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**Marla H. Wohlman, M.D.**

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3351 Main Street • P.O. Box 589  
Millbrook, AL 36054  
334-285-7808

**MEDICAL RELEASE FORM**

Effective April 13, 2003 (due to federal guidelines under HIPPA) we are now required to have a release form signed by the patient before we can give out any medical or financial information to any person other than the patient.

Please list below the names, relationship, and phone numbers of any authorized individuals (spouse, family members, friends, care givers, etc.) with which we may discuss your medical or financial information.

Name	Relationship	Phone Number
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

May we leave medical information on your "home" answering machine? Yes \_\_\_\_\_ No \_\_\_\_\_

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Signature of Patient/Parent Date

**OR**

If you do not want any of your medical or financial information discussed with anyone other than yourself please sign here:

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Signature of Patient/Parent Date

The above information is private and confidential and will be placed in your medical chart. The information on this form will remain valid until we are notified otherwise.

# Marla H. Wohlman, M.D.

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Account No.

**PLEASE PRINT**

**PATIENT REGISTRATION**

PATIENT	Last Name		First	Middle	Marital Status		
					M	S	D
	Street Address		Email Address		Cell Phone		
	City		State	Zip Code	Home Phone		
	Employed By		Address		Work Phone		
	Sex	Date of Birth	Mo / Day / Year	Social Security No.	Driver's License Co.	State Issued	
	Spouse's Name		Spouse's Social Security No.				
	Spouse's Employer		Address		Spouse's Employer Telephone No.		
	Nearest Friend or Relative Not Residing With You			Relationship to Patient	Telephone No.		
How Did You Learn About Us?							
<input type="checkbox"/> Community Reputation		<input type="checkbox"/> Friend		<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Internet	
<input type="checkbox"/> Television		<input type="checkbox"/> Another Patient		<input type="checkbox"/> Physician		<input type="checkbox"/> Newspaper	
						Other _____	
INSURANCE	Please Check:		<input type="checkbox"/> Medicare	<input type="checkbox"/> Health Choice	<input type="checkbox"/> United	<input type="checkbox"/> Other	
			<input type="checkbox"/> BCBS	<input type="checkbox"/> Aetna	<input type="checkbox"/> Tricare	What is your Copay/Deductible?	
	Insurance Company Name (Primary)			Insurance Company Address			
	Policy Holder	Date of Birth	Sex	Policy Number	Group Number		
			Mo / Day / Year				
Insurance Company Name (Secondary)		Insurance Company Address					
RESPONSIBLE PARTY	<b>COMPLETE THIS SECTION IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE</b>						
	Last Name	First	Middle	Date of Birth	Mo / Day / Year	Relationship to Patient	
Street Address		Social Security No.		Driver's License No.			
City		State	Zip Code	Home Telephone No.			
Employed By		Business Telephone No.					

**PLEASE READ BEFORE SIGNING**

**GUARANTEE OF ACCOUNT**

THE GUARANTOR IS RESPONSIBLE FOR PAYMENT OF ALL CHARGES HEREFTER INCURRED BY THE GUARANTOR AND THE GUARANTOR'S FAMILY. If insurance is filed by Dr. Wohlman the Guarantor is responsible for the insurance payment and any remaining balance. If we do not file insurance Guarantor is responsible for payment of charges at time of service. Any balance of 30 days past due will be charged an annual fee of 21%. Any charges not paid within 90 days will be turned over to our collection agency. Any cost incurred by Dr. Wohlman through collection, attorney fees, and court costs will be the responsibility of the Guarantor and the Guarantor will hereby waive the rights of exemption under the law of the state of Alabama and any other state. Any services rendered after an account has been turned over to our collection agency will be on a cash basis only. I agree to keep Dr. Wohlman advised on any change of address or any other change in the information furnished. I authorize the release of any credit information including but not limited to verification of employment and income as needed by Dr. Wohlman and/or her agents.

Authorization: I or we hereby authorize Dr. Wohlman and the Medical Staff to perform such Medical and Surgical procedures as are necessary and to release records as needed for received treatment. I acknowledge that no guarantees have been made as to the effect of such treatment.

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

\_\_\_\_\_  
Date

**Marla H. Wohlman, M.D.**

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**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly
- Obtain payment form third-party payers
- Conduct normal health care operations such as quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented: Date \_\_\_\_\_ Initials \_\_\_\_\_ Reason \_\_\_\_\_

**PHONE CONTACT AUTHORIZATION  
MARLA H. WOHLMAN, M.D.**

**Your signature authorizes Marla H. Wohlman, M.D. to disclose your personal health information in the following manner.**

Voice mail at home    Yes    No    Phone# \_\_\_\_\_

Voice mail at home    Yes    No    Phone# \_\_\_\_\_

Please list names of the individuals with whom we may discuss your medical information:

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

I understand I may revoke this authorization by contacting Marla H. Wohlman, M.D. in writing.

