OLYMPIC MEDICAL PHYSICIANS
Women's Health

939 Caroline St., Level 3 East ♦ Port Angeles, WA 98362
907 Georgiana St. ♦ Port Angeles, WA 98362
840 N. 5th Avenue, Suite 1500 ♦ Sequim, WA, 98382
Phone: (360) 565-0999 ♦ **Fax:** (360) 452-7303

Congratulations on your pregnancy!

Welcome to Olympic Medical Physicians Women's Health! Our experienced group practice includes physicians and certified nurse midwives. We are proud of this collaboration that ensures excellent care based on the wishes and unique needs of each woman and family.

Our nurses, specializing in obstetrical care, will explore any preferences you may have regarding your pregnancy and delivery, and will help you to determine whether physician or midwifery-led care is most appropriate for you. This will be discussed when you are contacted to schedule your first appointment.

About Certified Nurse Midwives

Midwifery care is an excellent choice for pregnant moms who wish to spend more time with their provider in the clinic and during the active phase of labor and delivery. Our certified nurse midwives have full hospital privileges, including pharmaceutical privileges, which is specifically helpful if you wish to utilize pain-relieving drugs such as epidural anesthesia as part of your delivery plan.

The midwives work in the hospital in collaboration with OMP physicians, and even more so if you need specialized care for any specific issues.

Essentially, you can expect personalized, high-touch support that is a defining characteristic of midwifery care, yet still have access to hospital services and urgent / emergent treatments if there are unexpected complications.

About OMP Physicians

OMP physicians are board-certified, providing obstetrics and gynecology as well as surgical care. Mothers-to-be with pre-existing health conditions or complicated pregnancies may be directed to the care of our physicians, who have specialty training in the management of high-risk obstetrics and obstetrical surgery, including C-sections.

Preparation for your first visit

Complete and return paperwork ASAP and or no later than 72 hours prior to your appointment or we may have to reschedule your appointment to a later date. This visit lasts about one hour and includes a full physical exam. During this first visit we can apprise you of milestones to expect (i.e. when you can expect to hear your baby's heartbeat in the clinic or when you should obtain your first ultrasound).

Please prepare for this visit by doing the following:

1. Bring a copy of your photo ID and current insurance card(s).
2. Bring all medications you are taking in their original bottles, *including* herbs and supplements.
3. Arrive to your appointment 15 minutes early and be prepared to leave a urine specimen. If you are unable to make your appointment, please notify us at least 24 hours in advance.
4. Young children need supervision. Please do not bring children to this first visit. Siblings, family and friends are welcome to attend all other appointments at your discretion.

We look forward to getting to know you and your family during the weeks and months ahead. Thank you for choosing OMP Women's Health to care for you during your pregnancy and participate in the birth of your child. Please feel free to contact us with any questions or concerns.

Sincerely,

OMP Women's Health Providers

Stephen Bush, MD
Katherine Hennessey, MD
Sheena Plamoottil, MD
Oksana Shklyanka, MD

Deborah Bopp, ARNP, CNM
Laurie Johnson-Driese, ARNP, CNM
Cheri Shields, ARNP, CNM

Registration and Update Form (Confidential)

- Please complete all ➢ **Required sections** of this form then
- Provide an **Insurance Card** and **Photo ID** for copying
- If you have any questions or concerns, please ask for assistance. We will be happy to help.

OLYMPIC MEDICAL CENTER

➢ Patient Information

Last Name:_____ First Name:_____ Middle Name:_____

Social Security #:_____ Gender:_____ Date of Birth:_____

Mailing Address:_____ City:_____

State:_____ Zip:_____

Phone (Mark the best) ❑ Home:_____ ❑ Work:_____

❑ Mobile:_____ ❑ Message:_____

Aliases / Nick Name:_____ E-mail:_____

➢ General

❑ Needs Interpreter If yes; Language:_____ Religion:_____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Legally Separated

Ethnicity: ❑ Hispanic ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American
❑ Native Hawaiian/Pacific Islander ❑ White/Caucasian ❑ Other:_____

Employer:_____ Employment Status: ❑ Part Time ❑ Full Time
❑ Never Employed ❑ Not Employed ❑ Active Military Duty ❑ Disabled ❑ Retired ❑ Self Employed
❑ Student Full Time ❑ Student Part Time

Employer Address:_____ City:_____ State:_____ Zip:_____

Occupation:_____ Phone_____

➢ Primary Care Doctor (Doctor, Nurse Practitioner, Physicians Assistant, etc.)

