Patient Information

PATIENT NAME (FIRST & LAST NAME)	CELL PHONE	HOME PHONE	OTHER PHONE
DATE OF BIRTH	SOCIAL SECURITY NUMBER	SEX (M OR F)	MARITAL STATUS
ADDRESS	CITY	STATE	ZIP
PATIENT EMAIL ADDRESS	EMERGENCY CONTACT	EMERGENCY NUMBER	EMPLOYER
RACE		ETHNICITY	
REFERRING DOCTOR NAME			
PRIMARY CARE DOCTOR NAME & ADDRESS			

Responsible Party

RESPONSIBLE PARTY (FIRST NAME & LAST NAME)	CELL PHONE	HOME PHONE
ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NUMBER
CITY, STATE, ZIP	SEX (M OR F)	RELATION TO RESPONSIBLE PARTY
EMPLOYER		OCCUPATION

Primary Insurance

INSURANCE COMPANY NAME	INSURANCE ID NUMBER	INSURED'S NAME (FIRST & LAST NAME)	
INSURANCE COMPANY ADDRESS		INSURED'S ADDRESS, CITY, STATE, ZIP	
INSURANCE COMPANY CITY, STATE, ZIP	INSURED'S DOB	PRIMARY PHONE	SECONDARY PHONE
INSURANCE PHONE NUMBER	INSURED'S SSN	INSURED'S SEX (M OR F)	RELATION TO INSURED

Preference Regarding Communication of Health Information

Name: ____ DOB: ____________________

How may we best contact you?

Phone Number: ____

May we leave a detailed message? YES NO

- Please understand that if we cannot leave messages, it will be **your** responsibility to initiate contact with us regarding follow up of lab, appointments, etc.

Please list anyone else we may discuss your health information with:

Name	Phone Number	Relationship
________________________________	___________________________	__________________
________________________________	___________________________	__________________

The duration of this authorization is **indefinite unless otherwise revoked in writing**. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of medical information.

_______________________________________ ___________________________

Signature of Patient / Legal Representative Date

Acknowledgement & Authorization

- I have read and understand the **HIPAA/Privacy Policy** for **Grace Gynecology & Wellness.**
- I hereby assign my insurance benefits to be paid directly to my healthcare provider.
- I authorize **Grace Gynecology & Wellness** to release my medical information for the purpose of healthcare operations.
- I have read and understand the **Financial Policy** for **Grace Gynecology & Wellness.**
- I authorize **Grace Gynecology & Wellness** to obtain/have access to my medication history.
- I am aware that I can request at any time copies of the **HIPAA/Privacy Policy & Financial Policy** from **Grace Gynecology & Wellness.**

_______________________________________ ___________________________

Signature of Patient / Legal Representative Date of Birth

_______________________________________ ___________________________

Printed Name of Patient / Legal Representative Date

Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

- I understand that the same standard care applies to a telemedicine visit as applies to an in-person visit.
- I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
- I understand there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    - If it is determined that the videoconferencing equipment and/or connection is not **adequate**., I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
- I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    - I may revoke my right at any time by contacting **Grace Gynecology & Wellness** at (469) 769 – 1961.
- I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
- I understand my health care information may be shared with other individuals for scheduling and billing purposes.
    - I understand that my insurance carrier will have access to my medical records for quality review/audit.
    - I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    - I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
- I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

______________________________	______________________
Signature of Patient / Legal Representative	Date of Birth
______________________________	______________________
Printed Name of Patient / Legal Representative	Date

Name: ______________________________ Date: ____________

Date of Birth: ____________ Age: ________ Why are you here today? ______________

How did you hear about us? ______________________________

Drug Allergies: ______________________________

OBSTETRICAL HISTORY:

Total number of pregnancies: ______________

Number of births: ______________

Number of Miscarriages: ________ Abortions: ________

Number of Ectopics: ______________

Any vacuum of forceps-assisted deliveries? Y N

Complications during pregnancy or delivery? Y N

Year	Weeks	Labor Length	Birth Wt	Sex	Type of Delivery (Vaginal/Cesarean Section)

Date of last PAP smear ____/____/____

Have you ever had an abnormal PAP Y N

If so, when? ______________

Colposcopy Y N

Cryotherapy Y N

Laser Y N

LEEP Y N

Other? ______________

Have you ever had an STD?

