

PATIENT REGISTRATION FORM

Flower Mound Women's Health, P.A.

Obstetrics, Gynecology & Infertility

Sylvie H. Paroski, M.D., F.A.C.O.G. • Amy S. Lungren, M.D.

• Margarita Edge, MSN, RN-C, WHCNP

Please clearly print your response to all requested information.

If you have any questions, please ask. THANK YOU!

PATIENT INFORMATION

Name _____

Primary Phone _____

Address _____ Apt _____

Work Phone _____

City _____ State _____ Zip _____

Alternate Phone _____

Date of Birth _____

Social Security # _____

Employer _____

Email Address _____

""Single" "" Married ""Divorced ""Widowed

HOLDER OF INSURANCE POLICY

(You do not need to fill out if you are the policy holder)

Name _____

Office Phone _____

Home Address _____

City _____ State _____ Zip _____

Employer _____

Occupation _____

Social Security # _____

Date of Birth _____ Age _____

Patients relationship to policy holder: Self Spouse Child Other (explain) _____

CONTACT FOR EMERGENCIES _____ **Relationship** _____

Home Telephone _____

Alternate Telephone _____
(Not previously given)

INSURANCE INFORMATION

(You do not need to fill out if we have a copy of the card)

Insurance Company _____

Member Serv. # _____

Address _____

City _____ State _____ Zip _____

Policy or ID Number _____

Group Number _____

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, PPO plans, and all other health plans to Flower Mound Women's Health, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. 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 needed to secure the payment.

Signed _____ Date _____

PATIENT CONSENT FORM

I understand that as a part of my healthcare, Flower Mound Women's Health, P.A. ("the PRACTICE") originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The PRACTICE'S Notice of Privacy Practices provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the Notice of Privacy Practices and understand that I have the right to review the notice prior to signing this consent. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that the PRACTICE is required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that the PRACTICE has already taken action in reliance on my prior consent. The consent is valid until revoked by me in writing.

- I request the following restrictions on the use and/or disclosure of my personal health information.

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed the PRACTICE'S *Notice of Privacy Practices* dated 10-01-02.

Signature of Patient or Legal Representative

Date

Print Name of Patient or Legal Representative

I hereby give my authorization to disclose my protected health information, only in the specific manner, for the names reason, and to the specific individual(s) below:

Specific description of information to be released:

Person(s) you allow to request and receive the information stated above:

I understand this authorization provides that:

- I have the right to access my protected health information to be used or disclosed.
- I may revoke this authorization at any time by contacting your Privacy Officer in writing, at the address above.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use of disclosure.
- I will receive a copy of this completed and signed authorization form.

Signature: _____ **Date:** _____

Relationship to patient (if signed by a representative of patient) _____

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Dear Patient,

Our practice has been fortunate to maintain such an extensive patient clientele. To accommodate the needs of our growing practice, we have four highly qualified and dedicated providers. Along with three female physicians, we also have an outstanding female nurse practitioner. However, unfortunately, on some occasions our doctors may be called out of the office for an emergency. In such instances you may be asked to see either the nurse practitioner or a different physician. While we make every attempt to allow you to see your preferred provider, we cannot always guarantee the outcome. In the event of an unforeseen situation, we would like to provide you with the same quality of care with another one of our providers. Please let us know if you would agree to see either the nurse practitioner or a different physician.

Check one:

Yes I would like to be seen by another provider.

No Please reschedule me with my physician. I understand that there may be a delay in rescheduling, depending on the doctor's next available appointment.

Print Patient Name

Patient Signature

Date

Please be respectful of our scheduled patients and call ahead before walking into the office. We will be happy to return any calls, and at that time address any needs that you may have.

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As a patient of Flower Mound Women's Health, we would like to inform you of our new office policy as it relates to cancelling or missed appointments.

Cancellation Policy:

Our office requires a 24 hour notice for all reschedules and cancellations. This allows us to offer these appointment times to other patients that may have been waiting to visit with the physician. A message left on our voicemail after business hours for the next business day is considered a cancellation. We do understand that last minute emergencies, such as sickness, flat tires, and family emergencies, do occur.

Flower Mound Women's Health will charge a \$25 fee for missed, rescheduled, or cancelled appointments with less than a 24 hour notice. To restate, we do understand last minute emergencies, and you will not be charged in those instances.

If you are running late to an appointment by more than 15 minutes past your scheduled appointment time, we may need to reschedule your appointment. This will ensure that we are able to spend quality time with you and see our next patient on time.

Please sign below to recognize that you have read and understand our office policy.

Print Patient/Guardian Name

Patient/Guardian Signature: _____ Date: _____

Flower Mound Women's Health, P.A.

