Messaging:**

- Your Provider may NOT feel that using the Healow messaging is appropriate and may request that you schedule an appointment.

#### **Dismissal:**

- Repeated failure to keep your scheduled appointments, failure to comply with practice policies, or having an unpaid balance after the 3<sup>rd</sup> billing statement without making payment arrangements may result in dismissal from the practice.
- You will be notified by regular and/or certified mail that you have 30 days to seek alternative care. During that 30-day period, your Provider will only be able to provide treatment on an emergent basis.

## Financial Policies

### **Patient Information:**

- We require a valid government issued ID and a valid insurance card (if insured) at **EVERY** appointment.
- To ensure proper communication, we depend on you to provide our office with your correct address, phone number and any changes to your emergency contact information.

### **Insurance:**

- It is your responsibility to ensure that the insurance information provided is current and accurate.
- Prior to your appointment, you must confirm with your insurance that Vineville Internal Medicine is in your covered network and, if required, that your selected Primary Care Provider (PCP) has been updated to a VIM Provider.
- **Many insurance plans require the use of specific labs, radiology facilities, pharmacies, etc. It is your responsibility to verify your coverage benefits prior to your appointment.**
- If additional information is requested by VIM or your insurance company, failure to respond will result in the charges being billed directly to you as patient responsibility.
- If you have an insurance plan that we do NOT accept, you will be considered a self-pay patient and payment is due in full at the time services are rendered.

### **Co-payments, Co-Insurance and Deductibles:**

- Payment of co-pays, co-insurance and deductibles are part of your contract with your insurance company and are required per our agreement to accept your plan. Please help us in upholding the terms of these contracts by paying your co-payment at each appointment.

### **Non-covered services:**

- You will be advised in advance if we believe the service requested (or deemed necessary by your Provider) may not be covered by your insurance. We will do our best to provide an estimate of the anticipated charges.
- Services that are never covered or services that exceed your limits of coverage will be billed directly to you.
- Cosmetic and non-medically necessary services are not filed with your insurance and payment is due in full at the time services are rendered.

### **Self-Pay Patients:**

- For all services rendered to patients without insurance or proper proof of insurance, a self-pay discount will be applied to your account.
- Payment is due in full at the time services are rendered unless previous arrangements have been made with the billing office.

### **Credit Balances:**

- In the event that a credit balance is created for any VIM date of service, we will verify that there are no outstanding balances on any other date of service and no future appointments are scheduled before initiating a refund.
- Because of the administrative expense of processing a refund, any credit balance of \$20.00 or less will remain on the account for use at a future appointment.

### **Collections:**

- If monthly payments are not received regularly, your account will move into our collection process. We are willing to work with you on your account balance, but communication with our billing office is essential. If you have questions regarding your billing statement or wish to set up payment arrangements, please contact our billing office by calling 478-405-0045, dialing ext. 888; or by selecting option #2.
- In the event your account balance is referred to a collection agency, your account will be made inactive and you will be dismissed from Vineville Internal Medicine.

#### **Administrative Fees:**

FMLA Paperwork:	\$75.00 (if needed within 3 or more days) or \$100.00 (if needed in 2 or less days)
Biometric Forms \$20.00	Disability Forms: \$75.00
Life Insurance Forms \$20.00	Medical Records Requests: \$25.00
Physician Statements \$20.00	Parking/Handicap Permits: \$10.00
Other Miscellaneous \$20.00	

### **I have read and understand the practice policies as stated above:**

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to Patient (if other than self)

\_\_\_\_\_  
Date

**General Patient Information**

Name (Last, First): \_\_\_\_\_ Gender: Male or Female

Preferred Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**Communication**

I authorize Vineville Internal Medicine to leave medical information pertaining to my care by the following methods and I will assume responsibility to notify them whenever this information changes:

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

May we leave a voice msg at this number? YES or NO      May we leave a voice/text msg at this number? YES or NO

Email: \_\_\_\_\_

\*\*Emergency Contact Name: \_\_\_\_\_ Relation: \_\_\_\_\_

\*\*Emergency Contact Phone: Home: \_\_\_\_\_ Mobile #: \_\_\_\_\_

\*\*May we discuss medical information with this contact? YES or NO

**Demographic Info**

(Check as applicable)

Ethnicity:    \_\_\_ Asian    \_\_\_ African American    \_\_\_ Caucasian    \_\_\_ Hispanic    \_\_\_ Other: \_\_\_\_\_

Language:    \_\_\_ English    \_\_\_ Spanish    \_\_\_ Other: \_\_\_\_\_

Marital Status:    \_\_\_ Single    \_\_\_ Married    \_\_\_ Divorced    \_\_\_ Widowed

Employment Status:    \_\_\_ Employed    \_\_\_ Unemployed    \_\_\_ Retired    \_\_\_ Disabled

Employer's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Health Information Disclosure (HID):**

List anyone that may discuss health information on your behalf.

1. Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Mobile Phone #: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Mobile Phone #: \_\_\_\_\_

**\*I attest that all the above information is true and accurate to the best of my knowledge.**

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_

(Please Print)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT PORTAL CONSENT:**

Vineville Internal Medicine complies with the Hitech Act of 2009 by communicating with our patients via patient portal. The patient portal is a secure, convenient and easy way to access your health information and communicate with your Provider.

- I **DO** want access to the Patient Portal. (Enter email here: \_\_\_\_\_) Upon registering for the Patient Portal, I will begin receiving electronic billing statements. (Initial here: \_\_\_\_)
- I **DO NOT** want access to the Patient Portal. (Initial here: \_\_\_\_)

**ELECTRONIC PAPERLESS BILLING CONSENT (If not using the Patient Portal):**

I authorize Vineville Internal Medicine to deliver my patient billing statements electronically via text message and/or email. This means that billing statements will no longer be submitted to my home by the postal service. This authorization will remain in effect until I provide written notice of termination to Vineville Internal Medicine.

Please Select: YES or NO (Initial here \_\_\_\_\_)

**HIPAA Notice of Privacy Practices: Your Information. Your Rights. Our Responsibilities.**

*(Detailed policy available upon request)*

**You have the right to:**

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

**You have some choices in the way that we use and share information as we:**

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental healthcare
- Market our services and sell your information
- Raise funds

**We may use and share your information as we:**

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
(Please Print)

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## Telemedicine Consent Form

- The purpose of the "Telemedicine Consent Form" is to obtain my consent to participate in telemedicine appointments. Signing this consent does not restrict my ability to participate in on-site office appointments with my Provider. This consent is to provide notification of the telemedicine service that is provided by Vineville Internal Medicine and use of this service is completely voluntary.
- Video conferencing will be used to affect such a consultation and will not be the same as a direct patient/healthcare Provider visit since I will not be in the same room as my healthcare Provider. The medical information related to history, records and tests will be discussed during my telemedicine appointment with video and audio. The telemedicine consultation will not be recorded and stored.
- I accept that I need access to a PC, laptop, or mobile device and an adequate internet connection to have an efficient telemedicine appointment. I accept that the session may be conducted via regular voice communication if the technical requirements, such as internet speed, cannot be met.
- I understand there are potential risks to technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare Provider or I can discontinue the telemedicine appointment if it is felt that the videoconferencing connections are not adequate for the situation.
- I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. I understand that I will be informed of the presence of other staff members that may be present during my consultation and that these staff members are required to maintain the confidentiality of the information obtained. I understand that I have the right to request the following: (1) omit specific details of my medical history; (2) ask non-medical personnel to leave; (3) terminate the consultation at any time.
- In choosing to participate in telemedicine appointments, I understand that some parts of the exam involving physical tests may be required to be done on-site at a physical location in the direction of my Provider. If I am receiving a schedule 2 drug, my Provider will do their best to e-prescribe this to my pharmacy. If this is unsuccessful, I will have to pick the prescription up from the office.
- I understand that the visit will be filed with my insurance company and any non-paid services are patient responsibility. Uninsured patients will need to contact the office for pricing and payment. I understand that 24-hour notice is required for appointment cancellation, or I will be charged a \$25.00 no show fee. All pre-paid fees are non-refundable.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Email: \_\_\_\_\_

Phone #: \_\_\_\_\_

**By signing this form, I certify:**

I understand that all laws that are protecting my privacy of medical history or information are applied to telemedicine practices.

I have read or had this form read to me and/or had this form explained to me.

I fully understand its contents including the risks and benefits of the process, and I have been given the opportunity to ask questions and have received answers to my satisfaction.