Dr. Name:_____ Phone:_____

➢ Patient Emergency Contacts-At least 1 immediate family member

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

➢ Financially Responsible Party (Guarantor) (Complete if Guarantor is the parent or anyone other than the patient)

Guarantor Name:_____ Relationship to Patient:_____

Address:_____ City:_____ State:_____ Zip:_____

Social Security #:_____ Gender:_____ Date of Birth:_____

Home Phone:_____ Work Phone:_____

Employer:_____ Employment Status: ❑ Part Time ❑ Full Time
❑ Never Employed ❑ Not Employed ❑ Active Military Duty ❑ Disabled ❑ Retired ❑ Self Employed
❑ Student Full Time ❑ Student Part Time

Employer Address:_____ City:_____ State:_____ Zip:_____

Occupation:_____ Phone:_____

➢ Coverage Information

Primary Insurance:_____ Subscriber ID:_____ Group #:_____

Subscriber Name:_____ Date of Birth_____ Relationship:_____

Address:_____ City: _____ State:_____ Zip:_____

Secondary Insurance:_____ Subscriber ID:_____ Group #:_____

Subscriber Name:_____ Date of Birth_____ Relationship_____

Address:_____ City: _____ State_____ Zip:_____

➢ Advanced Directives

Do you have any Advanced Directives? ❑ Yes ❑ No

Last Name: _____ First Name: _____ Date of Birth: _____

By providing the following information, you enable us to give quality care that meets your unique needs. Your answers to these questions are confidential, but will become a part of your medical record.

OLYMPIC MEDICAL PHYSICIANS
Women's Health

DATING INFORMATION

1. What was the first day of your last menstrual period? _____
2. Are you certain of this date? ❑ Yes ❑ No
3. Was this a normal period? ❑ Yes ❑ No If **NO**, please explain: _____
4. Do you have regular periods? ❑ Yes ❑ No If **YES**, how often? _____
5. Is this a planned pregnancy? ❑ Yes ❑ No
6. Were you using contraception when you became pregnant? ❑ No ❑ Yes
   If **YES**, what? _____
7. Have you had an ultrasound? ❑ No ❑ Yes If **YES**, where? _____

OBSTETRICAL HISTORY

Please list your pregnancies in chronological order

Date	Type: Term, Preterm, Stillbirth, Ectopic, Miscarriage or Abortion	Length of Pregnancy (weeks)	Length of Labor (hours)	Weight	Sex	Vaginal Delivery or C-Section	Type of Pain control	Place of Delivery	Name of Midwife or Doctor
Complications:									
Complications:									
Complications:									
Complications:									
Complications:									
Complications:									

MEDICATIONS

What is the name of your preferred pharmacy? _____

Please list any medications you have taken since conceiving, including vitamins and supplements

Medication	**Date Started**	**Dose**	**Frequency**	**Reason for taking**

Last Name: _____ First Name: _____ Date of Birth: _____

ALLERGIES

Please list all Medications, Foods and Environmental Factors to which you react

What caused the allergy?	Reaction

FAMILY HISTORY

Adopted: ❑ No ❑ Yes Family history unknown: ❑ No ❑ Yes

Relation	Name	Living or Deceased	Relation	Name	Living or Deceased
Mother			❑ Brother ❑ Sister		
Father			❑ Brother ❑ Sister		
❑ Brother ❑ Sister			❑ Brother ❑ Sister		

Please mark if you have any relatives with the following

Key: MGM = Maternal (mother's side) Grandmother; MGF = Maternal Grandfather; PGM = Paternal (father's side) Grandmother; PGF = Paternal Grandfather

Condition	Mother	Father	Sister	Brother	MGM	MGF	PGM	PGF	Other
Cancer									
Diabetes									
High Blood Pressure									
Three or more Miscarriages									
Stroke									
Rheumatoid arthritis									
Osteoartiritis									
Asthma									
Heart Failure									
High Cholesterol									
Migraines									
Rashes / skin problems									
Seizures									
Thyroid Disease									

Last Name: _____ First Name: _____ Date of Birth: _____

MEDICAL HISTORY

What is your usual weight? _____ What was your weight when you conceived? _____

What is your height? _____

When was your last pap smear? _____ Where was this done? _____

Please note any of the following that pertain to your personal medical history

Year	Medical Problem / Diagnosis	Details of Condition and Treatment
	Abnormal Pap	
	Anemia	
	Anesthetic complications	
	Asthma	
	Autoimmune disorders (lupus, eczema, arthritis)	
	Blood or clotting disorder	
	Blood transfusion	
	Breast Problems	
	Cancer	
	Chicken Pox or Varicella Vaccination	
	Diabetes	
	Drug or Alcohol use requiring treatment	
	IV drug use or a sexual partner who has used IV drugs	
	Gynecologic problems (fibroids, endometriosis, etc…)	
	Heart Problems	
	Herpes or a partner with Herpes	
	High blood pressure	
	HIV/AIDS	
	Other sexually-transmitted infections (chlamydia, gonorrhea, HPV, syphilis)	
	Infertility	
	Kidney or urinary tract problems	
	Liver disease	
	Mental health problems (Depression, anxiety, bipolar)	
	Rh incompatibility	
	Rash or viral illness during pregnancy	
	Seizures	
	Thyroid disease	
	Trauma / violence / abuse	
	Tuberculosis	
	Varicosities / Phlebitis	
	Other:	

