NEW PATIENT / ANNUAL REGISTRATION INFORMATION

(Please read and complete all pages)

NAME: LAST FIRST MIDDLE D.O.B. AGE

ADDRESS: APT#

CITY: STATE: ZIP CODE:

HOME PHONE: CELL PHONE:

WORK PHONE: EMAIL:

EMPLOYER/SCHOOL: OCCUPATION:

SOCUAL SECURITY: DRIVER'S LICENSE: MARITAL STATUS:

EMERGENCY CONTACT NAME:

PHONE: RELATIONSHIP TO THE PATIENT:

NAME OF PRIMARY INSURANCE: INSURANCE PHONE #

GROUP # ID #

SUBSCRIBER / POLICY HOLDER'S NAME: D.O.B.

S.S.N.: RELATIONSHIP TO THE PATIENT

PHONE: EMPLOYER:

DO YOU HAVE SECONDARY INSURANCE COVERAGE? ☐ YES ☐ NO

PRIMARY CARE PHYSICIAN:

WHO MAY WE THANK FOR REFERRING YOU TO THIS PRACTICE?

ARE YOU HERE TODAY FOR: ☐ ROUTINE ANNUAL EXAM ☐ PREGNANCY ☐ PROBLEM ☐ OR OTHER

IF YOUR VISIT IS FOR A PROBLEM OR OTHER, PLEASE DESCRIBE:

PHARMACY NAME: ZIP CODE:

PHONE: FAX:

Consent for Healthcare and Treatment:

I voluntarily consent to healthcare treatment from the physicians and staff of The ObGyn Centre. I consent to any lab work (including HIV testing and drug testing, cultures, pathology, and medication administration that the physician(s) deem necessary. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of treatments or examinations by my care givers.

NAME: DATE:

SIGNATURE:

THE OB/GYN CENTRE

6400 FANNIN, SUITE 1900, HOUSTON, TEXAS 77030 | PHONE 713.796.2200 | FAX 713.796.2232 | WWW.THEOBGYNCENTER.COM

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I hereby authorize The OB/GYN Centre to furnish information to my insurance carrier(s) regarding my condition and treatments, and I hereby assign to The OB/GYN Centre all payments for medical services rendered to me or my dependents.

I understand that I am responsible for any amount not covered by my insurance and that I am responsible with my insurance company which services are covered. I will also be financially responsible for any claims no paid by my insurance(s) as a result of my failure to provide accurate and complete insurance information in a timely manner (including secondary coverage).

NAME: DATE:

SIGNATURE:

Do you have secondary (dual) coverage?

Examples of dual coverage:

Medicaid

- Covered under private insurance and Medicaid
  - private insurance can be through yourself, a spouse, or a parent
  - private insurance information is required even if it provides NO maternity coverage

Patients covered by Medicaid are required to notify us of any additional coverage, as all private/commercial insurances must be billed first. Failure to do so is considered an unlawful act according to Chapter 36.002 of the Texas Medicaid Fraud Prevention Act.

Private/Commercial Insurance

- Coverage through your insurance, and your spouse's insurance
- Coverage through your insurance, and your parents insurance, as a dependent
- Both private insurances information is required even if it provides NO maternity coverage

☐ No - I do NOT have secondary coverage

☐ Yes - I have secondary coverage (list below)

NAME OF PRIMARY INSURANCE: INSURANCE PHONE #

GROUP # ID #

SUBSCRIBER / POLICY HOLDER'S NAME: D.O.B.

S.S.N.: RELATIONSHIP TO THE PATIENT

PHONE: EMPLOYER:

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THE OB/GYN CENTRE
NEW PATIENT HISTORY

PERSONAL PROFILE	
NAME:_____	NAME YOU WOULD LIKE US TO USE:_____
AGE:_____	OCCUPATION:_____
MARITAL STATUS:_____	

GYNECOLOGICAL HISTORY		
LAST MENSTRUAL PERIOD (FIRST DAY):	PRESENT BIRTH CONTROL	
AGE PERIOD BEGAN:	PAST METHODS OF BIRTH CONTROL:	
NUMBER OF DAYS BLEEDING:	LAST PAP SMEAR:	RESULT:
NUMBER OF DAYS BETWEEN PERIODS:	ABNORMAL PAP IN THE PAST?____NO____YES (DATE)_____	
ANY RECENT CHANGES IN PERIODS?	LAST MAMMOGRAM:	
ARE YOU CURRENTLY SEXUALLY ACTIVE?	ABNORMAL MAMMOGRAMS/BREAST BIOPSIES IN THE PAST?	
NUMBER OF SEXUAL PARTNERS (LIFETIME):	____NO____YES (DATE)_____	
SEXUAL ORIENTATION	DO YOU DO SELF BREAST EXAMS?	

