Southwest Ob / Gyn Associates, L.L.P

16651 Southwest Freeway, Suite 200 Sugar Land, TX 77479
7737 Southwest Freeway, Suite 895 Houston, TX 77074
Telephone: (713) 774-5131 Fax: (713) 774-4336

Patient Information (please print)

Treating Physician: (please circle)

Amajoh Daily Diase Galvan Haque Huebner Pehr Penkar Sherman Starr Swords

Last Name _____ First Name _____Middle Initial _____

Address _____ Apt # _____

City _____ State ____ Zip _____ Date of Birth _____ Age _____

Home Phone No. ( ) _____ Cell Phone No. ( )_____

Social Security No._____ Patient's Employer _____

Occupation _____ Work Phone No. ( )_____

Spouse's Name _____ Spouse's Employer _____

Spouse's Occupation _____ Work Phone No. ( )_____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Email Address _____ TX Drivers License No. _____

Emergency Contact (person who does not live in household with you)

Name _____ Phone No. ( )_____ Relationship _____

Referring Physician _____

COMPLETE OR ATTACH A PHOTOCOPY OF INSURANCE CARD

Name of Insurance Company_____ Policy # _____

Policy Holder: Spouse ☐ Parent ☐ Self ☐

Last Name _____ First Name _____Middle Initial _____

Address _____ City _____ State _____ Zip _____

Phone ( )_____ SS# _____ DOB_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby assign all payments for services rendered to me or my dependents to Southwest Obstetrics / Gynecology Associates, L.L.P. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to insurance carriers concerning my illness and treatment.

Signed (Insured or Authorized Person _____ Date _____

PATIENT HISTORY FORM

(Please Print)

Reason for your visit today _____

Is this a well woman visit _____

PAST MEDICAL HISTORY

(If YOU have EVER had any of these conditions, please indicate with an X)

Breast Conditions
_____ Abnormal Mammogram
_____ Breast Cancer ☐ Left ☐ Right
_____ Breast Implants
_____ Fibrocystic Breasts
_____ Other _____

Gyn Problems
_____ Abnormal Pap Smear
_____ Cervical Cancer (Neoplasm)
_____ Dysmenorrhea (Painful Menses)
_____ Endometrial (Uterine) Cancer
_____ Endometriosis
_____ Fibroids
_____ Herpes
_____ Human Papilloma Virus Infection (HPV)
_____ Ovarian Cancer
_____ Ovarian Cysts
_____ Pelvic Inflammatory Disease (PID)
_____ Polycystic Ovarian Syndrome (PCOS)
_____ Sexually Transmitted Disease (STD)
_____ Vaginal Cancer (Neoplasm)
_____ Vulvar Cancer (Neoplasm)
_____ Other _____

Heart or Circulation Conditions (Cardiovascular)
_____ Congenital Heart Disease
_____ Congestive Heart Failure
_____ Coronary Artery Disease
_____ CVA (Stroke)
_____ Hypertension (High Blood Pressure)
_____ Irregular Heart Beat
_____ Mitral Valve Disorders (MVP)
_____ Pulmonary Embolism (Blood Clot in Lung)
_____ Thrombophlebitis (Blood Clot in Extremity)

Endocrine (Glandular) Disorders
_____ Diabetes – Type I (Insulin-Dependent)
_____ Diabetes – Type II
_____ Pituitary Gland Disorder
_____ Thyroid Disease
_____ Other _____

Immune System Diseases
_____ Chronic Fatigue Syndrome
_____ Systemic Lupus Erythematosis
_____ Other _____

Gastrointestinal (GI) Problems
_____ Colitis, Ulcerative
_____ Crohn's Disease
_____ Hepatitis A
_____ Hepatitis B
_____ Hepatitis C
_____ Irritable Bowel Syndrome
_____ Other _____

Blood (Hematologic) Disorders
_____ Anemia
_____ Bleeding Disorder
_____ Clotting Disorder
_____ Sickle Cell Trait or Disease
_____ Thalassemia
_____ Other _____

Musculoskeletal Disorders
_____ Arthritis or Joint Pain
_____ Arthritis, Rheumatoid
_____ Fibromyalgia
_____ Osteopenia
_____ Osteoporosis
_____ Scoliosis
_____ Other _____

Neurologic Disorders
_____ Common Migraines
_____ Headaches (Other)
_____ Multiple Sclerosis
_____ Seizure Disorder (Epilepsy)
_____ TIA or Stroke
_____ Other _____