Last Name: _____ First Name: _____ Date of Birth: _____

SURGICAL HISTORY

Please list any non-obstetric surgeries or hospitalizations, when they occurred, and where you were treated

Year	Reason for Hospitalization and/or type of Operation	Hospital and Location

SOCIAL SCREENING

1. Who is the father of your baby? _____
2. What is your relationship with the father of your baby? _____
3. Are any of your children in the custody of someone else? ❑ No ❑ Yes
   If **YES**, please explain: _____
4. What is your occupation? _____
5. What is your partner's occupation? _____
6. Who do you live with? _____
7. With whom are you sexually active? ❑ Male(s) ❑ Female(s) ❑ Both
8. Do you feel safe in your current relationship? ❑ Yes ❑ No _____
9. Have you ever been hit, slapped, physically hurt or threatened by a partner? ❑ No ❑ Yes
   _____
10. Is anyone in your life misusing your money or property? ❑ No ❑ Yes

Please note any past or present substance use:

Substance	Never	Former User	Daily (# per day)	Once a Week	Once a Month	Start Date	Quit Date
Cigarettes							
E-Cigarettes							
Second-Hand Smoke							
Chewing Tobacco							
Alcohol							
Sleep Medications							
Narcotic Pain Medications (opioids)							
Anxiety Medications							
Marijuana							
Crack or Cocaine							
Methamphetamine							
Heroin or Methadone							

Last Name: _____ First Name: _____ Date of Birth: _____

GENETIC SCREENING

Have you been tested to determine whether you are a carrier of the Cystic Fibrosis gene? ❑ No ❑ Yes

If **YES**, when was this test and what was the result? _____

Please mark the ethnic backgrounds of both the Mother and Father of the Baby:

Ethnic Origin	Mother	Father of the Baby
Caucasian		
Native American		
Ashkenazi Jewish		
French Canadian		
African American, African or Black		
Hispanic		
Pacific Islander		
Asian		
Eastern European (Italian, Greek)		
Middle Eastern		
Other		

GENETIC RISK ASSESSMENT Please mark if there is family history of any of the following:

Condition	Mother	Father of the Baby
Thalassemia		
Neural Tube Defect (Spina Bifida, Anencephaly, Meningomyelocele)		
Congenital Heart Defect		
Down Syndrome		
Tay-Sachs		
Canavan Disease		
Familial Dysautonomia		
Sickle Cell Disease or Trait		
Hemophilia or other Blood Disorder		
Muscular Dystrophy		
Cystic Fibrosis		
Huntington's Chorea		
Intellectual Disability		
Fragile X		
Maternal Metabolic Disorder (Diabetes, PKU…)		
Recurrent Pregnancy Loss or Stillbirth		
Multiples (Twins, etc…)		
Other birth defect or inherited condition		

MOOD SCREENING Please mark if there is family history of any of the following:

How often do you feel…	Never (0)	Sometimes (1)	Usually (2)	Always (3)
1. Nervous, anxious or on edge?				
2. Unable to stop worrying?				
3. Down, depressed or hopeless?				
4. Little interest or pleasure in doing things?				

Thank you!

OLYMPIC
MEDICAL PHYSICIANS

PERSONAL RELEASE OF PROTECTED HEALTH INFORMATION

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PATIENT INFORMATION

Patient Name (printed):_____ Previous Name(s):_____

Date of Birth:_____ Daytime Telephone Number:_____

INFORMATION TO BE RELEASED FROM:

I hereby authorize Olympic Medical Physicians Clinics to release the following information contained in my medical record and/or information regarding my medical care or condition as described in detail below.

INFORMATION TO BE RELEASED TO:

Name:_____

Relationship:_____ Phone Number:_____

Name:_____

Relationship:_____ Phone Number:_____

Name:_____

Relationship:_____ Phone Number:_____

GENERAL INFORMATION TO BE RELEASED

❑ You may release test results and appointment information to the above named person(s)

❑ You may discuss my medical condition(s) and/or current treatment with the above named person(s)

DISCLOSURES REQUIRING SPECIAL CONSENT

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for (Please initial beside the specific information to disclose):

_____ Drug and Alcohol Abuse/Treatment

_____ Mental Health/Psychiatric Disorders

_____ HIV/AIDS Virus

_____ Sexually Transmitted Diseases

CONSENT TO DISCLOSE

By my signature below I indicate that I understand that I have the right to revoke this authorization in writing at any time. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

This authorization will be valid until:_____

Date	Signature of patient or representative	Relationship to patient

FOR FACILITY USE ONLY

Date Received:_____ Date Information Released:_____ Chart #:_____

Person/Department Sending Records: _____

❑ Faxed ❑ Mailed ❑ Picked Up:_____ ❑ Other:_____

OLYMPIC MEDICAL CENTER

Financial Assistance Plain Language Summary

Do I qualify?
Based on your income and family size, you may qualify for a discount of 30-100% of your bill.