I am responsible for any fees my insurance does not cover.

Patient Signature: \_\_\_\_\_

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



# CENTRAL GEORGIA HEALTH EXCHANGE

*The next generation of patient information*

## Permission to Create a Health Exchange record and Share My Medical Information with my Healthcare Providers

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. To do this, all your doctors participating in the Central Georgia Health Network (CGHN) would like your permission to share your Health Information (as defined below) through the *Central Georgia Health Exchange* electronic medical record program (*Health Exchange*). This will authorize your CGHN-participating doctors to disclose your Health Information so that it can be shared electronically with other providers of healthcare to you.

I acknowledge that I have read the information set forth below and understand the permission I am giving in this document, and have had the opportunity to have my questions answered about the *Health Exchange and this permission form*.

- Yes, I AGREE to participate** in the Central Georgia Health Exchange electronic medical record
- No, I do not wish to participate** in the Central Georgia Health Exchange electronic medical record at this time

\_\_\_\_\_ / / \_\_\_\_\_ / /  
**Printed Name of Patient/Representative**      **DOB**      **Signature**      **Date**

### AUTHORITY OF REPRESENTATIVE: POA

I, \_\_\_\_\_ do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis: Relationship to Patient: \_\_\_\_\_

[A signed copy of this permission will be provided to the patient/representative]

This authorization will allow your CGHN-participating doctors to disclose your demographic, insurance, and medical information so that it can be shared with other providers of healthcare to you (including doctors, nurses, and other health professionals, as well as hospitals and other healthcare facilities) and CGHN, through the *Health Exchange* electronic medical record system. Only authorized healthcare providers and their contractors, and others whose job it is to maintain, secure, monitor and evaluate the operation of the information system and quality of care, would be able to access your information. The *Health Exchange v II* allow your providers access to your health information more quickly and accurately than with paper charts.

By signing this authorization, I authorize all of my doctors who participate in CGHN to use and disclose my Health Information and to make such Health Information available through the *Health Exchange* to other healthcare providers who need access to my Health Information for the purposes described in this document. The Health Information may include, but is not limited to the following: Information contained in medical records; physicians' records; surgeons' records; x-rays, CAT scans, MRI films, photographs, or other radiological, nuclear medicine or radiation therapy films; pathology materials, slides or tissues; laboratory reports; genetic testing results; discharge summaries; progress notes; consultations; prescriptions; records of child abuse, spousal abuse, drug abuse and alcohol abuse; HIV/AIDS and sexually transmitted diseases diagnosis or treatment; physicals and histories; nurses' notes; patient intake forms; correspondence; social workers' records; insurance records; consents for treatment; and any other documents concerning any treatment, examination, periods of hospitalization, confinement, diagnosis or other information concerning my physical or mental condition. Information disclosed pursuant to this permission may no longer be protected by federal health information privacy laws and may be subject to re-disclosure. However, the *Health Exchange* system incorporates access controls. Encryption technology and other security features designed to protect the privacy and security of your Health information. In addition, access to the *Health Exchange* will be limited to only those users who have agreed to use the *Health Exchange* consistent with your permission. Information shared through the *Health Exchange* will be used and disclosed for the following purposes and disclosures: clinical care; obtaining reimbursement for health care services; for administrative functions related to the provision of and payment for care; quality monitoring and improvement; and administrative management of the *Health Exchange* and CGHN.

You can learn more about the *Central Georgia Health Exchange* by reading the information booklet, "A Guide to the Central Georgia Health Exchange" that is available at the CGHE website (<https://www.CGHE.net>) or on request from your healthcare provider's office.

I understand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Health Exchange, 111 Perimeter Parkway Macon, GA 31210. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on this permission. This permission will expire automatically if the *Central Georgia Health Exchange* program is discontinued.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent I have refused permission, I understand that my Health Information will not be available to my other healthcare providers (including, but not limited to, participating Emergency Rooms, Urgent Care Centers, Hospitals, Surgery Centers, and Doctors' Offices) through the *Central Georgia Health Exchange*.



Dr. Mary Bell Vaughn

### Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/facility listed below.

