



THE WOMAN'S CENTER FOR ADVANCED PELVIC SURGERY

Specializing in Pelvic Floor Disorders, Urinary Incontinence & Pelvic Organ Prolapse

Dear Patient,

Thank you for contacting The Woman's Center for Advanced Pelvic Surgery. We look forward to meeting you. To help us better serve you we ask for your help with the following:

- Please contact your referring physician to request a copy of your **MEDICAL RECORDS** to be sent to our office. The records should be mailed to our office prior to your appointment.
- Please ensure that your primary care physician has processed a **REFERRAL/AUTHORIZATION** and that this information is communicated to our office prior to your appointment *failure to do so will result in rescheduling of your appointment*. If you are self-referring, please contact our office so we can assist you in determining if you need a referral or authorization.
- Please bring your **HEALTH INSURANCE CARD** to your appointment.
- **YOUR COPAYMENT /COINSURANCE IS DUE AT TIME OF SERVICE.**
We accept Visa, MasterCard, Cash or Check
- **24 HOUR NOTICE IS REQUIRED FOR RESCHEDULING OR CANCELLATIONS OF THIS AND ANY FUTURE APPOINTMENTS FAILURE TO DO SO WILL RESULT IN A \$25 FEE BILLED TO THE PATIENT.**

Thank you for your help. We appreciate your assistance in these matters.

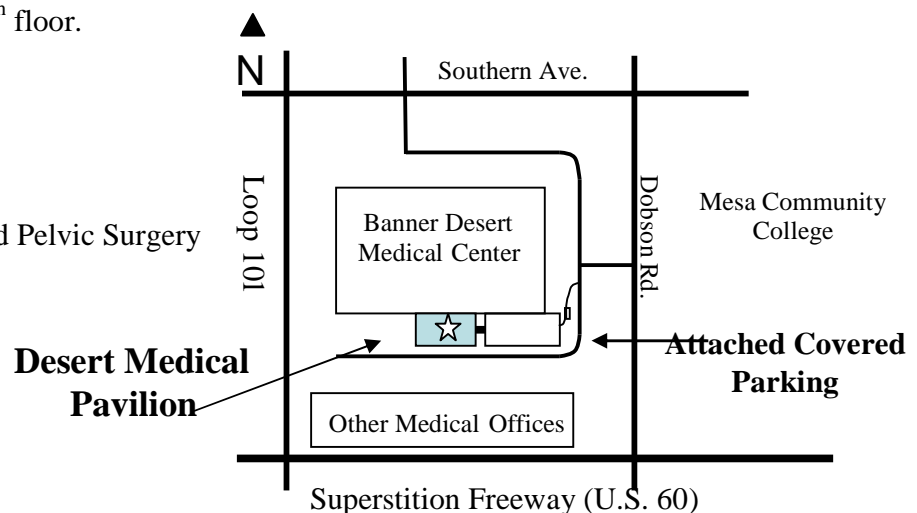
Traveling to the office should be easy. A map can be found on the website at www.twcaps.com. When you arrive, please enter the covered parking structure. Parking is FREE. Please let the attendant know you are coming to see Dr. Ronald Burton/ Dr. Ryan Stratford.

We are located on the fifth floor, **suite 509**. You will find the entrance to the office down the hall on your left after you exit the elevator on the 5th floor.

We look forward to meeting you.

Respectfully,

The Woman's Center for Advanced Pelvic Surgery





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PATIENT REGISTRATION FORM

DR BURTON

DR STRATFORD

PATIENTS NAME: _____
FIRST MIDDLE INITIAL LAST DATE OF BIRTH

ADDRESS: _____

CITY, STATE, ZIP: _____ MARITAL STATUS: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

OKAY TO LEAVE MESSAGE AT HOME Y/N OKAY TO LEAVE MESSAGE AT WORK Y/N OKAY TO LEAVE MESSAGE ON CELL Y/N

PREFERRED CONTACT PHONE CIRCLE ONE: HOME WORK CELL

OCCUPATION: _____ SS#: _____ EMPLOYER: _____

EMERGENCY CONTACT INFORMATION:

