



PATIENT NAME: _____ DATE OF BIRTH: _____

New Patient Information – Postmenopausal

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 assessed 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.
- I understand that failure to provide correct information may result in additional charges.
- I understand that there is a fee of \$30.00 for the completion of all FMLA paperwork.
- I understand that if I am more than 15 minutes late for my appointment, it may be rescheduled.
- I understand that my appointments must be cancelled or rescheduled at least 24 hours in advance, or I will be charged a \$25.00 fee for any appointment that I miss.

Signature: _____

Date: _____



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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: _____



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Important Notice Regarding Medicaid Coverage as a Secondary Payor

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: _____

Pharmacy Information



PATIENT NAME: _____ DATE OF BIRTH: _____

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: _____

How did you hear about us? Google Yelp Other internet: _____

Referred by doctor – name: _____

Referred by Friend/Family – name: _____

Other: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

What is the reason for your appointment today?

How old were you when you entered menopause? _____

Have you ever been on Hormone Replacement Therapy? YES NO

If yes, what kind and for how long? _____

Are you sexually active? YES NO

Men Women Both

One partner More than one partner

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?

PATIENT NAME: _____ DATE OF BIRTH: _____

When was your last mammogram? _____

Was it normal? YES NO

Do you have any family history of breast or ovarian cancer? YES NO

If yes, which family member and how old were they when diagnosed?

When was your last colonoscopy (or other colon cancer screening)? _____

Was it normal? YES NO

Do you have any family history of colon cancer? YES NO

If yes, which family member and how old were they when diagnosed?

When was your last bone density scan? _____

Was it normal? Normal Osteopenia Osteoporosis

If it was abnormal, what kind of treatment are you on?

How many times have you been pregnant?

___ vaginal deliveries # ___ c-sections # ___ miscarriages, ectopics, or abortions

How many pounds did your largest baby weigh at birth? _____

Do you have a FAMILY history of any of the following?

High blood pressure Diabetes Heart disease

Cancer – if yes, what kind? _____ Which relative had it? _____

How old were they when they were diagnosed? _____

Other: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

Health Assessment

Do you have any of the following symptoms? (check box)	NEVER	MILD	SEVERE
Hot flashes			
Night sweats			
Decreased sex drive/libido			
Difficult to climax sexually			
Insomnia			
Mood changes/irritability			
Mental confusion or memory loss			
Vaginal dryness			
Vaginal itching or irritation			
Painful intercourse			
Weight gain			
Dry skin			
Hair falling out			
Cold all the time			
Vaginal bleeding			
Spotting after intercourse			
Leaking urine			
Frequent urination or urgency			
Waking up often at night to urinate			
Pain with urination			
Constipation			
Prolapse (bladder/uterus falling out, bulge from vagina)			

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Do you have any of the following medical conditions?

- | | | |
|--|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> GERD (acid reflux) |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Migraines | <input type="checkbox"/> Epilepsy/seizures |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Liver disease |

Other: _____

What medications are you currently taking? *Include vitamins and supplements*

- | | | |
|-------------|-------------|------------------|
| Name: _____ | Dose: _____ | Frequency: _____ |
| Name: _____ | Dose: _____ | Frequency: _____ |
| Name: _____ | Dose: _____ | Frequency: _____ |
| Name: _____ | Dose: _____ | Frequency: _____ |
| Name: _____ | Dose: _____ | Frequency: _____ |
| Name: _____ | Dose: _____ | Frequency: _____ |
| Name: _____ | Dose: _____ | Frequency: _____ |
| Name: _____ | Dose: _____ | Frequency: _____ |

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

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Please list any surgeries you have had in the past:

Surgery: _____ Year: _____

Surgery: _____ Year: _____

Surgery: _____ Year: _____

Surgery: _____ Year: _____

Surgery: _____ Year: _____

Surgery: _____ Year: _____

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 FAMILY history of any of the following? High blood pressure Diabetes Heart disease Cancer -- if yes, what kind? _____ Which relative had it? _____

How old were they when they were diagnosed? _____

 Other: _____