Date of Last Pap Smear_____

Date of Last Mammogram_____

Date of Last Bone Density_____

Date of Last Colonoscopy_____

Psychiatric or Emotional Conditions
_____ ADHD/ADD
_____ Bipolar (Manic-Depressive)
_____ Major Depression
_____ OCD (Obsessive-Compulsive)
_____ Postpartum Depression
_____ Severe Anxiety or Panic Attacks
_____ Other _____

Respiratory (Lung) or ENT Disorders
_____ Asthma
_____ COPD
_____ Lung Cancer
_____ Pneumonia - Recurrent
_____ Sleep Apnea
_____ Tuberculosis
_____ Other _____

Skin Conditions
_____ Acne (severe)
_____ Eczema
_____ Hirsutism (Excess Hair Growth)
_____ MRSA
_____ Psoriasis
_____ Other _____

Urinary (Urological) Disorders
_____ Calculus (Kidney Stones)
_____ Pyelonephritis
_____ Stress Incontinence
_____ Urge Incontinence/Overactive Bladder
_____ Urinary Tract Infections (UTI)
_____ Other _____

Genetic Disorders
_____ Cystic Fibrosis
_____ Muscular Dystrophy
_____ Other _____

PAST SURGICAL HISTORY

Surgery	Reason	When

HERBS, VITAMINS AND SUPPLEMENTS YOU ARE TAKING

Product name	Dose (if known)	How Often	Start Date	Reason

MEDICATIONS YOU ARE TAKING

Drug name	Dose	How Often	Start Date	Prescribed by

Primary Pharmacy Name _____ phone # _____

Pharmacy Address: _____

ALLERGIES

Do you have any known medication allergies? ☐ YES ☐ NO

Allergic to any of the following (circle those that apply):

Contrast Dye Nickel Peanuts Latex Shellfish Other _____

If yes, please list all allergies here and the allergic reaction

Allergic to	Reaction

FAMILY MEDICAL HISTORY

(If **ANY** close relative of YOURS - such as brothers, sisters, parents, other children - has EVER HAD or CURRENTLY HAS any of the problems listed below, please ENTER AN X in the YES column and then enter the relationship to you; please include maternal or paternal. Also include the approximate age at which this person developed the illness.

Mental Illness	☐ Yes	☐ No	Who: _____
Birth Defects	☐ Yes	☐ No	Who: _____
Blood Clots	☐ Yes	☐ No	Who: _____
Breast Cancer	☐ Yes	☐ No	Who: _____
Colon Cancer	☐ Yes	☐ No	Who: _____
Diabetes	☐ Yes	☐ No	Who: _____
Endometriosis	☐ Yes	☐ No	Who: _____
Genetic Disease	☐ Yes	☐ No	Who: _____
Heart Disease	☐ Yes	☐ No	Who: _____
High Blood Pressure	☐ Yes	☐ No	Who: _____
High Cholesterol	☐ Yes	☐ No	Who: _____
Osteoporosis	☐ Yes	☐ No	Who: _____
Other Cancer	☐ Yes	☐ No	Who: _____
Ovarian Cancer	☐ Yes	☐ No	Who: _____
Thyroid Disease	☐ Yes	☐ No	Who: _____
Uterine Cancer	☐ Yes	☐ No	Who: _____
Uterine Fibroids	☐ Yes	☐ No	Who: _____

MENSTRUAL HISTORY

Menopause: ☐ Yes ☐ No Age of First Menstrual Period _____ Cycle Length (28 days or?) _____

Number of Days of Bleeding with Period _____ # of heavy days _____ # of light days/spotting _____

Severe Pain or Cramps ☐ Yes ☐ No Are you Sexually Active ☐ Yes ☐ No

Number of Sexual Partners: <3 lifetime_____ >3 lifetime _____ Are your sexual partners ☐ Men ☐ Women

Date of Last Normal Menstrual Period (if abnormal, describe) _____

Birth Control Method _____

(*period means # days of bleeding; cycle length means total # of bleeding and non-bleeding days until the next period begins)

PREGNANCY SUMMARY

Total Number of Pregnancies	Full Term Births (> 37 wks)	Premature Births (< 37 wks)	Terminations	Miscarriages	Ectopic pregnancies	Number of Living Children

Comments: _____

_____

PREGNANCY DETAILS

Child's Birthdate	Child's Name	# weeks at Deliver	Length of Labor	Birth Wt.	M or F	Type of Delivery (Vaginal or C/S)	Anesthesia	Complications/ Problems	Physician	Location