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

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, or paper, or orally, are kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders of information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to a reasonable request to receive confidential communication of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information
- The right to obtain, and we have the obligation to provide to you, a paper copy of this notice from us at your first office visit.
- The right to receive, and we are obligated to obtain, a written acknowledgment that you have received a copy of our Notice of Privacy Practices.

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Please return your form to the Doctor when you have finished. The Doctor will meet with you to review your information.

**1. Patient Information**

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

Name \_\_\_\_\_

Birth Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email \_\_\_\_\_

MALE

FEMALE

Height \_\_\_\_\_

Weight \_\_\_\_\_

2. Lifestyle Information	Do you use?	If YES, how often and how much?
Tobacco (smoke, chew, dip)	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
Alcohol (beer, wine, hard liquor)	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
Caffeine (cola drinks, tea, coffee)	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____

**IMPAIRMENTS:** Check if you experience any of the following:

Physical Impairment  Visual Impairment  Hearing Impairment

**EXERCISE:** Do you exercise regularly? YES  NO  If YES, describe what you do and how often.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**STRESS MANAGEMENT:** Do you practice any stress management techniques? YES  NO

If YES, describe what you do and how often. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DIET:** Describe your typical daily food intake.

First Meal	Second Meal	Third Meal	Any Snacks

**3. Doctor Information:** Are you currently under the care of a physician? YES  NO

If YES, please list each doctor from whom you seek care, including address and phone number, if you know it.

Doctor Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Doctor Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Doctor Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Patient Name: \_\_\_\_\_ SS# \_\_\_\_\_

**4. Allergies:** Please check all that apply.

- |                                     |   |   |  |
|-------------------------------------|---|---|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Morphine       | <input type="checkbox"/> dye allergies      | <input type="checkbox"/> pet allergies     |
| <input type="checkbox"/> Codeine    | <input type="checkbox"/> aspirin        | <input type="checkbox"/> nitrate allergy    | <input type="checkbox"/> seasonal (pollen) |
| <input type="checkbox"/> Sulfa drug | <input type="checkbox"/> food allergies | <input type="checkbox"/> no known allergies | Other _____                                |

**5. Over-the-counter (OTC) issues:**

Please check all products that you use occasionally or regularly. Check all that apply.

- |   |  |
|---|--|
| <input type="checkbox"/> Pain reliever                                    | <input type="checkbox"/> Combination product (cough-cold reliever – example: TriamicDM®) |
| <input type="checkbox"/> Aspirin  | <input type="checkbox"/> Sleep aids (examples: Excedrin PM®, Unisom®, Somnex®, NytoI®)   |
| <input type="checkbox"/> Acetaminophen (example: Tylenol®)                | <input type="checkbox"/> Antidiarrheals (examples: Imodium®, Pepto Bismol®, Kaopectate®) |
| <input type="checkbox"/> Ibuprofen (example: Motrin IB®)                  | <input type="checkbox"/> Laxatives/stool softeners (examples: Doxidan®, Correctol®)      |
| <input type="checkbox"/> Naproxen Sodium (example: Aleve®)                | <input type="checkbox"/> Diet Aids/weight loss products (example: Dexatrim®)             |
| <input type="checkbox"/> Ketoprofen (example: Orudis KT®)                 | <input type="checkbox"/> Antacids (examples: Maalox®, Mylanta®)                          |
| <input type="checkbox"/> Cough Suppressant (example: Robitussin DM®)      | <input type="checkbox"/> Acid blockers (examples: Tagamet HB®, Pepcid AC®, Zantac 75®)   |
| <input type="checkbox"/> Antihistamine product (example: Chlor-Trimeton®) | <input type="checkbox"/> Other (please list) _____                                       |
| <input type="checkbox"/> Decongestant product (example: Sudafed®)         | _____  |

**NUTRITIONAL/NATURAL SUPPLEMENTS: Please identify and list the products you are using.**

- Vitamins (examples: multiple or single vitamins such as B complex, E, C, beta carotene) \_\_\_\_\_
- 
- Minerals (examples: Calcium, Magnesium, Chromium, colloidal minerals, various single minerals) \_\_\_\_\_
- 
- Herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.) \_\_\_\_\_
- 
- Enzymes (examples: digestive formulas, Bean-Zymn B, Bromelain, CoEnzyme Q10, etc.) \_\_\_\_\_
- 
- Nutrition/protein supplements (examples: shark cartilage, protein powders, amino acids, fish oils, etc.) \_\_\_\_\_
- 
- Others: (glucosamine, etc..) \_\_\_\_\_
- 

