OB/GYN OF HOUSTON
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NEW PATIENT REGISTRATION INFORMATION

HOME PHONE_____ CELL PHONE _____

NAME_____ SOC SEC_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

SEX M___ F___ AGE_____ BIRTHDATE_____ SINGLE____ MARRIED___ WIDOWED___ DIVORCED___

PATIENT EMPLOYED BY_____ OCCUPATION_____

BUSINESS PHONE_____ PHARMACY PHONE _____

WHOM MAY WE THANK FOR REFFERING YOU?_____

IN CASE OF EMERMGENCY WHO SHOULD WE NOTIFY?_____

RELATION_____ PHONE_____

-PRIMARY INSURANCE-

POLICY HOLDER'S FULL NAME_____

RELATION TO PATIENT_____ BIRTHDATE_____ SOC SEC#_____

ADDRESS_____ PHONE_____

CITY_____ STATE_____ ZIP_____

INSURANCE COMPANY_____

SUBSCRIBER ID #_____ GROUP #_____

-SECONDARY INSURANCE-

POLICY HOLDER'S FULL NAME_____

RELATION TO PATIENT_____ BIRTHDATE_____ SOC SEC#_____

ADDRESS_____ PHONE_____

CITY_____ STATE_____ ZIP_____

INSURANCE COMPANY_____

SUBSCRIBER ID #_____ GROUP #_____

ASSIGNMENT OF BENEFITS

This medical practice works with the patient to minimize difficulty in the payment of fees for service. Upon leaving from your appointment, you will be asked to pay those minimal unmet deductible amounts and co-insurance amounts that your insurance company authorizes to be collected. Please insure that the primary and secondary information above is correct.

Authorization of Benefits: I the undersigned hereby authorize OB/GYN of Houston to release all information pertaining to the patient's treatment to his/her insurance company or companies and to any other physician or healthcare provider to whom the undersigned may be referred.

Assignment of Benefits: I hereby assign all medical and /or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plan to: OB/GYN of Houston.

Financial Responsibility: I understand that I am financially responsible for all services received, regardless of my insurance coverage.

_____ _____
(Patient/Parent/Guardian Signature) (Date)

_____ _____
(Guarantor/Responsible Party Signature) (Date)

OB/GYN OF HOUSTON
FINANCIAL STATEMENT

PATIENT_____DOB_____

PATIENT RESPONSIBILITIES

In order to receive proper care, patients must accept certain responsibilities. You are responsible for providing accurate and complete information regarding your Insurance policy (ies). You are responsible for your financial obligation.

FINANCIAL TREATMENT

In Consideration of the services to be rendered to the patient and/or the legally responsible person signing this Consent assumes full financial responsibility for the payment of the patient's account. If the account is referred to an attorney or collection agency, the same person agrees to pay actual attorney's fees and collection expense. If charity services are required, eligibility determination should be requested upon first visit or receipt of itemized bill or statement.

IRREVOCABLE ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and direct all Insurance company (ies) under which I am insured to pay directly to OB/GYN of Houston for all charges incureed, or alternately, for all charges in excess of the sums actually paid by the said policy (ies). Each person signing the Consent is financially responsible for charges not collected by this assignment.

RELEASE OF INFORMATION

To the extent necessary to determine liability for payment and to obtain reimbursement, I Authorize OB/GYN of Houston to disclose my health care information to any person, Social Security Administration, Insurance or benefit payor, health benefit plan or worker's compensation carrier which is, or may be, liable for all or a portion of the physician's charges, and to complete claim forms on behalf of the patient. I understand that OB/GYN of Houston may disclose my health care information without my written authorization to: members of audit, quality assurance, applicable State and Federal agencies; or to a court pursant to a court order or subpoena. I also understand that my health care information will not be provided to any person including next to kin, close personal friends, florists, delivery personnel or physicians who are not currently treating me without my written authorization.

FOR MEDICARE PATIENTS
ADVANCE BENEFICIARY NOTICE THAT MEDICARE WILL NOT PAY

Medicare does not pay for all of your health care costs. Medicare only pays for covered benefits. Some items and services are not Medicare, benefits and Medicare will not pay for them. When you receive and item or service that is not covered, you are responsible to pay for it, personally or through any other insurance that you may have.

DECLARATION

I have read and understand the above agreements, authorizations, and irrevocable assignments. The terms and consequences of this document have been fully explained to me and I have signed it freely an without inducement other than the rendition of services. All questions have been fully answered. I do understand the above agreements, authorizations, and irrevocable assignments. The terms and consequences of this document have been fully explained to me and I have signed it freely an without inducement other than the rendition of services. All questions have been fully answered. I do understand that I am responsible for any amount not covered by Insurance

Patient Signature	Print Name	Date
Guarantor/Insured Signature	Print Name	Date
Witness	Print Name	Date

OB/GYN OF HOUSTON
HIPAA PRIVACY
Acknowledgment of Receipt of Privacy Notice

By signing this acknowledgment of Receipt of Notice of Privacy Practices (the "Notice"); I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below.

I understand that the Company may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, health exam information and/ or type of products provided) to another party to permit the Company to perform its administrative duties, provide me with health care services and products, process my health benefit claims and communicate with me regarding health care services provided by the Company (for example, mailings of health reminders or information about services / products provided by the Company).