EMERGENCY CONTACT NAME: _____ PHONE #: _____ RELATIONSHIP TO PATIENT: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE

SECONDARY INSURANCE

INSURANCE COMPANY NAME: _____ INSURANCE COMPANY NAME: _____

POLICY HOLDER: _____ POLICY HOLDER: _____

INSURANCE ID#: _____ INSURANCE ID#: _____

INSURANCE GROUP#: _____ INSURANCE GROUP#: _____

POLICY HOLDERS SS#: _____ POLICY HOLDERS SS#: _____

POLICY HOLDERS DOB: _____ POLICY HOLDERS DOB: _____

POLICY HOLDERS EMPLOYER: _____ POLICY HOLDERS EMPLOYER: _____

RELATIONSHIP TO PATIENT: _____ RELATIONSHIP TO PATIENT: _____

REFERRAL INFORMATION:

HOW DID YOU HEAR OF THIS PRACTICE: _____

REFERRING PHYSICIAN:

REFERRING PHYSICIAN NAME REFERRING PHYSICIAN PHONE #

REFERRING PHYSICIAN ADDRESS, CITY, STATE, ZIP

PRIMARY CARE PHYSICIAN:

PRIMARY CARE PHYSICIAN NAME PRIMARY CARE PHYSICIAN PHONE#

PRIMARY CARE PHYSICIAN ADDRESS, CITY, STATE, ZIP

AUTHORIZATION TO PAY BENEFITS, RELEASE INFORMATION & REQUEST MEDICAL SERVICES:

I hereby authorize The Woman's Center for Advanced Pelvic Surgery (TWCAPS) to release any information acquired in the course of my examinations and/or treatments to insurance carriers and/or treating physicians. I hereby authorize payment to TWCAPS for medical and/or surgical benefits to which I am entitled. I hereby request medical services from TWCAPS. I understand I am financially responsible for the charges not covered by my insurance. In the event of default, I promise to pay collection costs and reasonable fees as may be required to obtain collection of this account.

I have read and understand each of the above statements

X _____
PATIENT SIGNATURE PARENT/LEGAL GUARDIAN DATE

CANCELLATION POLICY: If I am unable to keep my appointment(s), I will notify TWCAPS no later than 24 hours prior to my scheduled appointment. If I fail to notify TWCAPS, I agree to pay a \$25 cancellation fee.

X _____
PATIENT SIGNATURE PARENT/LEGAL GUARDIAN DATE



PATIENT/INSURED AGREEMENT

Benefits for medical, diagnostic, and surgical services vary from plan to plan. Benefits are subject to deductibles that can range from \$200 - \$2500 or more for various types of services.

We cannot bill your insurance company unless you provide us current and valid insurance information.

In an effort to provide clear communication with our patients please be aware of the following:

- The contractual agreement for your medical benefits is between you and your insurance company. *We provide billing as a courtesy.*
- For all insurance companies that we have a contract with, we will accept the “In Network” benefits as outlined on the Individual Explanation of Benefits. You the patient/insured will still be responsible for any and all co-pays, deductibles, and coinsurance amounts due in accordance with the Explanation of Benefits.
- **Our insurance contracts require us to collect deductibles and co-pays at the time of service.**
- For all insurance companies that we DO NOT have a contract with, we will accept the “Out of Network” benefits if such benefits are available. You the patient/insured are responsible for any and all co-pays, deductibles and coinsurance amounts due in accordance with the Explanation of Benefits.
- For all non-contracted insurance companies, you the patient/insured will be responsible for all charges in accordance with The Woman’s Center for Advanced Pelvic Surgery’s “Private Pay” fee schedule.
- When insurance benefits have been exhausted and/or terminated, you the patient will be responsible for the charges incurred in accordance with The Woman’s Center for Advanced Pelvic Surgery’s “Private Pay” fee schedule.
- Our staff will call to verify coverage and benefits for medical/diagnostic and surgical services provided by our office. This information is based on the information your insurance company provides and is not always a guarantee of payment.
- It is the patient/insured’s responsibility to notify our office if your insurance plan or benefits change. Any costs incurred because of incorrect information provided to us by you will be your responsibility.
- **When scheduling surgery co-insurance amounts and deductibles will apply. Payment is expected prior to surgery based on the information provided to our office by your insurance company.**
- In all cases, you the patient/insured will be responsible for any non-covered services, deductibles, co-pays, and co-insurance amounts deemed as patient responsibility by your insurance company
- **Rescheduling of surgery will result in a \$100 fee.** Scheduling of surgery has a huge impact on many schedules including the surgeon, hospital operating room, surgical assistant and anesthesiologist. If you need to reschedule due to illness or unexpected circumstances, the fee may be waived.

