9200 Pinecroft, Suite 345
The Woodlands, Texas 77380
281-602-7380 / 281-602-7386 (fax)

PATIENT INFORMATION FORM

Date: _____

Patient Name: _____

DOB: _____ Social Security #: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Work phone: _____

Cell Phone: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Employer: _____

Email Address: _____

Spouse Name: _____

Spouse DOB: _____ Spouse Social Security #: _____

Spouse Work Phone: _____ Spouse Cell: _____

How did you hear about us? _____

Primary Care Physician: _____

RESPONSIBLE PARTY:

Insured/Responsible Party Name: _____

Insured/Responsible Party DOB: _____

Insured/Responsible Party Social Security #: _____

Address: _____City/State/Zip:_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Employer: _____

Email address: _____

Relationship to Patient: _____

Please provide proof of insurance and photo identification upon submission of these forms

All About Women
OBSTETRICS & GYNECOLOGY

Medical History Form

Patient Name: _____ DOB: _____

Gynecologic History

What was the first day of your last period?	Are you currently sexually active? Yes / No If no, have you ever had sex? Yes / No
At what age did your periods start?	Any abnormal vaginal discharge? Yes / No
How often do you have a period? Every _____ days	Have you ever been treated for a pelvic infection? Yes / No
How many days does your period last? _____ days	Any pain with sex? Yes / No
Any pain with your periods? Yes / No	Have you ever been treated for infertility? Yes / No
Any changes in your periods? Yes / No	Have you ever had herpes? Yes / No
When was your last pap test?	Your present method of birth control is _____
Have you ever had an abnormal pap? Yes / No If yes, when…… If yes, explain……	Are you trying to get pregnant? Yes / No

Obstetrical History

	Number		Number		Number
Total Pregnancies		Abortions		Miscarriages	
Preterm Births (<37 wks)		Term Births		Living Children	

No.	Birth Date	Weight	Baby's Sex	Gestational Age @ Delivery	Vaginal or C-Section	Complications
1						
2						
3						
4						
5						
6						

Any history of diabetes, high blood pressure or pre-eclampsia with your pregnancies?
Any history of depression?
History of chicken pox or chicken pox vaccination?
History of rheumatic fever or heart disease?

Medical History

Are you allergic to any medications? Yes / No

If so, please provide name and list reaction...

Any History of…….

Asthma	Yes / No	Heart Failure	Yes / No
Diabetes	Yes / No	Heart Attack	Yes / No
Eating Disorder	Yes / No	High Blood Pressure	Yes / No
Bowel Problems	Yes / No	Abnormal Heart Rhythm	Yes / No
Ulcer or Gastritis	Yes / No	Blood Clots	Yes / No
Liver Problems	Yes / No	Lupus	Yes / No
Thyroid Problems	Yes / No	Sexually Transmitted Disease	Yes / No
Blood Problems	Yes / No	Cancer	Yes / No
Kidney Problems	Yes / No	If so, where?	

Serious Illness? If yes, explain…
Hospitalization? If yes, explain…
Blood Transfusion? If yes, explain…
Surgeries? If yes, list along with date…
Recent Immunizations: Hepatitis B? Tetanus?

Social History

Marital Status: ____ Single ____ Married ____ Partner ____ Widowed ____ Divorced

Tobacco: ____ Never smoked ____ Quit
____ Smoker (____ years smoked, ____ packs per day)

Alcohol: ____ Never ____ <1 week ____ 1-5 per week ____ Other

Drug Use: ____ Yes ____ No

Seat belt use: ____ Yes ____ No

Regular exercise: ____ Yes ____ No

Do you take calcium or dairy products: ____ Yes ____ No

Have you been hurt by anyone: ____ Yes ____ No

Do you have an advance directive (living will): ____ Yes ____ No

Family History

Any history of these in a parent, sibling, child, grandparent or other relative?

Stroke	Yes / No	Osteoporosis	Yes / No
Diabetes	Yes / No	Bleeding Tendencies	Yes / No
Heart Problems	Yes / No	Sickle Cell or Thalassemia	Yes / No
Heart Attack	Yes / No	Hereditary Defects	Yes / No
High Blood Pressure	Yes / No	Cystic Fibrosis	Yes / No
Abnormal Heart Rhythm	Yes / No	Arthritis or Gout	Yes / No
Blood Clots in legs or lung	Yes / No	Mental Illness	Yes / No
High Cholesterol	Yes / No	Cancer	Yes / No
Tuberculosis	Yes / No	If so, where?	