**6. Medical Conditions/Diseases:** Please check all that apply to you.

- |  |   |
|--|---|
| <input type="checkbox"/> Heart disease (example: Congestive Heart Failure)     | <input type="checkbox"/> Lung Condition (examples: asthma, emphysema, COPD) |
| <input type="checkbox"/> High cholesterol or lipids (examples: Hyperlipidemia) | <input type="checkbox"/> Diabetes   |
| <input type="checkbox"/> High blood pressure (example: Hypertension)           | <input type="checkbox"/> Arthritis or joint problems                        |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Depression   |
| <input type="checkbox"/> Ulcers (stomach, esophagus)                           | <input type="checkbox"/> Epilepsy   |
| <input type="checkbox"/> Thyroid disease                                       | <input type="checkbox"/> Headaches/migranes                                 |
| <input type="checkbox"/> Hormonal related issues                               | <input type="checkbox"/> Eye disease (glaucoma, etc.)                       |
| <input type="checkbox"/> Blood clotting problems                               | <input type="checkbox"/> Other (please list) _____                          |

**7. Prescription Medications:** Please list all prescription medications you are currently using. Be sure to include all mail order or physician samples. You may write on the back of this sheet if you need more space.

Medication Name	Dose	How many times per day?	Doctor
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			

Patient Name: _____	SS# _____
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1. How did you arrive at the decision to consider Prescription Bioidentical Hormone Replacement Therapy (BHRT)?

Doctor  Self  Friend/family member

2. Bone size:  Small  Medium  Large

3. Body type:  Androgenic (male)  Estrogenic (female)

4. Were you prematurely gray?  No  Yes

**FEMALE PATIENTS ONLY COMPLETE BELOW**

5. Have you ever used oral contraceptives?  No  Yes

5a. If YES, any problems?  No  Yes

5b. Nature of problem \_\_\_\_\_

6. Have you been pregnant?  No  Yes

6a. If yes, how many pregnancies? \_\_\_\_\_ 6b. How many children? \_\_\_\_\_

7. Have you had a hysterectomy?  No  Yes

7a. If YES, Date of surgery: \_\_\_\_\_ Total \_\_\_\_\_ Uterus Only \_\_\_\_\_

8. Have you had a tubal ligation?  No  Yes

9. Do you have a family history of any of the following? Check all that apply.

Uterine Cancer  Ovarian Cancer  Heart Disease  Breast Cancer  Osteoporosis

10. Have you had any of the following tests performed? Check those that apply and note date of last test.

Mammography  No  Yes Date: \_\_\_\_\_

PAP Smear  No  Yes Date: \_\_\_\_\_

11. Since you first began having periods, have you ever had what YOU would consider to be abnormal cycles?

No  Yes If YES, please explain (such as age when this occurred, symptoms, etc.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. When was your last period? \_\_\_\_\_

12a. How many days did it last? \_\_\_\_\_

13. Do you have, or did you ever have Premenstrual Syndrome (PMS)?  No  Yes

13a. If YES, explain symptoms: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_ SS# \_\_\_\_\_

## Female Hormone Replacement Therapy Patient Symptom Questionnaire

Have you experienced any of the following symptoms recently? Please circle the number that best describes your experiences, with 1 being extremely mild and 10 being extremely severe.

Sleep Disruptions	1	2	3	4	5	6	7	8	9	10
Fatigue	1	2	3	4	5	6	7	8	9	10
Vaginal Dryness	1	2	3	4	5	6	7	8	9	10
Irritability	1	2	3	4	5	6	7	8	9	10
Nervousness	1	2	3	4	5	6	7	8	9	10
Breast Tenderness	1	2	3	4	5	6	7	8	9	10
Hot Flashes	1	2	3	4	5	6	7	8	9	10
Dry Skin	1	2	3	4	5	6	7	8	9	10
Mood Swings	1	2	3	4	5	6	7	8	9	10
Arthritis	1	2	3	4	5	6	7	8	9	10
Loss of Recent Memory	1	2	3	4	5	6	7	8	9	10
Weight Gain	1	2	3	4	5	6	7	8	9	10
Decreased Sex Drive	1	2	3	4	5	6	7	8	9	10
Depression	1	2	3	4	5	6	7	8	9	10
Fluid Retention	1	2	3	4	5	6	7	8	9	10
Headaches	1	2	3	4	5	6	7	8	9	10
Night Sweats	1	2	3	4	5	6	7	8	9	10
Hair Loss	1	2	3	4	5	6	7	8	9	10
Harder to Reach Climax	1	2	3	4	5	6	7	8	9	10
Bladder Symptoms	1	2	3	4	5	6	7	8	9	10
Other: _____	1	2	3	4	5	6	7	8	9	10
Other: _____	1	2	3	4	5	6	7	8	9	10
Other: _____	1	2	3	4	5	6	7	8	9	10

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Patient Name: _____ SS# _____
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