What was the infection? *Please circle.*

Chlamydia Gonorrhea Hepatitis B Herpes

PID Syphilis Warts

Have you ever had sex? Y N

Are you currently sexually active? Y N

Sexual partners? ____ Male ____ Female ____ Both

Total Number of Partners? ______________

GYNECOLOGICAL HISTORY:

First day of last period? ______________

Age at 1st period? ______________

Birth control method? ______________

Do you have regular cycles? Y N

How long do they last? ______________

Number of days from start of one cycle to the start of the next? __________ days.

Have you gone through menopause? Y N

Age at menopause? __________

Bleeding:

Between periods? Y N

After intercourse? Y N

Heavy cycles? Y N

Pain with periods? Y N

Urination:

Loss of urine when you cough? Y N

Difficulty holding your urine? Y N

Get up at night to urinate? Y N

PAST MEDICAL HISTORY:

Have you ever had any of the following?

Asthma / Allergies? Y N

Cancer Y N

What kind? ______________

Diabetes Y N

Heart Disease Y N

Hospitalizations Y N

Kidney Disease Y N

Liver Disease Y N

Pneumonia Y N

Skin Disease Y N

Thyroid Disease Y N

Tuberculosis Y N

Urinary Infection Y N

Other ______________

Name: ____ DOB: ________________

SURGICAL:

What kind? ____ Date ____/____/____

____ Date ____/____/____

____ Date ____/____/____

Complications with anesthesia? Y N Blood Transfusions? Y N

MEDICATIONS:

Name: ________________________________ Dose: _______________ How often? _______________

Name: ________________________________ Dose: _______________ How often? _______________

Name: ________________________________ Dose: _______________ How often? _______________

Name: ________________________________ Dose: _______________ How often? _______________

SOCIAL HISTORY:

Do you smoke? Y N Number of packs per day? ___________________

Do you drink alcohol? Y N How many per day? _______________________

Do you use street drugs? Y N What kinds? _____________________________

Marital status? ____

Occupation? ____

FAMILY HISTORY: *Anyone in the family with the following disease?*

_____ Breast Cancer Relationship: _____________________________

_____ Colon Disease Relationship: _____________________________

_____ Diabetes Relationship: _____________________________

_____ Heart Disease Relationship: _____________________________

_____ High Blood Pressure Relationship: _____________________________

_____ Ovarian Cancer Relationship: _____________________________

_____ Stroke Relationship: _____________________________

_____ Thyroid Disease Relationship: _____________________________

_____ Other Relationship: _____________________________

Name: ____ DOB: __________________

REVIEW OF SYMPTOMS: *Have you recently had any of the following?*

Breast

_____ Breast pain

_____ Breast skin change

_____ Nipple discharge

Endocrine

_____ Always hot or cold

_____ Always tired

Gastrointestinal

_____ Bloody stools

_____ Constipation

_____ Diarrhea

_____ Unintended weight loss

_____ Vomiting

_____ Vomiting blood

Genitourinary

_____ Blood in urine

_____ Pain with urination

_____ Urge to urinate all the time

Head

_____ Dizziness

_____ Severe headaches

_____ Vision loss

Heart

_____ Chest pain

_____ Palpitations

Lungs

_____ Coughing up blood

_____ Night sweats

_____ Shortness of Breath

_____ Night sweats

Musculoskeletal

_____ Muscle weakness

_____ Pain in joints

Neurological

_____ Convulsions/Seizures

_____ Loss of consciousness

Psychiatric

_____ Anxiety

_____ Depression

_____ Panic Attacks

Skin

_____ Changes in mole

_____ Rash

Throat

_____ Difficulty swallowing