OBSTETRIC HISTORY		

PLEASE LIST EACH PREGNANCY BELOW						
NO.	DATE	WEIGHT	SEX	WEEKS PREGNANAT	COMPLICATIONS	TYPE OF DELIVERY (VAG/C-SEC
1.						
2.						
3.						
4.						
5.						

CURRENT MEDICATIONS (INCLUDE VITAMINS, HERBS, ETC.) - CHECK HERE IF NONE							
DRUG NAME	DOSE	DRUG NAME	DOSE	DRUG NAME		DOSE	
1.		2.		3.			
4.		5.		6.			

ALLERGIES - CHECK HERE IF NONE			
DRUG NAME	DOSE	DRUG NAME	DOSE
1.		2.	
4.		5.	

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NEW PATIENT HISTORY

SOCIAL HISTORY
CIGARETTES:_____NEVER:_____CURRENT:_____PAST:_____PACKS PER DAY:_____YEARS_____
ALCOHOL:_____NONE:_____# DRINKS PER DAY:_____# DRINKS PER WEEK
RECREATIONAL DRUGS (DESCRIBE):_____CURRENT:_____PAST
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE?:_____ NO _____ YES

PERSONAL PAST HISTORY OF ILLNESS				
ILLNESS	YES	NO	UNSURE	DETAILS (DATE/DESCRIPTION)
ASTHMA				
LUNG DISEASE/PNEUMONIA				
KIDNEY INFECTIONS/STONES				
TUBERCULOSIS				
HERPES				
OTHER SEXUALLY TRANSMITTED DISEASES				
HIV/AIDS				
HEART ATTACK/ANGINA				
DIABETES				
HIGH BLOOD PRESSURE				
STROKE				
RHEUMATIC FEVER				
BLOOD CLOTS IN LEGS OR LUNGS				
LUPUS/COLLAGEN VASCULAR DISEASE				
EATING DISORDER				
CHICKENPOX				
CANCER				
REFLUX/STOMACH ULCER				
DEPRESSION/ANXIETY				
ANEMIA				
BLOOD TRANSFUSION				
SEIZURES				
BOWEL PROBLEMS				
GLAUCOMA				
CATARACTS				
ARTHRITIS/JOINT PROBLEMS				
BROKEN BONES				

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NEW PATIENT HISTORY

ILLNESS (CONT.)	YES	NO	UNSURE	DETAILS (DATE/DESCRIPTION)
HEPATITIS/LIVER DISEASE				
THYROID DISEASE				
GALLBLADDER DISEASE				
HEADACHES				
OTHER				

OPERATIONS / HOSPITALIZATIONS

PROCEDURE/REASON HOSPITALIZED	DATE	HOSPITAL	COMPLICATIONS
1.			
2.			
3.			
4.			
5.			

INJURIES/ILLNESS

DATE	INJURY/ILLNESSES
1.	
2.	
3.	
4.	

FAMILY HISTORY

MOTHER_____LIVING_____DECEASED-AGE/CAUSE OF DEATH

FATHER_____LIVING_____DECEASED-AGE/CAUSE OF DEATH

SIBLINGS # LIVING_____ # DECEASES_____ AGE/CAUSE OF DEATH

CHILDREN # LIVING_____ # DECEASES_____ AGE/CAUSE OF DEATH

ILLNESS	YES	WHICH RELATIVES/AGES OF ONSET
DIABETES		
STROKE		
HEART DISEASE		
BLOOD CLOTS IN LEGS OR LUNGS		
HIGH BLOOD PRESSURE		
HIGH CHOLESTEROL		
OSTEOPOROSIS		
HEPATITIS		
TUBERCULOSIS		

