Women's OB/GYN CENTER

PATIENT NAME: _____ DATE OF BIRTH: _____

New Patient Information (age <40)

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: _____

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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: _____

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

☐ Referred by doctor – name: _____

☐ Referred by Friend/Family – name:_____

☐ Other: _____

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What is the reason for your appointment today?

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

How often do you get your period? _____ How long does it last? _____

On your heaviest day, how often do you change your pads or tampons? _____

Does your period interfere with your work or social life? ☐ **YES** ☐ **NO**

Do you often overflow and stain your clothing/sheets? ☐ **YES** ☐ **NO**

Are your periods painful? ☐ **YES** ☐ **NO**

If yes, have you ever been treated for painful periods? How?

Are you sexually active? ☐ **YES** ☐ **NO**

☐ Men ☐ Women ☐ Both

☐ One partner ☐ More than one partner

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Are you currently using any form of birth control? ☐ **YES** ☐ **NO**

If yes, what kind of birth control are you using?

☐ Tubes tied ☐ Vasectomy ☐ Condoms ☐ Nuvaring ☐ Patch ☐ Other

☐ Pill – which one? _____ ☐ Nexplanon – when was it placed? _____

☐ IUD – type? _____ when was IUD placed? _____

Do you plan on becoming pregnant in the near future? ☐ **YES** ☐ **NO**

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?

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?

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

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

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: _____

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Do you have any of the following symptoms? (check box)	**NEVER**	**MILD**	**SEVERE**
Decreased sex drive/libido			
Difficult to climax sexually			
Painful intercourse			
Weight gain			
Dry skin			
Hair falling out			
Cold all the time			
Spotting after intercourse			
Leaking urine			
Waking up often at night to urinate			
Constipation			
Prolapse (bladder/uterus falling out, bulge from vagina)			

How many times have you been pregnant? Please fill in numbers below:

#____ full-term vaginal deliveries #____ premature vaginal deliveries

#____ full-term c-sections #____ premature c-sections

#____ miscarriages (managed with D&C) #____ miscarriages (managed at home)

#____ ectopic pregnancy (had surgery) #____ ectopic pregnancy (had methotrexate)

#____ abortions (using procedure) #____ abortions (using medications)

Total number of living children: #_____

Have you ever been diagnosed with:

☐ Fibroids ☐ Endometriosis ☐ PCOS ☐ STD – type: _____

☐ Other Gynecologic problem: _____

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Do you have any of the following medical conditions?

☐ High blood pressure	☐ Diabetes	☐ GERD (acid reflux)
☐ High cholesterol	☐ Heart disease	☐ Arthritis
☐ Thyroid disease	☐ Migraines	☐ Epilepsy/seizures
☐ Depression	☐ Kidney disease	☐ 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? _____