# Dallas E&W OB/GYN Clinic

**Patient Registration**

## PATIENT INFORMATION

**LEGAL NAME:**_____ **SS#:**_____
Last name First name

**PREFERRED NAME**:_____ **AGE:** _____ **BIRTHDAY:** _____

**ADDRESS:**_____**APT #:**_____

**CITY:** _____**STATE:**_____**ZIP CODE:** _____

**CELL PHONE #:** _____**HOME PHONE#:**_____

**MARITAL STATUS:** Single_____Married_____Divorced_____Other_____

**REFERRED BY:**_____**PCP:**_____**PHONE #:** _____

**PHARMACY:**_____ **PHONE #:** _____

**EMERGENCY CONTACT:**_____ **RELATIONSHIP:**_____ **PHONE #:**_____

## PRIMARY INSURANCE HOLDER (IF APPLICABLE)

**POLICY HOLDER NAME:**_____ **SS#:** _____

**BIRTHDAY:**_____**RELATION TO PATIENT:** SELF_____SPOUSE_____PARENT____OTHER

**ADDRESS:**_____**CITY:**_____**STATE**_____**ZIP** _____
(if different from patient)

**HOME PHONE #:**_____ **CELL PHONE #:** _____

## SECONDARY INSURANCE (IF APPLICABLE)

**POLICY HOLDER NAME:**_____ **BIRTHDAY:** _____

**HOME PHONE #:**_____ **CELL PHONE #:** _____

I hereby assign all medical and /or surgical benefits, including major surgery benefits to which I am entitled - through private insurance or any other health plan- to Dallas E&W OB/GYN Clinic. I authorize the release of any medical information necessary to process insurance claims. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are covered by insurance. A photocopy of this assignment shall be considered as valid as the original. If payment has not been received from my insurance company within 60 days, I understand it is my responsibility to contact the insurance company and ensure timely payment. Any overpayment on my account will be promptly credited or refunded. I also understand that the quote provided by my insurance company does not guarantee payment. The actual payment amount will be determined once the explanation of benefits is received**. Consent to treatment:** I hereby authorize the physician to treat myself - or if a **minor**, my daughter - as deemed medically necessary.

**PATIENT/LEGAL GUARDIAN SIGNATURE:**_____**DATE:**_____

# Medical History

**Name:**_____**DOB:** _____

**Only Check √ if yes to yourself and your family members**

| **Self** | **Family** | | **Self** | **Family** | |
|---|---|---|---|---|---|
| ( ) | ( ) | Anemia/Blood Disease | ( ) | ( ) | Arthritis/Osteoporosis |
| ( ) | ( ) | Hypertension/Stroke | ( ) | ( ) | Blood Clots in Legs |
| ( ) | ( ) | Heart Disease | ( ) | ( ) | Uterine Fibroids |
| ( ) | ( ) | High Cholesterol | ( ) | ( ) | Endometriosis |
| ( ) | ( ) | Diabetes | ( ) | ( ) | Heavy/Irregular Periods |
| ( ) | ( ) | Depression/Anxiety | ( ) | ( ) | Breast Mass/Breast Pain |
| ( ) | ( ) | Thyroid Disease | ( ) | ( ) | Epilepsy/Neural Disease |
| ( ) | ( ) | Asthma/Lung Disease | ( ) | ( ) | Urinary Incontinence/Infection |
| ( ) | ( ) | Hepatitis/Liver Disease | ( ) | ( ) | Uterine Prolapse |
| ( ) | ( ) | Gall Bladder Disease | ( ) | ( ) | Cancer History |
| ( ) | ( ) | Kidney Disease | ( ) | ( ) | Excessive Weight Gain/Loss |
| ( ) | ( ) | Bowel Problems | ( ) | ( ) | Sexual Transmitted Disease |

**Height:** _____**Usual Weight:**_____**lbs/kg**

**List of Surgeries (if any)**

| Date | Type of Surgery |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Current Medications:**

_____

_____

_____

**Medication Allergies (if any)**

_____

_____

**Alcohol** YES/NO **Smoking** YES/NO **Drug use** YES/NO **Exercise** YES/NO

**IMMUNIZATION STATUS:**

Hep B Carrier: YES NO ?

Hep A Antibody: YES NO ?

Hep B Antibody: YES NO ?

⇨ for Preventing liver disease/liver cancer

Gardasil (HPV vaccine): YES NO ?

⇨ for preventing cervical, vaginal, vulvar cancer in females

**MENSTRUAL HISTORY:**

Age of first period? _____

Days of flow/bleeding: _____ Do you have cramps? YES / NO

1st day of last menstrual period:_____ ( ) unsure ( ) menopause

# Of days between periods: _____ Age of menopause: _____

Flow (check applicable): ( ) Light ( ) Medium ( ) Heavy ( ) clots

( ) bleeding between periods

Period pattern: ( ) Regular ( ) Irregular

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**PREGNANCIES:**

Gravida:_____ Full term:_____ Preterm:_____ Miscarriages:_____ Abortion:_____ Ectopic:_____

| Birth date | Length of Pregnancy | C/S or Vaginal | Sex | Birth Weight |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Any Complications? Please explain:**_____

_____

**WELLNESS HISTORY:**

| | |
|---|---|
| Date of last pap smear:<br>normal/abnormal | History of **abnormal** pap: YES / NO<br>Any treatment done?:<br>Colpo biopsy/Cryo |
| Last mammogram: | Last Bone Density Scan: |
| Last colonoscopy: | Last Pelvic sonogram: |
| General health panel (blood): | Sexually active: YES / NO |

Current method of birth control:

*Do you need any information about birth control?* ( ) YES ( ) NO

**Reason for your visit:**_____

_____

_____

**WENLIANG SHI, MD, PhD**
**DALLAS E&W OB/GYN CLINIC**

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## CONFIDENTIALITY & AUTHORIZATION FOR USE / DISCLOSURE OF HEALTH INFORMATION

### Acknowledgment of Notice of Privacy Practices

I acknowledge that a copy of Dallas E&W; OB/GYN Clinic's Notice of Privacy Practices has been made available to me and explains how my protected health information may be used and disclosed.

### Authorization for Use and Disclosure

I authorize Dallas E&W; OB/GYN Clinic to use and disclose my health information for treatment, payment, and healthcare operations as permitted by law. I understand I may revoke this authorization in writing at any time.

### Authorization for Electronic Communication (Email & Text)

I authorize Dallas E&W OB/GYN Clinic to communicate with me and send my medical information, including laboratory results, imaging reports, visit summaries, and other medical records, by email and/or text message (SMS) at the contact information I have provided. I understand that email and text message communication may not be secure and may be viewed by unauthorized persons. I accept this risk. This authorization remains in effect unless I revoke it in writing.

**Text authorization (please initial ONE):**

**_____ YES, I agree to receive medical and billing information by text message (SMS).**
initial

**_____ NO, I do NOT agree to receive medical and billing information by text message (SMS).**
initial

**Patient Information**

Patient Name | Date of Birth

Email | Mobile Phone #

Signature | Date signed

Patient Representative / Legal Guardian (if applicable): _____

Relationship to Patient: _____

**Authorized Person(s) to Discuss Medical and Billing Information (Optional)**

*If no one is listed below, no other person is authorized.*

Name | Relationship | Phone#

Name | Relationship | Phone#