SOCIAL HISTORY

Alcohol Use: ☐ Yes ☐ No How Much: _____

Illegal Drug Use: ☐ Yes ☐ No Which Drug(s): _____ How Often: _____

Tobacco Use: ☐ Yes ☐ No How Much: _____

Caffeine Use: ☐ Yes ☐ No How Much: _____

Exercise Habits: ☐ Yes ☐ No What: _____ How Often: _____

Occupation: _____

Hobbies: _____

Notes: _____

REVIEW OF SYSTEMS

Place a check by any problem you are currently experiencing

EAR, NOSE & THROAT
_____ Earaches
_____ Ringing in ears
_____ Hearing problems
_____ Sore throat
_____ Mouth sores
_____ Dental problems

BREAST
_____ Breast lumps
_____ Nipple discharge
_____ Breast pain

CARDIOVASCULAR
_____ Painful breathing
_____ Chest Pain or Pressure
_____ Difficulty Breathing on Exertion
_____ Swelling of legs
_____ Rapid or Irregular heartbeat

RESPIRATORY
_____ Wheezing
_____ Chronic Cough
_____ Shortness of breath
_____ Coughing up blood

GASTROINTESTINAL
_____ Frequent diarrhea
_____ Bloody stool
_____ Nausea
_____ Vomiting
_____ Indigestion
_____ Constipation
_____ Involuntary loss of gas / stool

URINARY TRACT
_____ Blood in urine
_____ Pain with urination
_____ Strong urgency to urinate
_____ Frequency
_____ Involuntary / unintended loss of urine
_____ Urine loss when coughing / lifting

GYNECOLOGICAL
_____ Abnormal bleeding
_____ Painful periods
_____ Premenstrual Syndrome (PMS)
_____ Painful intercourse
_____ Fibroids
_____ Endometriosis
_____ Infertility
_____ DES exposure
_____ Abnormal vaginal discharge

SKIN
_____ Rash (persistent)
_____ Sores
_____ Dry skin
_____ Moles (change in color or shape)

MUSCULOSKELETAL
_____ Muscle pain
_____ Joint pain

ENDOCRINE
_____ Hair loss
_____ Heat / Cold intolerance
_____ Abnormal thirst
_____ Hot flashes

PSYCHIATRIC
_____ Depression
_____ Severe anxiety
_____ Severe sleep difficulties

EYES
_____ Double vision
_____ Spots before your eyes
_____ Vision changes
_____ Glasses / contacts

CONSTITUTIONAL
_____ Weight Loss
_____ Weight Gain
_____ Fever
_____ Fatigue
_____ Weight

I attest the information provided is true and correct to the best of my belief.

Patient Signature _____ Date _____

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Patient Authorization for Release of Information

I authorize Southwest Ob / Gyn Associates to disclose or provide protected health information about me to the following person (s):

Name: _____ Relationship: _____

Name: _____ Relationship:_____

By signing below I authorize Southwest Ob Gyn Associates to leave a **DETAILED** message regarding my health care (including, but not limited to: test results, recent visits, medication requests, appointment information, nurse triage call backs, billing/insurance information and provider call backs).

The above information can be left on any of the following phone number(s):

#1_(_____)_____-_____ _____cell _____work _____ home

#2_(_____)_____-_____ _____cell _____work _____ home

#3_(_____)_____-_____ _____cell _____work ____ home

_

Signature_____ Date:_____

Patient Disclosure of Protected Health Information **(state required questions)**

Nationality or Ethnic Background

- ☐ **(1) Hispanic Latino** (21352)
- ☐ (2) **Not Hispanic/Latino** (21865)
- ☐ (3) **I (patient or patient's legal guardian) refuse to answer the question.**

Race

- ☐ **(1) American Indian / Eskimo / Aleut (10025)**
- ☐ **(2) Asian or Pacific Islander (20289)**
- ☐ **(3) Black (20545)**
- ☐ **(4) White (21063)**
- ☐ **(5) Other** *Includes all other responses not listed above. Patients who consider themselves as multiracial or mixed should chose this category (21311)*
- ☐ **(6) I (patient or patient's legal guardian) refuse to answer the question**

Marital Status

- ☐ **(1) Single**
- ☐ (2) **Married**
- ☐ (3) **Widowed**
- ☐ **(4) Divorced**
- ☐ **(5) Separated**
- ☐ **(6) Other**

Preferred Method of Communication

- ☐ **(1) Telephone**
- ☐ (2) **Email**
- ☐ (3) **Mail**

Preferred Language _____

Patient or Legal Guardian Signature: _____ **Date** _____

Printed Name of Patient _____

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Patient Financial Policy

Our mission at Southwest Ob Gyn Associates is to provide the highest standard of health care, and to help our patients be as informed as possible regarding your health care benefits. Southwest Ob Gyn Associates participate in most major health insurance plans to make care more accessible to you.

