Reason for Today's Visit

Name: _____

I AM HERE FOR:

_____ROUTINE WELL WOMAN EXAM

A Well Woman Exam, preventive visit, includes a medical history, physical exam, cervical cancer screening, evaluation and counseling. **An additional fee may be billed if an additional medical problem is addressed or if significant additional time is spent in counseling at the time of your annual exam. If additional services are not covered by your insurance it will be the patient's financial responsibility.**

_____ PROBLEM TO DISCUSS:

___Breast Lump/Nipple Discharge	___Breast Pain	___Abnormal Bleeding
___Pelvic Pain	___Birth Control	___Pain with Intercourse
___Vaginal Discharge	___STD Screening	___Severe Menstrual Cramps
___Urinary Leakage	___Urinary Frequency	___Urinary Tract Symptoms
___Pregnancy Test	___Menopause Issues	___ Irregular Periods

___OTHER_____

_____PROCEDURE:

___Colposcopy	___Repeat Pap	___Endometrial Biopsy	
___IUD Insertion	___IUD Removal	___Injection	___Essure

_____ CONSULT Referred by: _____

____I am aware that I will be financially responsible for any balances due if my insurance company does not cover any of the above problems or procedures.

Signature: _____ Date:_____