THIS AGREEMENT SUPERSEDES ALL OTHER VERBAL AGREEMENTS

I have read and agree to be financially responsible for all services both COVERED and NON COVERED by my insurance company.

PATIENT/INSURED SIGNATURE

DATE

THIS OFFICE IS NOT RESPONSIBLE FOR DISPUTING INSURANCE COMPANY DECISIONS REGARDING COVERAGE



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Name: _____

Appointment Date: _____

Referring Doctor: _____

Date of Birth: _____

In order to give you the best possible care, please complete this health history questionnaire. This confidential information will give your providers the information they need to better understand your pelvic floor health (bowel, bladder and female organs). If you don't understand any question, please place a "?" in the column. Your provider will review this questionnaire and ask specific questions from your answers during your appointment. Please bring this completed questionnaire and your bladder diary to your appointment. Thank you.

CC: Nature of Problem (Please summarize your bladder, bowel or pelvic floor problem(s) as briefly as possible)

Which symptom is the most bothersome? _____

Duration: How long have you had these symptoms? _____

Severity: Is your lifestyle limited because of your urinary or pelvic floor problem(s)? No Yes

If indicated, are your urinary or pelvic floor problem(s) bad enough for you to request surgery to fix them? No Yes

BLADDER FUNCTION

Frequency

How often do you typically urinate during the day? Every 15 min. 30 min. 1 hr. 2 hrs. 3hrs.

How often do you wake up to urinate during the night after going to bed? 0-1 2-3 4-5 >5

Do you ever wet the bed at night? No Yes

How often do you wet the bed? every night 2-3/wk. 1-2/wk. 1-2/mo.

Do you have a history of bedwetting or involuntary urine leakage as a child? No Yes

Urgency

When you feel the urge to urinate, do you have to rush to the bathroom? No Yes

How severe is the urge? mild moderate severe

Does the sound, sight or feel of running water cause you to lose urine? No Yes

SUI

Do you ever lose urine during any of the following activities? (check all that apply)

exercising sneezing laughing hard cough gentle cough straining walking bending

standing from a sitting position any change in position total incontinence all the time

If you leak from the above causes, is it usually: few drops wet soaked

If you leak from the above causes, how often does it occur? 1-2/mo. 1-2/wk. 1-2/day 3-5/day >5/day

For how long have you leaked from these causes? 3-6 mo. 6-12 mo. 1-2 yr. 3-5 yrs. >5 yrs.

Urge

When you feel the urge to urinate, do you ever lose urine before reaching the toilet? No Yes

If yes, when you leak is it usually: few drops wet soaked

How often do you leak from the above cause? 1-2/mo. 1-2/wk. 1-2/day 3-5/day >5/day

For how long have you leaked from these causes? 3-6 mo. 6-12 mo. 1-2 yr. 3-5 yrs. >5 yrs.

