Dallas E&W OB/GYN Clinic

Patient Registration

PATIENT INFORMATION

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

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

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

ST: _____ **ZIPCODE:** _____ **CELL PHONE #:** _____

HOME PHONE #: _____ **WORK PHONE #:** _____

*** BEST NUMBER TO CALL WITH RESULTS:** _____ *** OK TO LEAVE VOICE MAIL / TEXT MESSAGE? YES / NO**

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	
_____	_____
_____	_____
_____	_____

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

Total # of **PREGNANCIES:** _____

Vaginal deliveries#:_____ C-section#:_____ Miscarriages/Abortions#:_____ Living children:_____

WELLNESS HISTORY

Date of last pap smear: normal/abnormal	History of **abnormal** pap: YES / NO Any treatment done?: 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 and Disclosure of Health Information

I acknowledge that a copy of Dallas E & W OB/GYN Clinic's HIPAA Notice of Privacy Practices is available to me, which explains how my medical information will be used and disclosed.

Other Uses and Disclosures: Disclosure of your health information for any purpose other than what is listed in the "Notice of Privacy Practices" it will require your specific authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke will not affect or undo any disclosure made before your revocation date. You have the right to request restrictions on the use and disclosure of your health information.

Note: If I have provided e-mail addresses for my Preferred Contacts, my signature below indicates that I understand and acknowledge that e-mail communication is not secure. E-mail can be intercepted during transmission. Unencrypted messages (and any attachments) can be read and potentially copied and forwarded by others. E-mails can be easily viewed by someone other than the intended recipient if, for example, I access messages via a smartphone or tablet.

➔ _____

Print Patient Name **Date of Birth**

➔ _____

Signature of Patient **Date**

_____

Patient Representative /Legal Guardian **Relationship to Patient**

E-Mail: _____

Authorized Person to discuss your medical condition:

Name of Person **Relationship** **Phone #**

_____

_____