Medications (include over the counter medications, herbal remedies and vitamins)

Name	Dose	Times per day	Why do you take it?

Preferred Pharmacy

Preferred Pharmacy Name: _____

Preferred Pharmacy Address: _____

City/State/Zip: _____

Pharmacy Phone Number: _____

Pharmacy Fax Number: _____

Signature of Patient/Legal Guardian: _____

Date: _____

All About Women
OBSTETRICS & GYNECOLOGY

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for All About Women Obstetrics and Gynecology to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. All About Women Obstetrics and Gynecology reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy may be obtained by forwarding a written request to 9200 Pinecroft Dr., Suite 345, The Woodlands, TX 77380.

With this consent, All About Women Obstetrics and Gynecology may call, mail, email, leave a message on voicemail or in person, to my home or other alternative location in reference to any items that assist the practice in carrying out TPO. Such items include: appointment reminder calls and cards, patient statements, insurance items and any calls pertaining to my clinical care, including laboratory test results.

I have the right to request that All About Women Obstetrics and Gynecology restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I authorize my insurance carrier to release information regarding my coverage to All About Women Obstetrics and Gynecology. I also authorize agents of any hospital, treatment center or previous physicians to furnish All About Women Obstetrics and Gynecology copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within this office.

By signing this form, I am consenting to allow All About Women Obstetrics and Gynecology to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, All About Women Obstetrics and Gynecology may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Relationship to Patient

_____

Print Patient's Name

_____ _____

Print Name of Legal Guardian (if applicable) Date

Release of Medical Information

OPTIONAL: ***ONLY SIGN IF YOU WANT US TO BE ABLE TO RELEASE YOUR MEDICAL INFORMATION TO SOMEONE ELSE.***

By signing the following form I, _____ , allow the following person, _____ (name of relative or spouse who you would like information released to) to have access to my medical information associated with All About Women Obstetrics and Gynecology. This includes any personal information that should be documented in the chart, results of any lab work and phone calls.

If you want to release information to more than one person, please list the names and relationships below…..

_____

_____

_____

THIS AGREEMENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING

_____ _____

Patient Signature/Legal Guardian Date

All About Women
OBSTETRICS & GYNECOLOGY

Financial Policy and Procedures

All About Women Obstetrics and Gynecology believes all patients deserve the best medical care that can be provided. In order to provide the highest quality medical care and current technology, we must ensure we are able to meet the expenses necessary to operate this facility. To ensure these expenses are met, we provide you with this agreement to acquaint you with our financial policy.

Payment At Time of Service

As a courtesy, we will bill your insurance for all office visits, procedures, surgeries and obstetrical care and delivery. We ask that you pay any portion not covered by your insurance due to deductibles or copayments on the day of service.

Appointment Policy

Due to the nature of our busy obstetric practice, if you are more than 15 minutes late you will be asked to reschedule. Should you need to cancel your appointment, please give 24 hour prior notice in consideration to other patients. Failure of 24 hour notification will result in a $25.00 fee.

Insurance Claims

We will submit your insurance claims to your insurance company. However, it is important to remember your insurance is a contract between you and your insurer. Although we file insurance claims as a courtesy to you, you are still responsible for payment of services regardless of the amount your insurance pays.

Balances Due After Insurance Pays

Any remaining balance after your insurance carrier pays is due in 30 days. We attempt to collect these balances prior to any services, but this is an estimate. You will receive a statement from our office regarding any balance due.

Outstanding Balances

We encourage you to keep your account current. Outstanding balances will need to be cleared before appointments can be made. Account balances past due will be sent to an outside agency for collections. At this point the account is out of our hands. To make appointments after accounts have been sent to an outside agency, you will need to clear your account with the collection agency. You will be responsible for the full amount of your account balance and any charges incurred with the agency. It is your responsibility to contact our business office if there are special circumstances regarding your account before your account is turned over to an outside agency.

Payment Options

Our office accepts VISA, MasterCard, Discover, cash or check. A $35.00 fee is charged for returned checks.

I have read the above statements and accept the terms.

_____ _____

Patient's Signature Date

_____ _____

Responsible Party's Signature Date

_____

Relationship to patient