If you leak from both stress and urge-related causes, which bothers you more? stress urge

Fluids

How would you describe your daily fluid intake? 2-3 glasses 4-8 glasses > 8 glasses

Do you drink any **caffeinated** beverages? (check all that apply)

coffee number of cups/day: 0-1 2-3 4-5 >5

tea number of cups/day: 0-1 2-3 4-5 >5

soda number of cans/day: 0-1 2-3 4-5 >5

other number per day: 0-1 2-3 4-5 >5



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Pads

- Do you wear protection (pads, tissues etc.) for urine loss? No Yes
- What type of protection do you use? tissue mini-pad regular heavy (diaper)
- How many pads do you wear in the daytime? 0-1 2-3 4-5 >5
- How many pads do you wear at night? 0-1 2-3 4-5 >5
- How wet are your pads when you change them? few drops wet soaked

Modifying Factors

- Have you ever tried Kegel or pelvic floor exercises to help your problem? No Yes
- If so, did they help? No Yes
- Have you ever been given medication to help with your leakage problem? No Yes
- If so, did it help? No Yes
- What medication(s) have you used? _____

Associated Signs & Symptoms

- Do you have pain or burning when you urinate? No Yes
- Do you have pain when your bladder is full? No Yes
- If so, does the pain resolve when you empty? No Yes
- Can you feel when your bladder is full? No Yes
- Can you feel when you have leaked urine? No Yes
- Have you ever had blood in your urine not associated with a bladder infection? No Yes

Obstructive Symptoms

Check all that apply

| | Never | Sometimes | Often | Always | Don't know |
|----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Delay in starting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Straining to urinate | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Slow urine flow | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Urine flow that stops and starts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Incomplete emptying | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dribbling after void | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Can't empty at all | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

BOWEL FUNCTION

- How many bowel movements do you have? 1-2/day every other day 1-2/wk. 1-2/mo.
- How often do you have to strain hard to have a bowel movement? <25% 25-50% 50-75% >75%
- Do you require laxatives to have a bowel movement? No Yes

Anal Incontinence

- Do you ever leak stool or gas accidentally? No Yes
- How often do you leak gas? 1-2/day 1-2/wk. 1-2/mo. 1-2/yr. 1-2 times in my lifetime
- How often do you leak liquid stool? 1-2/day 1-2/wk. 1-2/mo. 1-2/yr. 1-2 times in my lifetime
- How often do you leak solid stool? 1-2/day 1-2/wk. 1-2/mo. 1-2/yr. 1-2 times in my lifetime
- When was the last time you accidentally leaked solid stool? few weeks ago few months ago year ago

PROLAPSE

- Do you ever feel a bulge or feel that something is "falling out" of the vagina? No Yes
- If so, when was the first time you noticed it? _____ (month / year)
- Have you ever used a vaginal support device (pessary)? No Yes

Splinting

- Do you have to use your fingers to apply pressure on the vagina or rectum to have a bowel movement? N Y
- If yes, where? In the vagina On the outside between the vagina and rectum
- Do you have to manually remove stool with a finger in the rectum to have a bowel movement? No Yes
- Do you ever have to push tissue back into the vagina to urinate or defecate? No Yes



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SEXUAL FUNCTION

Pelvic floor problems often interfere with sexual relations. In order to best treat you, it is important to obtain this information. If you feel uncomfortable answering these questions prior to your appointment, please discuss these issues with your provider at the time of your initial visit.

- Are you sexually active at this time in your life? No Yes
- Do those sexual activities include vaginal intercourse? No Yes
- Is your sex life satisfactory for you? No Yes
- Do you have any sexual concerns that you would like to address? No Yes

Dyspareunia

- Do you have pain with intercourse? No Yes
- If so, where is the pain? superficial deep both
- Do you have vaginal dryness? No Yes

Associated Signs & Symptoms

- Are your sexual activities limited due to vaginal relaxation (prolapse)? No Yes
- Do you ever leak urine with vaginal intercourse? No Yes
- If so, when does it occur? with penetration with orgasm both

MEDICAL HISTORY

Please note if you have had any of the following medical conditions:

- | | | | | |
|------------------------------|--|--------------------|--|--------------------|
| Neurological disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Urinary infections | <input type="checkbox"/> No <input type="checkbox"/> Yes | # in last yr _____ |
| Diabetes | <input type="checkbox"/> No <input type="checkbox"/> Yes | Thyroid disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| Asthma / Lung disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Kidney infections | <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| Heart disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Kidney stones | <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| High blood pressure | <input type="checkbox"/> No <input type="checkbox"/> Yes | Liver disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| Blood transfusion | <input type="checkbox"/> No <input type="checkbox"/> Yes | History of cancer | <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| Psychiatric disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Pelvic radiation | <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| Other medical history: _____ | | | | |