Name: _____ Age: _____ Date: _____

Occupation _____ Single Married Divorced Widowed

Tobacco? Yes No How much/week _____ Alcohol? _____ Drugs? _____

Referred by _____ Relationship _____

REASON FOR VISIT:

PREGNANCY HISTORY:

TOTAL PREGNANCIES: _____ FULL TERM: _____ PRETERM: _____ MISCARRAIGE/ABORTION: _____

<u>DATE</u>	<u>LENGTH PREGNANCY</u>	<u>TYPE OF DELIVERY</u>	<u>SEX</u>	<u>WEIGHT</u>	<u>LIVING</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

MENSTRUAL HISTORY

At what age did you start having menstrual periods? _____

Number of days between first day of one and first day of next period? _____

Length of period? _____ Regular or Irregular? _____

Do you have cramps? _____

Would you call your periods- ()Light ()Medium ()Heavy ()Clots

When was the first day of your last menstrual period? _____

Was it a normal period? _____ If not, when was the last normal one? _____

Have you ever had a sexually transmitted disease? _____

Comments _____

When was your Cholesterol last checked? _____

Date of last Mammogram _____ Have you ever had an abnormal mammogram? _____

If yes, please give date and explain: _____

Date of last pap smear? _____ Have you ever had an abnormal pap smear? _____

If yes, please give dates, type(CIN I, HPV, etc.), and treatments: _____

Have you ever used birth control pills? _____ How long? _____ Any problems? _____

If anything, what do you use now for contraception? _____

Are you currently sexually active? _____

Have you been sexually active in the past? _____

Have you had a bone density scan? If so, when? _____

Have you had a colonoscopy? If so, when? _____

Do you have uncontrolled loss of urine? _____

In the event of any life threatening emergency, will you agree to accept a transfusion of blood products?

When was your last tetanus shot? (CDC guidelines recommend one at least every ten years!) _____

Name: _____ Date: _____

PAST MEDICAL HISTORY

Please check if you have or have had a history of any of the following:

<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>	
		Anemia			Venereal Disease
		Dizziness			Herpes
		Epilepsy			Rheumatic Fever
		Diabetes			Asthma
		Tuberculosis			Bronchitis
		Pneumonia			Emphysema
		Heart Disease			Ulcers
		Angina			Spastic Colon
		Heart Murmur			Kidney Infections
		Hypertension			Bladder Infections
		Hepatitis			Blood Clotting Problems
		Thyroid Problems			Sickle Cell Disease
		Nervous Disorder/Depression			Drug/Alcohol Abuse
		Hospitalizations, if yes please explain: _____			

PAST SURGICAL HISTORY:

DATES: _____	PROCEDURE: _____
_____	_____
_____	_____
_____	_____

ALLERGIES TO MEDICATIONS:

If yes, please name the medicine and describe type of reaction: _____

MEDICATIONS: Please give the name and the dosage.

FAMILY HISTORY:

<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>	
()	()	Breast Cancer	()	()	Hypertension
()	()	Ovarian Cancer	()	()	Diabetes
()	()	Uterine Cancer	()	()	Epilepsy/Seizures
()	()	Colon Cancer	()	()	Depression
()	()	Heart Disease	()	()	Other
()	()	High Cholesterol			

If yes, please explain: _____

Patient Name: _____ Date of Birth: _____ Date: _____

Please check all that currently apply.

1. General Symptoms

- Weak, tired all the time
- Fevers
- Weight loss, unintentional
- Weight gain
- Lack of appetite
- None

2. Eyes

- Vision changes
- None

3. Ears, Nose, Throat

- Sinus trouble (sinusitis)
- Headache
- Tinnitus (ears ringing)
- None

4. Cardiovascular (Heart)

- Chest pains
- Shortness of breath
- Swelling of the feet
- Heart pounding or irregular heartbeat
- Difficulty breathing when sleeping
- None

5. Pulmonary (Lungs)

- Cough
- Wheezing
- Blood in sputum (spit)
- None

6. Gastrointestinal

- Diarrhea
- Constipation
- Rectal bleeding
- Stomach pains
- Gas/Bloating
- Leakage of stool
- Nausea or vomiting
- None

7. Urinary

- Blood in urine
- Burning with urination
- Frequent urination
- Urgency with urination
- Leakage of urine
- Incomplete emptying after urination
- Kidney Stones
- None

8. Musculoskeletal

- Muscle weakness
- Joint pains
- Back pain
- None

9. Skin and Breasts

- Rash
- Breast lump
- Breast pain
- Discharge from the nipple
- None

10. Neurologic

- Fainting
- Seizures
- Numbness
- Trouble walking or with balance
- None

11. Psychiatric

- Depression
- Anxiety
- None

12. Endocrine

- Hot flashes
- Diabetes mellitus
- Thyroid gland problems
- None

13. Hematologic & Lymphatic

- Bruising easily
- Bleeding
- Enlarged lymph glands
- None

14. Gynecologic

- Problem becoming pregnant
- Abnormal vaginal bleeding
- Abnormal vaginal discharge
- Pelvic pain
- Pain with sexual intercourse
- Pelvic infections
- Mass protrusion from vagina/fullness
- None

15. Do you have any relatives with?

- Ovarian Cancer
- Uterine Cancer
- Breast Cancer
- Colon Cancer
- Stomach Cancer

15. Do you smoke?

- Yes No

16. Do you regularly exercise?

- Yes No

17. Do you feel that you practice healthy eating habits?

- Yes No

Other symptoms:

I have reviewed the above findings.

Healthcare Provider's Signature: _____

Date: _____