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NEW PATIENT HISTORY

ILLNESS	YES	WHICH RELATIVES/AGES OF ONSET
BIRTH DEFECTS		
ALCOHOL OR DRUG ADDICTION		
BREAST CANCER		
OVARIAN CANCER		
COLON CANCER		
UTERINE CANCER		
OTHER CANCERS		
MENTAL ILLNESS/DEPRESSION		
ALZHEIMER'S DISEASE		
OTHER		

REVIEW OF SYSTEMS				
PLEASE CHECK IF YOU HAVE EVER HAD ANY OF THE FOLLOWING SYMPTOMS				
1. CONSTITUTIONAL	NOW	PAST	NEVER	NOTES
UNEXPLAINED WEIGHT LOSS				
UNEXPLAINED WEIGHT GAIN				
FEVER				
FATIGUE				
CHANGE IN HEIGHT				
2. EYES	NOW	PAST	NEVER	NOTES
DOUBLE VISION				
SPOTS BEFORE EYES				
VISION CHANGES				
GLASSES/CONTACTS				
3. EAR NOSE AND THROAT	NOW	PAST	NEVER	NOTES
EARACHES				
RINGING IN EARS				
HEARING PROBLEMS				
SINUS PROBLEMS				
SORE THROAT				
4. CARDIOVASCULAR	NOW	PAST	NEVER	NOTES
PAIN WITH BREATHING				
CHEST PAIN				
SHORTNESS OF BREATH				
IRREGULAR HEARTBEAT				

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5. RESPIRATORY	NOW	PAST	NEVER	NOTES
WHEEZING				
SPITTING BLOOD				
CHRONIC COUGH				
6. GASTROINTESTINAL	NOW	PAST	NEVER	NOTES
DIARRHEA				
BLOODY STOOL				
NAUSEA/VOMITING				
CONSTIPATION				
INVOLUNTARY LOSS OF STOOL				
7. GENITOURINARY	NOW	PAST	NEVER	NOTES
BLOOD IN URINE				
PAIN WITH URINATION				
STRONG URGENCY TO URINATE				
FREQUENT URINATION				
INCOMPLETE BLADDER EMPTYING				
INVOLUNTARY LOSS OF URINE				
URINE LOSS WITH COUGH/STRAIN				
ABNORMAL VAGINAL BLEEDING				
PAINFUL PERIODS				
PAINFUL INTERCOURSE				
FIBROIDS				
ENDOMETRIOSIS				
INFERTILITY				
ABNORMAL VAGINAL DISCHARGE				
8. MUSCULOSKELETAL	NOW	PAST	NEVER	NOTES
MUSCLE WEAKNESS				
MUSCLE OR JOINT PAIN				
9. SKIN	NOW	PAST	NEVER	NOTES
RASH				
SORES				
DRY SKIN				
MOLES				

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10. BREASTS	NOW	PAST	NEVER	NOTES
PAIN IN BREAST				
LUMPS				
NIPPLE DISCHARGE				
11. NEUROLOGIC	NOW	PAST	NEVER	NOTES
DIZZINESS				
SEIZURES				
NUMBNESS				
TROUBLE WALKING				
SEVERE MEMORY PROBLEMS				
SEVERE HEADACHES				
12. PSYCHIATRIC	NOW	PAST	NEVER	NOTES
DEPRESSION				
SEVERE ANXIETY				
13. ENDOCRINE	NOW	PAST	NEVER	NOTES
HAIR LOSS				
HEAT/COLD INTOLERANCE				
ABNORMAL THIRST				
HOT FLASHES				
14. HEMATOLOGY/LYMPHATIC	NOW	PAST	NEVER	NOTES
EASY BRUISING/EASY BLEEDING				
ENLARGED GLANDS				

PATIENT SIGNATURE: DATE:

PHYSICIAN REVIEW (INITIAL AND ANNUAL)

SIGNATURE: DATE:

SIGNATURE: DATE:

SIGNATURE: DATE:

SIGNATURE: DATE:

SIGNATURE: DATE:

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THE OB/GYN CENTRE

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, the physicians and staff of The OB/GYN Centre may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to the Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The physicians and staff of The OB/GYN Centre reserve the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by Offer at 6400 Fannin, Suite 1900, Houston, Texas 77030.

