ALLEN OB/GYN

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: _____

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PATIENT HISTORY FORM

PATIENT NAME:		DATE OF BIRTH:
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

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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

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

☐	Breast Cancer	WHO:		Age:
☐	Ovarian Cancer	WHO:		Age:
☐	Colon Cancer	WHO:		Age:
☐	Endometrial Cancer	WHO:		Age:
☐	Diabetes	WHO:		Age:
☐	High Blood Pressure	WHO:		Age:
☐	Heart Disease	WHO:		Age:
☐	Stroke	WHO:		Age:
☐	Thyroid Disease	WHO:		Age:
☐	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:	

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

Procedure	Reason	Year/Date

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

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

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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: _____

Submit

**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 elvira.baptista@eclinicalworks.com

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