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Records being requested from:

Dr. \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Dr. \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Dr. \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Dr. \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

The information you may release subject to this signed release form is as follows:

- Complete Records (**last 2 years**)
- Progress Notes
- H&P
- Other (Please specify below)
- Lab Reports
- Radiology Report
- Rx Records
- Pathology Reports
- Immunization Records
- Hospital Reports

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**(ONLY if this applies to you): HIV/AIDS:** I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. If this applies, initial and date this form. Initial: \_\_\_\_\_ Date: \_\_\_\_\_

Release my protected health information to the following physician/facility:  
Dr. Mary Bell Vaughn **Phone: 478-405-0045**  
Vineville Internal Medicine **Fax: 478-405-0054**  
3448 Vineville Ave  
Macon, Ga 31204

Patient Name (Please Print) \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Patient History Intake Form

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Reason(s) for Visit (in order of priority):

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

### Past Medical History (Please specify when able)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Asthma / COPD / Other Lung Disease                    | <input type="checkbox"/> Diabetes Mellitus (Type 1 / 2)               | <input type="checkbox"/> Parkinson's Disease                                       |
| <input type="checkbox"/> Autoimmune Disease (Type)                             | <input type="checkbox"/> Eye Disease (Glaucoma, Macular Degeneration) | <input type="checkbox"/> Peptic Ulcer Disease / Reflux Disease                     |
| <input type="checkbox"/> Bleeding / Clotting Disorder or Blood Transfusions    | <input type="checkbox"/> Hearing Loss                                 | <input type="checkbox"/> Psychiatric Illness (Anxiety, Depression, Bipolar, Other) |
| <input type="checkbox"/> Bone / Joint Disorder (Arthritis, Gout, Osteoporosis) | <input type="checkbox"/> Heart Disease / Failure                      | <input type="checkbox"/> Seizure Disorder / Epilepsy                               |
| <input type="checkbox"/> Cancer (Breast, Ovarian, Colon, Uterine, Skin, Other) | <input type="checkbox"/> High Blood Pressure                          | <input type="checkbox"/> Skin Disease (Eczema, Psoriasis, etc)                     |
| <input type="checkbox"/> Dementia / Memory Loss                                | <input type="checkbox"/> High Cholesterol                             | <input type="checkbox"/> Sleep Apnea (Obstructive / Central)                       |
|  | <input type="checkbox"/> HIV/AIDS                                     | <input type="checkbox"/> Stroke  |
|  | <input type="checkbox"/> IBD (Crohn's Disease / Ulcerative Colitis)   | <input type="checkbox"/> Thyroid Disease (Hypothyroid / Hyperthyroid, Other)       |
|  | <input type="checkbox"/> Kidney Disease / Stones                      |  |
|  | <input type="checkbox"/> Liver Disease                                |  |
|  | <input type="checkbox"/> Migraines / Headache                         |  |

### Past Surgical History

Procedure	Dates

### Hospitalizations/Major Diagnostic Procedures (within the last year)

Reason	Dates



**Family History**

Family Member	Diseases	If Deceased, Causes	Age of Death
Mother			
Father			
Other			

**Social History**

**Alcohol Use:**

Current  Yes  No    Former  Yes  No    Drinks per day / week / month:    How long:  
 Year Quit:                      Drink of Choice (Beer, Wine, Liquor):  
 Do you feel the need to cut back?  Yes  No

**Smoking/Tobacco Use (cigarettes, cigar, chew, snuff, E-cigarettes or vapes):**

Current  Yes  No    Former  Yes  No    How much per day:    How long:    Year Quit:  
 Are you interested in quitting and open to discuss possible treatment options?  Yes  Not yet

**Recreational or illicit Drug Use:**

Current  Yes  No    Former  Yes  No    Type:                      Amount per day / week / month:  
 Last Used:

**Preventive Medicine**

	Date	Results (Abnormal/Normal)
Last Wellness/Routine Physical Exam		
Last Mammogram		
Last Colonoscopy		
Last Pap Smear		
Last DEXA (Bone Density) Scan		
Hepatitis B/C/HIV Screening		
AAA Screening (Male smokers only)		

**Females:**

Age of onset menstrual cycle:                      First day of last period:  
 Number of: Pregnancies:                      Live births:                      Miscarriages:                      Abortions:

**Adult Immunization History**

Vaccination	Dates
Tetanus	
Annual influenza	
Pneumococcal	
Shingles (Shingrix or Zostavax)	
Human Papilloma Virus "HPV" (Gardasil)	