MEDICATIONS *(Please list all medications, including dosage, that you are taking)*

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

ALLERGIES

- Do you have any drug allergies? No Yes
- If yes, please list them: _____

SURGICAL HISTORY

1. Have you had a hysterectomy? No Yes If yes, what type? Vaginal Abdominal
2. Have you had your ovaries removed? No Yes
3. Please list all other surgeries you have had – the type and year of each surgery.

| | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |



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GYNECOLOGIC HISTORY

When was your last menstrual period? _____ (month / day / year)

Have you had any abnormal uterine bleeding? No Yes

If you **have not** reached menopause: What do you use for birth control? _____

If you **have** reached menopause: Have you ever been on hormone replacement therapy? No Yes

If yes, what medication did you use? _____ For how long? _____ Years Months

Have you ever had an **abnormal** pap smear? No Yes

If so, when was it abnormal? _____ (month / year)

When was your last pap smear? _____ (month / year)

Pregnancy

(Please include all pregnancies)

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---------------------------------------|---|---|---|---|---|---|---|---|
| Year of birth | | | | | | | | |
| Gestational age at delivery (weeks) | | | | | | | | |
| Type of delivery (vaginal, c-section) | | | | | | | | |
| Birth weight | | | | | | | | |
| Were forceps or vacuum used? | | | | | | | | |
| Episiotomy performed? | | | | | | | | |
| Were lacerations sutured in vagina? | | | | | | | | |
| Duration of labor (hrs.) | | | | | | | | |
| Duration of pushing (hrs.) | | | | | | | | |

FAMILY HISTORY

Mother: Living Deceased – Cause _____ Age _____

Father: Living Deceased – Cause _____ Age _____

Siblings: Number living _____ Number Deceased _____ Cause(s) _____

Has anyone in your family had any of the following diseases? (Check all that apply)

| | | | |
|----------------|--|----------------|--|
| Kidney disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Breast cancer | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Diabetes | <input type="checkbox"/> No <input type="checkbox"/> Yes | Ovarian cancer | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Colon cancer | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Hypertension | <input type="checkbox"/> No <input type="checkbox"/> Yes | Other cancer | _____ |

SOCIAL HISTORY

Do you have a regular exercise program? No Yes, please describe _____

Have you worked outside the home? No Yes, please describe _____

What is your marital status? Single Married Divorced Widowed Other

How many people live in your household? _____

Smoking: Never smoked Smoked in the past Currently smoke -- For how many years? _____

How many **packs** of cigarettes do/did you smoke in a day? _____

Alcohol? No Yes How many drinks do you consume on average? 1-2/mo. 1-2/wk. 1-2/day

>2/day

Review of Systems (Please circle any of the following problems that you have experienced over the last year)

| | | | |
|-------------------------|---------------------|---------------------|--------------------------|
| Constitutional | Unusual fatigue | Weight loss | Loss of appetite |
| Eyes: | Double vision | Blurred vision | Glasses / Contacts |
| ENT: | Deafness | Hoarseness | Ringing in ears |
| Cardiac: | Chest pain | Irregular beats | Palpitations |
| Pulmonary: | Shortness of breath | Chronic cough | Wheezing |
| Musculoskeletal: | Muscle weakness | Lower back pain | Hip pain |
| Skin: | Bruising | Hair loss | Unexplained rash |
| Neurologic: | Seizures | Frequent headaches | Numbness |
| Psychiatric: | Depressed | Difficulty sleeping | Memory loss |
| Endocrine: | Hot flashes | Dry skin | Sensitive to heat / cold |
| Blood disease: | Anemia | Bleeding problems | Enlarged lymph gland |
| Allergy: | Sinus problems | Allergic reaction | Conjunctivitis |