Thank you for choosing Southwest Ob Gyn Associates as your health care provider. We ask that you read and sign this Financial Policy prior to any treatment, service or procedure. Please let us know if you have any questions.

SOUTHWEST OB GYN ASSOCIATES RESPONSIBILITIES:

- Provide you and/or your insurance company with a timely and accurate statement of all charges for services rendered.
- Fully explain all charges for services rendered and acceptable payment methods.
- Secure all pre-authorizations and/or referrals that your health insurance plan requires a physician's office to obtain for your ongoing care or treatment.

PATIENT RESPONSIBILITIES: **Patient Initials** _____

- Provide Southwest Ob Gyn Associates with proof of your current insurance information, valid photo identification, employment, and demographic information at the time of each visit. Notify us within ten (10) days if you have a change in insurance status or demographic data.

- Pay in full, the expected portion for the balance of your account at the time of service. This includes co-pays. Our office's policy is to collect co-payment when you arrive for your appointment; deductibles and payment for non-covered services are also expected to be paid in full at time of service

- Patients who do not have insurance coverage (or proof of coverage) are expected to pay in full at time of service. If you cannot pay the full amount of your bill, then you must make satisfactory payment arrangements with our billing department ***prior*** *to* receiving services.

ANCILLARY SERVICES: **Patient Initials** _____

Subsequent charges may be applied to your account if additional test are performed due to Lab test results. (i.e. urine culture performed due to urinalysis results, HPV performed due to abnormal Pap smear results, or Pap smear interpretation performed due to abnormal Pap smear results.)

Lab Corp is the preferred lab for Southwest Ob Gyn Associates. When labs, x-rays or other test are ordered by Southwest Ob Gyn Associates, you are responsible to check with your insurance company as to where you are authorized to have these services performed. We will not be responsible for any bill if you have a test done at the wrong location.

Patient Initials _____

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.**I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.**

Signature of Patient_____ **Date** _____ **Printed**

Name of Patient_____

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Summary of Privacy Practices

In the course of providing healthcare services to you we are required by law to maintain the privacy of protected health information, provide you this notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice that is currently in effect.

How we may use and disclose health information:

- Treatment
- Payment
- Health Care Operations
- Appointment Reminders
- Treatment Alternatives
- Health - Related Benefits and Services
- Individuals Involved in Your Care
- Individuals Involved in Payment for your care
- Research

Special Situations:

- To Avert s Serious Threat to Health or Safety
- Our Business Associates
- Organ and Tissue Donation
- Military and Veterans
- Workers' Compensation
- Public Health Risks
- Health Oversight Activities
- Lawsuits and Disputes
- Law Enforcement
- Coroners, Medical Examiners & Funeral Directors
- National Security and Intelligence Activities
- Protective Services for the President & Others
- Inmates and Individuals in Custody

**Other uses and disclosures of medical information not covered by our Notice of Privacy Practices or the laws that apply to us will be made only with a patient's written permission.

Patient Rights:

Patients have the following rights regarding Health Information maintained by Southwest Ob / Gyn Associates:

- Right to inspect and Copy
- Right to Amend
- Right to Accounting of Disclosures
- Right to request restrictions on who has access to your information
- Right to Request Confidential Communication
- Right to a Paper Copy of this notice
- Right to File a complaint

**A complete copy the complete "Notice of Privacy Practices" is available by accessing our website at www.swobgyn.com or by calling 713-774-5131.

Important Contact Information:

Southwest Ob / Gyn Associates, L.L.P
Michelle Benton, Practice Administrator
16651 Southwest Freeway, Suite 200
Sugar Land, TX 77478
Telephone (713) 774-5131
Fax (713) 774-4336

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free: 1-877-696-6775
www.hhs.gov

By signing this form, I acknowledge that I have been made aware of the Southwest Ob / Gyn Associates, L.L. P. "Notice of Privacy Practices".

Patient's Name or Legal Guardian_____ Relationship to patient _____

Patient's Signature or Legal Guardian _____ Date _____