PATIENT NAME: _______________ DATE OF BIRTH: __________

New OB Patient

Full Name: ____ **Date of Birth**: ______ /_______ /________

Telephone: ____________________ ☐ Cell ☐ Home **Email**: ____________________

Address: ____ City: _______________ Zip: ________

Social Security #: ___________ - ________ - ___________ **TX Drivers License** #: ___________________

Occupation: _______________________ Employer: ___________________Work Phone: ____________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Emergency Contact: ______________________ Relationship:_____________ Telephone:____________

Primary Insurance: ____________________ Policy #: _________________ Group #: ________________

Primary Insured: ☐ Same as above. Other: ________________________ Birthdate: _____________

Secondary Insurance: __________________ Policy #: _________________ Group #: ________________

Primary Insured: ☐ Same as above. Other: ________________________ Birthdate: _____________

Assignment & Release

- I understand I am responsible to Women's OB/GYN Center for the charges incurred by my dependents or myself
- Returned checks will be assets a fee or turned over to the District Attorney for prosecution
- I hereby authorize Women's OB/GYN Center to release any information requested by the above named insurance company or companies and their representatives for payment of all services rendered.
- I have received the notice of privacy policies for Women's OB/GYN Center
- I consent to have treatment provided to me by the physician of Women's OB/GYN Center
- Failure to provide correct information will result in charges being billed to you
- There will be a fee of $30.00 for the completion of all FMLA paper work prior to picking up forms
- A $25.00 fee will be placed on your account for any no show appointments. Appointments must be cancelled at least 24 hours prior to visit to avoid the fee

Signature: ____________________________________ **Date:** _______________________

PATIENT NAME: _______________ DATE OF BIRTH: __________

Patient Confidentiality Statement

Patients of Women's OB/GYN Center have the right of patient confidentiality on all medical information and laboratory results. All information shall be held in confidential and shall not be disclosed to any person, except upon the expressed consent of the patient or by the guidelines of his/her medical insurance. All biopsy reports and laboratory results will only be given to the PATIENT unless otherwise noted below. If the patient is a minor, all information will be explained to the parents or legal guardian.

The following individuals are authorized to access my medical information:

Authorized Person: _________________________ Relation: ______________ Birthdate:_____________

Authorized Person: _________________________ Relation: ______________ Birthdate:_____________

Authorized Person: _________________________ Relation: ______________ Birthdate:_____________

Authorized Person: _________________________ Relation: ______________ Birthdate:_____________

Can we mail correspondence to your home address: ☐ Yes ☐ No

Can we leave a message on your cell/home voicemail: ☐ Yes ☐ No

Can we leave a message for you on your work phone number: ☐ Yes ☐ No

Signature: ___________________________________ Date: __________________________

PATIENT NAME: _______________ DATE OF BIRTH: __________

Important Notice Regarding Medicaid Coverage as a Secondary Payor

Please be advised that Women's OB/GYN Center **DOES NOT** accept Texas Medicaid as **Secondary Coverage.**

If you have Medicaid as secondary coverage or intend to apply for it we can continue to see you, However we will only accept and file your claims to your primary insurance carrier and you will be responsible for any copays, deductible and coinsurance cost applied. We can only accept Medicaid if it's your only insurance coverage.

Patient Name: ____________________________________ Birthdate: _________________________

Patient Signature: __________________________________ Date: _____________________________

Private Pay Agreement

I understand Women's OB/GYN Center is accepting me as a private pay patient for the period of:

______ / ______ / ______ through _____ / _____ / _____.

I will be solely responsible for paying for any services I receive. The provider will not file a claim to Medicaid, Medicare, or my private insurance company for services provided to me during this time.

Signature: ___________________________________

Print Name: ________________________________ Date: ____________________

PATIENT NAME: _______________ DATE OF BIRTH: __________

Pharmacy Information

Unless otherwise stated **all prescriptions are sent electronically** to your pharmacy. To help make this process easier for you and for your provider please provide us with your pharmacy information.

Name of your Pharmacy:

☐ CVS ☐ Walgreens ☐ Walmart

☐ Other: ____

Address of your Pharmacy:

Address: ____

City: ____

Zip Code: _________________________

Telephone: ________________________

Women's OB/GYN CENTER

PATIENT NAME: ______________ DATE OF BIRTH: __________

When was the first day of your last menstrual period? ______________

Are your periods regular/monthly? ☐ YES ☐ NO

How sure are you about this date? ☐ Definite/tracking ☐ Uncertain/best guess

Have you had an ultrasound yet for this pregnancy? ☐ YES ☐ NO

If yes, where? __________ When? __________ What is your due date? __________

Pregnancy History Total number of living children: _______

Date	Type	# Weeks	Gender	Weight	Complications
	☐ vaginal ☐ c-section		☐ male ☐ female		
	☐ vaginal ☐ c-section		☐ male ☐ female		
	☐ vaginal ☐ c-section		☐ male ☐ female		
	☐ vaginal ☐ c-section		☐ male ☐ female		
	☐ vaginal ☐ c-section		☐ male ☐ female		

Did you have any of the following complications with any pregnancy?