In some cases, we'll evaluate criteria other than income. For example, if you experience a catastrophic event, you may qualify regardless of income.

Examples:

Individual with $18,000 income = 60% discount	Couple with $48,000 income = 30% discount	Family of four with $24,000 income = 100% discount
		

For a full list of family incomes, family sizes, and discounts, see the next page.

What does the Program cover?
The Program covers medically necessary care provided by us or by one of our providers.

How do I apply?
Consult a Patient Financial Service Representative at 360-417-7111 for help applying.
For a free copy of the entire Financial Assistance Policy and an application:

- **Online:** www.olympicmedical.org then go to Patients & Visitors, Billing & Financial Services
- **In Person:** Visit the Patient Financial Services Department at 519 S Peabody, Port Angeles, WA 98362
  Office hours are Monday-Friday 8:00 AM to 4:30 PM
- **Mail:** Mail a request to Olympic Medical Center, 519 S Peabody, Port Angeles, WA 98362
- **Telephone:** Call Patient Financial Services at (360) 417-7111 or (800) 854-2844

Mail or bring your completed application and required documentation to Olympic Medical Center, 519 S Peabody St., Port Angeles, WA 98362. We process submitted applications only once they are complete. If your application is not complete, we will notify you and provide an opportunity to send the missing documentation or information.

	Olympic Medical Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
Spanish Español	Olympic Medical Center cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-360-417-7000 TTY: 1-360-417-8686
Chinese 繁體中文	Olympic Medical Center 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-360-417-7000 TTY: 1-360-417-8686

OLYMPIC MEDICAL CENTER

Financial Assistance Sliding Scale 2018

Gross Monthly Income					
Family Size	100% Discount (100% FPG)	80% Discount (125% FPG)	60% Discount (150% FPG)	45% Discount (200% FPG)	30% Discount (300% FPG)
1	0 - 1012	1,013 - 1,265	1,266 - 1,518	1,519 - 2,023	2,024 - 3,035
2	0 - 1372	1,373 - 1,715	1,716 - 2,058	2,059 - 2,743	2,744 - 4,115
3	0 - 1732	1,733 - 2,165	2,166 - 2,598	2,599 - 3,463	3,464 - 5,195
4	0 - 2092	2,093 - 2,615	2,616 - 3,138	3,139 - 4,183	4,184 - 6,275
5	0 - 2452	2,453 - 3,065	3,066 - 3,678	3,679 - 4,903	4,904 - 7,355
6	0 - 2812	2,813 - 3,515	3,516 - 4,218	4,219 - 5,623	5,624 - 8,435
7	0 - 3172	3,173 - 3,965	3,966 - 4,758	4,759 - 6,343	6,344 - 9,515
8	0 - 3532	3,533 - 4,415	4,416 - 5,298	5,299 - 7,063	7,064 - 10,595

Based on Annual Gross Income					
Family Size	100% Discount (100% FPG)	80% Discount (125% FPG)	60% Discount (150% FPG)	45% Discount (200% FPG)	30% Discount (300% FPG)
1	0 - 12,140	12,141 - 15,175	15,176 - 18,210	18,211 - 24,280	24,281 - 36,420
2	0 - 16,460	16,461 - 20,575	20,576 - 24,690	24,691 - 32,920	32,921 - 49,380
3	0 - 20,780	20,781 - 25,975	25,976 - 31,170	31,171 - 41,560	41,561 - 62,340
4	0 - 25,100	25,101 - 31,375	31,376 - 37,650	37,651 - 50,200	50,201 - 75,300
5	0 - 29,420	29,421 - 36,775	36,776 - 44,130	44,131 - 58,840	58,841 - 88,260
6	0 - 33,740	33,741 - 42,175	42,176 - 50,610	50,611 - 67,480	67,481 - 101,220
7	0 - 38,060	38,061 - 47,575	47,576 - 57,090	57,091 - 76,120	76,121 - 114,180
8	0 - 42,380	42,381 - 52,975	52,976 - 63,570	63,571 - 84,760	84,761 - 127,140

Due to yearly updates to this information, there may be a more recent version.
The latest version will be posted on our website:
www.olympicmedical.org then go to Patients & Visitors, Billing & Financial Services