With my consent, the physicians and staff of The OB/GYN Centre may call my home or any other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, the physicians and staff of The OB/GYN Centre may mail to my home or any other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and test results as long as they are marked "Personal" and/or "Confidential".

With my consent, the physicians and staff of The OB/GYN Centre may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements, and test results. I have the right to request that the physicians and staff of The OB/GYN Centre restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this aggreement.

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, the physicians and staff of The OB/GYN Centre may decline to provide treatment to me.

Signature of Patient or Legal Guardian:_____

Printed Name of Patient:_____

Date:_____

THE OB/GYN CENTRE

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I give the physicians and staff of The OB/GYN Centre permission to contact me regarding the indicated items in the following manner:

List numbers we can call, circle yes or no if we may leave a detailed message, and indicate type of info we can leave in the message.

Home #_____ Message Ok? Yes No

☐ Appointments ☐ Scheduling ☐ Results ☐ Billing ☐ Rx

Work #_____ Message Ok? Yes No

☐ Appointments ☐ Scheduling ☐ Results ☐ Billing ☐ Rx

Cell #_____ Message Ok? Yes No

☐ Appointments ☐ Scheduling ☐ Results ☐ Billing ☐ Rx

Email #_____ Message Ok? Yes No

☐ Appointments ☐ Scheduling ☐ Results* ☐ Billing ☐ Rx

*abnormal results will not be sent via email without specific request

Ok to leave messages/discuss with _____
(individual's name/relationship)

☐ Appointments ☐ Scheduling ☐ Results* ☐ Billing ☐ Rx

I give my permissions as above, and I understand that these will remain in force until such time I request a change in writing.

Signature:_____

Date:_____

THE OB/GYN CENTRE

WELLNESS ACKNOWLEDGEMENT

In most cases an annual wellness exam and corresponding diagnostic and/or laboratory testing is covered by insurance at 100%.

In some cases, what your insurance considers to be "wellness" and what our physicians feel is appropriate for your specific case may differ. If you have any health complaint or condition that is being addressed at the same time as your wellness exam, certain labs or other testing may not fall under the umbrella of wellness. These tests will likely not be covered at 100%, but fall to a deductible or co-insurance.

Our physicians are dedicated to providing the most appropriate and comprehensive care to our patients and do not limit their recommendations based on insurance coverage. They do however respect your right to be informed of possible charges that may be incurred.

Patient Acknowledgement:

Signature:_____

Date:_____

THE OB/GYN CENTRE

PHYSICIAN DISCLOSURE OF FINANCIAL INTEREST

The physicians and staff at The OB/GYN Centre provide the highest quality, complete women's health care services including normal and high risk obstetrics, gynecology, infertility, adolescent care, and menopausal management. The ability to provide patient access to high quality obstetrical and gynecological providers and services is an essential component to any quality-based women's health practice. Ownership interests in the following entities reflect our commitment to providing the highest standard of patient care in the office, laboratory, and surgery settings and enhance our ability to direct the manner in which your care is delivered.

Memorial Hermann Ambulatory Surgery Center
Fannin Fertility Center, LLC
Victory Medical Center Houston
Gala Histology Laboratory
vitaMedMD
Piney Point Women's Center

The entities listed above are not contracted with insurance companies and will be considered "out of network" when claims are processed. If you obtain services from these entities, and the service is covered under your benefit plan, the costs of the services will be covered under the "out of network" portion of your benefit plan. If your benefit plan does not have out of network benefits, it is possible that you may not have coverage for the service and will be required to pay the costs yourself. Further, your physician may receive a benefit from the referral.

If you have any concerns regarding your referral to any of the above-indicated entities, please do not hesitate to contact our office to request additional information, including an alternative referral. Please be aware of your right to request a referral to an alternative facility.

Sincerely,

Paul Cook, MD
Roz Nanda, MD
Ziad Melhem, MD

Patient Acknowledgement

I hereby acknowledge receipt of a copy of the foregoing Physician's Disclosure of Financial Interest.

Signature:_____

Print Name:_____

Date:_____