- ☐ High blood pressure or preeclampsia
- ☐ Gestational diabetes
- ☐ Bad vaginal laceration (3rd/4th degree)
- ☐ Blood transfusions
- ☐ Baby admitted to NICU
- ☐ Shoulder dystocia or other birth trauma
- ☐ Birth defects (including heart)
- ☐ Baby with genetic disorder or autism
- ☐ Forceps or vacuum used for delivery
- ☐ Stillborn or death of child after delivery

Have you ever had a miscarriage, abortion, ectopic or molar pregnancy?

Year	Type	# weeks in pregnancy	Treatment
	☐ miscarriage ☐ abortion ☐ ectopic ☐ molar	☐ <12 ☐ 13-16 ☐ 16-20 ☐ >20	☐ D&C ☐ medication ☐ none ☐ methotrexate
	☐ miscarriage ☐ abortion ☐ ectopic ☐ molar	☐ <12 ☐ 13-16 ☐ 16-20 ☐ >20	☐ D&C ☐ medication ☐ none ☐ methotrexate
	☐ miscarriage ☐ abortion ☐ ectopic ☐ molar	☐ <12 ☐ 13-16 ☐ 16-20 ☐ >20	☐ D&C ☐ medication ☐ none ☐ methotrexate
	☐ miscarriage ☐ abortion ☐ ectopic ☐ molar	☐ <12 ☐ 13-16 ☐ 16-20 ☐ >20	☐ D&C ☐ medication ☐ none ☐ methotrexate

Gynecologic History

Have you ever been diagnosed with:

☐ Fibroids ☐ Uterine septum ☐ Bicornuate uterus ☐ Genital Herpes

☐ Other Gynecologic problem: _____________

When was your last pap smear? _______________

Was it normal? ☐ **YES** ☐ **NO**

Have you ever had an abnormal pap smear? ☐ **YES** ☐ **NO**

If yes, did you have any treatment? What kind of treatment? When?

____

Do you have any of the following symptoms? (check box)	**NEVER**	**MILD**	**SEVERE**
Vaginal Bleeding			
Pelvic cramping/pain			
Nausea			
Vomiting			

Women's OB/GYN CENTER

PATIENT NAME: _______________ DATE OF BIRTH: __________

Do you have any of the following medical conditions?

☐ High blood pressure ☐ Diabetes ☐ Heart disease

☐ Thyroid disease ☐ Migraines ☐ Epilepsy/seizures

☐ Depression ☐ History of blood clots (DVT or PE)

☐ Other: ____

What medications are you currently taking?

☐ Taking prenatal vitamins – brand? _________________________

Name: ________________________ Dose: _________________

Name: ________________________ Dose: _________________

Name: ________________________ Dose: _________________

Name: ________________________ Dose: _________________

Are you allergic to any medications? ☐ **YES** ☐ **NO**

If yes, which medication(s)? ____

Are you allergic to **latex?** ☐ **YES** ☐ **NO**

Are you allergic to **iodine?** ☐ **YES** ☐ **NO**

Please list any surgeries you have had in the past:

Surgery: __________________________ Year: _________________

Surgery: __________________________ Year: _________________

Surgery: __________________________ Year: _________________

Surgery: __________________________ Year: _________________

Surgery: __________________________ Year: _________________

Women's OB/GYN CENTER

PATIENT NAME: _______________ DATE OF BIRTH: __________

Family History

☐ Mom/sister with preeclampsia ☐ Mom/sister with recurrent miscarriages

☐ Mom/sister with preterm labor

☐ Diabetes – which family member(s)? ____

☐ Blood clotting disorder – which family member(s)? _________________________________

☐ Genetic disorder – what type? ______________ which family member(s)? _____________

☐ Birth defect – what type? ______________ which family member(s)? _________________

☐ Other: ____

Does the father of the baby have any medical conditions or a family history of birth defects or genetic disorders? ☐ NO ☐ YES – type: ____

Do you use tobacco products? ☐ **NO**

☐ **YES** -- How many cigarettes per day? ___________ For how many years? ___________

☐ **Not anymore** -- When did you quit? _________ How many years did you smoke? _____

Do you drink alcohol? ☐ **NO**

☐ **YES** -- How many drinks do you have per week? _________

☐ **Not anymore** -- When did you quit? _________ Have you been to rehab? ___________

Do you use drugs? ☐ **NO**

☐ **YES** – How often? ________________ What type(s)? _____________________________

☐ **Not anymore** -- When did you quit? _________ Have you been to rehab? ___________

Do you have a cat at home? ☐ **NO** ☐ Indoors cat ☐ Outdoors only

Do you work/live somewhere where you could be exposed to chemicals? ☐ **NO**

If yes, what kind? ____

Do you feel safe at home? ☐ **YES** ☐ **NO**

Have you ever been a victim of domestic violence? ☐ **YES** ☐ **NO**