



17183 I-45 S, Suite 410  
The Woodlands, TX 77385  
(281) 602-7380 / (281) 602- 7386 Fax

**PATIENT INFORMATION**

Name (as it appears on your insurance card):

Preferred Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Hm #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Employer: \_\_\_\_\_ Email: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Pharm#: \_\_\_\_\_

**SPOUSE INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN#: \_\_\_\_\_

Contact Phone #: \_\_\_\_\_

**EMERGENCY INFO**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relationship: \_\_\_\_\_

**\*\*Please be advised that we are NOT Medicaid providers, if at any time you apply or become eligible to receive Medicaid, we will no longer be able to provide services to you. \*\***

**\*\* Please remember to bring your insurance card and picture ID with you to your appointment. \*\***

**PRIMARY INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_  
Member ID: \_\_\_\_\_ Group #: \_\_\_\_\_  
Mailing Address for Claims: \_\_\_\_\_

**PRIMARY INSURED/RESPONSIBLE PARTY**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS #: \_\_\_\_\_  
Address (if different): \_\_\_\_\_ City/Zip: \_\_\_\_\_  
Hm #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Email: \_\_\_\_\_  
Relationship to Patient:  Self  Spouse  Significant  Parent

**SECONDARY INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_  
Member ID: \_\_\_\_\_ Group #: \_\_\_\_\_  
Mailing Address for Claims: \_\_\_\_\_

**SECONDARY INSURED/RESPONSIBLE PARTY**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS #: \_\_\_\_\_  
Address (if different): \_\_\_\_\_ City/Zip: \_\_\_\_\_  
Hm #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Email: \_\_\_\_\_  
Relationship to Patient:  Self  Spouse  Significant Other  Parent



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
At what age did you periods stop?	Have you ever tested positive for HPV? 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**

	<b>Number</b>		<b>Number</b>		<b>Number</b>
Total Pregnancies		Abortions		Miscarriages	
Preterm Births (<37 weeks)		Term Births		Living Children	

No.	Birth Date	Weight	Baby's Sex	Number of weeks @ 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 postpartum depression? Prescribed medication?
History of chicken pox or chicken pox vaccination?
History of rheumatic fever or heart disease?
History of shoulder dystocia?
History of gestational diabetes mellitus?
History of 4 <sup>th</sup> degree laceration?

**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 in legs/lungs	Yes / No
Liver Problems	Yes / No	Lupus	Yes / No
Thyroid Problems	Yes / No	Sexually Transmitted Disease	Yes / No
Blood Problems	Yes / No	If yes, what?	
Kidney Problems	Yes / No	Cancer	Yes / No
		If so, where?	

Do you have any medical problems you take medication for? 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  
 Same sex partner

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?	
		___ Breast	___ Other
		___ Ovarian	
		___ Uterine	

**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: \_\_\_\_\_



## Patient Consent for Use of 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 **17183 I-45 S, Suite 410, The Woodlands, TX 77385**.

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 with in 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 our 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

*All About Women*  
OBSTETRICS & GYNECOLOGY

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I, \_\_\_\_\_ give  
(Print Patient Name)

authorization to release my protected health information including laboratory test(s),  
biopsy results, and/or other test results to the following designated representative(s).

Patient Initials

\_\_\_\_\_ Spouse: (Name) \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ Child(ren): (Name) \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ Other: (Name) \_\_\_\_\_ DOB: \_\_\_\_\_

Mark all that apply and initial:

May leave detailed voicemail on cell and/or home number on file \_\_\_\_\_  
Initial

May leave detailed voicemail on work number on file \_\_\_\_\_  
Initial

Do not release any of my protected health information to anyone other than  
myself \_\_\_\_\_  
Initial

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

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



## 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 our 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, American Express, 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

## What is an Annual Well-Woman Exam?

With the new health care laws regarding the coverage of preventive screening, we feel it is important to keep routine preventive screening separate from all other visits. This helps to ensure that accurate processing and payment from your insurance company for your routine well-woman visit is obtained and that you receive the full benefit of your plan allowances.

**An annual well-woman exam is a routine examination of a patient, who is in general, not having any current health issues. These well-woman visits are scheduled separately from other visits which address specific problem health issues.**

A routine, annual well-woman exam consists of the following. All items are recorded in the visit notes:

- \*Record vital signs
- \*Update personal and family medical history
- \*Update surgical history
- \*Update current medications and medication history
- \*Update allergies
- \*Update reproductive history
- \*Update social history
- \*Physical exam
- \*General discussion regarding findings during exam
- \*General counseling about health and well-being
- \*Pap smear (if needed)
- \*HPV testing (if applicable)
- \*Breast cancer screening
- \*Ordering of routine blood work (if applicable)
- \*Ordering of other routine testing such as management bone density study (if needed)
- \*Refill of maintenance medications pertinent to gynecological care and/or change in medications or dosage

We ask that you schedule any visit for a specific health-related problem separately from your visit for an annual exam. There are times when a general problem that you might be having can obscure some of the testing done at your annual well woman exam, so it is always better to schedule these visits separately, to potentially avoid having to repeat tests.

If a specific health-related problem is addressed at your annual exam, please be aware you may be charged an additional copay and visit.

I have read and understood the above information.

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Patient Signature

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Printed Name

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Date



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### **E-Prescribing PBM Consent Form**

E-Prescribing is defined as a physician’s ability to electronically send an accurate error free and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

We are pleased to offer a new feature to our patients. We can now automatically obtain your prescription history from Pharmacy Benefits Managers (PBM) via Surescript and download the prescription information into your electronic medical chart. It will make it easier for you to share your medical history with us and give us the ability to provide you with better, more efficient quality care.

We must obtain your authorization for you to take advantage of this program, please mark in the below section whether or **GIVE** or **DO NOT GIVE** permission:

- I **GIVE** permission to All About Women OB/GYN to obtain my prescription history directly to PBM.
  
- I **DO NOT GIVE** permission to All About Women OB/GYN to obtain my prescription history from PBM.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_