



New Patient Form

DATE: PATIENT NAME:

SEX: M F MARRIED SINGLE WIDOWED DIVORCED

RACE: ETHNICITY: PRIMARY LANGUAGE SPOKEN:

DATE OF BIRTH:

RESPONSIBLE PARTY: RELATIONSHIP:

STREET ADDRESS: CITY: ZIP CODE:

HOME TELEPHONE #: () CELL TELEPHONE #: ()

EMAIL:

EMPLOYED BY: OCCUPATION:

WORK #: () BUSINESS ADDRESS:

EMERGENCY CONTACT: RELATIONSHIP: PHONE #: ()

PRIMARY PHARMACY: PHONE #: () LOCATION:

REFERRED BY:

PRIMARY CARE PHYSICIAN:

PREVIOUS OBGYN:

REASON FOR VISIT:

If injury, is it related to: WORK AUTO OTHER DATE OF INCIDENT:



ALLEN OB/GYN

PATIENT HISTORY FORM

PATIENT NAME:		DATE OF BIRTH:	<input type="text"/>
Allergies: Medication or item (i.e., latex)	Reaction (Type & severity):	Date of onset:	

CURRENT MEDICATIONS (please list ALL medications, including vitamins and supplements):

Name	Dose	Frequency



GYNECOLOGIC HISTORY: please check all that apply

Date of last pap:
 Birth Control
 Last Mammogram:

Abnormal Pap
 Type:
 HPV Vaccine

Menopausal
 Last Period:

Age at onset:
 Age at 1st Period:

SEXUAL HISTORY: please check all that apply

Sexually Active
 STI/STD

Men Women
 Type:

Sexual Problems
 Type:
 How long:

Abuse History:

OBSTETRIC HISTORY: please include info on ALL pregnancies

Total pregnancies:
 Full Term:
 Premature:
 Abortions:

Miscarriages:
 Ectopic(s):
 Multiples:
 Living children:

PAST PREGNANCIES: please include ALL info below

Delivery Date	Weeks Pregnant	Gender	Birth Weight	Hours in Labor	Vaginal/ Cesarean	Anesthesia	Complications



FAMILY HISTORY (please check all that apply and indicate which family member/side of family):

<input type="checkbox"/> Breast Cancer	WHO: _____	Age: _____
<input type="checkbox"/> Ovarian Cancer	WHO: _____	Age: _____
<input type="checkbox"/> Colon Cancer	WHO: _____	Age: _____
<input type="checkbox"/> Endometrial Cancer	WHO: _____	Age: _____
<input type="checkbox"/> Diabetes	WHO: _____	Age: _____
<input type="checkbox"/> High Blood Pressure	WHO: _____	Age: _____
<input type="checkbox"/> Heart Disease	WHO: _____	Age: _____
<input type="checkbox"/> Stroke	WHO: _____	Age: _____
<input type="checkbox"/> Thyroid Disease	WHO: _____	Age: _____
<input type="checkbox"/> Osteoporosis	WHO: _____	Age: _____

SOCIAL HISTORY:

Your Occupation: _____

Marital Status: Single Married Divorced Widowed Partner Name or Spouse (if applicable): _____ DOB: _____

Children's names (if applicable): _____

Current Smoker If yes, how much: _____ Previous Smoker: Quit: _____

Drink Alcohol If yes, what type: _____ How often: _____

Drink Caffeine If yes, what type: _____ How often: _____

Use IV Drugs If yes, what type: _____ How often: _____

Use Marijuana If yes, how often: _____ Last used: _____



SURGICAL HISTORY (please list any surgeries you have had):

Procedure	Reason	Year/Date

PAST MEDICAL HISTORY (your personal history) Please check ALL that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Abuse | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Ovarian Cancer |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> PCOS |
| <input type="checkbox"/> Acne | <input type="checkbox"/> G.I. Problems | <input type="checkbox"/> Polyps |
| <input type="checkbox"/> Anesthesia Complications | <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Preeclampsia |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Headaches | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> ART (IVF of FET) | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pulmonary (TB, etc) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hematologic Dysfunction | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Birth Defect | <input type="checkbox"/> History of STI/STD | <input type="checkbox"/> Other: <input type="text"/> |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> History of Abnormal Pap | |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Hypertension | |
| <input type="checkbox"/> Breast Problems | <input type="checkbox"/> Infertility | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney/Bladder Problems | |
| <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Lung Disease | |
| <input type="checkbox"/> Depression/Postpartum | <input type="checkbox"/> Neurologic/Epilepsy | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis | |

1105 N. Central Expressway, Suite 2360, Allen, Texas 75013
 Office: 469-270-6430
 Fax: 469-270-6431
 www.allenobgyn.com



Financial Responsibility and Consent to Treat

I hereby assign payment directly to Allen OBGYN for any medical/surgical procedures performed. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. I agree to be financially responsible to Allen OBGYN for all charges in the event that I have no insurance, or my insurance is rejected, and for any balance or fee not covered by my insurance and/or determined to be my responsibility. I understand and acknowledge that if Allen OBGYN files my insurance claim, I will remain responsible for the account, and I will be expected to pay any amount due if my insurance does not pay the claim within 45 days. I acknowledge that any amounts quoted as my "out of pocket costs" are only an estimate and that the exact determination of my financial responsibility will be made after my insurance company processes the claim. Payment is expected at the time of service. Methods of payment accepted include check, cash and credit card.

I further agree to pay all costs of collection, including reasonable attorney's fees, at the legal rate of interest on the account until paid in full, and I agree to waive all rights of exemption under the Constitution and the laws of the State of Texas.

I hereby request and authorize all doctors, nurses, technicians or affiliated medical personnel, hospitals and healthcare facilities to furnish all records and reports, including x-rays, copies, and abstracts or excerpts of all records, and any other information requested relating to any hospitalizations, examinations, treatments, tests or opinions concerning any condition for which I am presently being treated, including AIDS related testing, psychiatric or substance abuse information. A copy of this authorization shall be as valid as the original of this document.

GENERAL CONSENT TO TREATMENT By signing below, I (or my authorized representative on my behalf) authorize Allen OBGYN physicians, practitioners and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to affectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

RIGHT TO REFUSE TREATMENT In giving my general consent to treatment, I understand I retain the right to refuse any examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating healthcare providers. I also understand the practice of medicine is not an exact science and no guarantees have been made to me as to the results of my evaluation and/or treatment.

DATE:

PATIENT'S FULL NAME:

PATIENT'S SIGNATURE: _____

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HIPPA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand this:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed y law.
- The practice has the right to restrict the use of information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on you answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

This consent was signed by:

(PRINT NAME PLEASE)

Signature: _____

Date:

Signature: _____

Date:

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No-Show Policy

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That is why it is very important that you keep your scheduled appointment with us and arrive on time. As a courtesy, and to help patients remember their scheduled appointments, Allen OBGYN sends text message and email reminders in advance of the appointment time. If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as those patients who are wanting to schedule with the physicians, please give us at least 24 hours' notice. If you do not cancel or reschedule your appointment within at least 24 hours' notice, we may assess a \$25 "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it. After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you. I understand the "no-show" policy of Allen OBGYN and agree to pay a \$25 fee before being seen if I no-show an appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential no-show charge.

Signature: _____ Date:

****You will need the latest version of Acrobat Reader to submit this form online. Alternatively, you may also fill up this form online, download as a PDF, and email us at receptionist@allenobgyn.com**

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