I can be assured that this Company does not sell my personal health information of any kind to a third party for such party's own use. I authorize the Company to submit my health benefit claims to my plan sponsor or health plan to receive reimbursement directly for the health services and products that I have received from the Company.

_____ _____

Patient Signature or Patient's legal Representative Date

Refusal of Acknowledgment

For Office Use Only

For Company Use ONLY: This section is to be completed by the Company only if unable to obtain the patient or patient's legal representatives written acknowledgment of receipt the Notice of Privacy Practices for the following reasons:

_____ (Please initial here) Patient's legal representative refused to sign.

_____ (Please initial here) Other: (Please specify, e.g., emergency care)

_____

_____

_____

_____

Provider / Associate Name (Print)

_____

Provider / Associate Signature

NOTE: PLACE THIS FORM IN THE PATIENT'S FILE, AND RETAIN INDEFINITELY.

REVIEW OF SYSTEMS

Patient Name_____ Date_____ DOB_____

Please place a check (✓) in each box for every "yes" answer to the following questions. Use the space on the back of this form to write in any explanations or other information you would like us to know. Have you had any of the following conditions or medical problems?

A. Constitutional

1. Weight loss (recent) ☐
2. Weight gain (recent) ☐
3. Fevers or chills (recent) ☐
4. Loss of appetite ☐
5. Unusual fatigue ☐
6. Sleeping difficulty ☐
7. Drenching night sweats ☐

B. Eyes

1. Double vision ☐
2. Failing vision ☐
3. Red eyes ☐
4. Eye Pain ☐
5. Glaucoma ☐
6. Cataracts ☐

C. Ear / Nose / Throat

1. Decreased hearing ☐
2. Ringing in the ears ☐
3. Frequent ear infections ☐
4. Vertigo or dizziness ☐
5. Snoring ☐
6. Nosebleeds (recent) ☐
7. Sinus disease ☐
8. Problems with teeth ☐
9. Gum pain or bleeding ☐
10. Hoarseness ☐
11. Speech problems ☐

D. Respiratory

1. Constant cough ☐
2. If yes, any sputum? ☐
3. Pneumonia ☐
4. Bronchitis ☐
5. Asthma ☐
6. Wheezing ☐
7. Tuberculosis (Tb) ☐
8. Positive skin test, Tb ☐
9. Pleurisy ☐
10. Emphysema ☐

E. Heart / Blood Vessels

1. Chest pain or tightness ☐
2. Short breath - activity ☐
3. Short breath - lying flat ☐
4. Swelling of the feet ☐
5. Palpitations ☐
6. Heart murmur ☐
7. Rheumatic fever ☐
8. High blood pressure ☐
9. High cholesterol ☐
10. Heart attack (M.I.) ☐
11. Heart failure ☐
12. Fainting ☐
13. Calf pain, walking ☐
14. Phlebitis ☐

F. Gastrointestinal

1. Difficulty swallowing ☐
2. Nausea, vomiting ☐
3. Hepatitis ☐
4. Pancreatitis ☐
5. Stomach/Ulcer ☐
6. Pain/abdomen (recent) ☐
7. Bright red blood / stool ☐
8. Black or tarry stool ☐
9. Diarrhea (recent) ☐
10. Constipation ☐
11. Recent change in bowel habits ☐
12. Bloating ☐
13. Colon polyps ☐
14. Hemorrhoids ☐
15. Hernia ☐
16. Irritable bowel / spastic colon ☐

G. Genital / Urinary

1. Kidney disease ☐
2. Blood in urine ☐
3. Kidney stones ☐

Urination

4. Burning ☐
5. Frequent ☐
6. Nighttime (2 or more) ☐
7. Loss of control ☐
8. Sexually transmitted disease ☐
9. Herpes infection ☐

Women

10. Painful intercourse ☐
11. Abnormal discharge ☐
12. Irregular periods ☐

H. Muscles / Bones / Joints

1. Arthritis ☐
2. Joint pain(s) ☐
3. Joint locking, clicking ☐
4. Swollen joints ☐
5. Joint stiffness ☐
6. Neck pain ☐
7. Lower back pain ☐
8. Fracture or injury ☐
9. Gout ☐
10. Osteoporosis ☐

I. Skin / Breast

1. Lumps in breast ☐
2. Breast disease ☐
3. Rash (recent) ☐
4. Hives ☐
5. Eczema ☐
6. Psoriasis ☐
7. Mole, new or change ☐
8. Hair loss ☐

J. Neurologic

1. Seizures / epilepsy ☐
2. Headaches, frequent ☐
3. Migraines (diagnosed by doctor) ☐
4. Numbness / tingling ☐
5. Strength loss, specific body part ☐
6. Stroke ☐
7. Personality change ☐
8. Tremor / shaking ☐

K. Psychiatric / Mental Health

1. Depression ☐
2. Anxiety/nervousness ☐
3. Insomnia, recent ☐
4. Memory loss ☐
5. Moodiness ☐
6. Mental illness ☐

L. Endocrine

1. Diabetes ☐
2. Thyroid Disease ☐
3. Hot Flashes ☐

M. Blood / Lymphatic

1. Anemia ☐
2. Cancer of any type ☐
3. Swollen lymph nodes ("glands") ☐
4. Bruising easily ☐
5. Clots in leg ☐

N. Allergic / Immunologic

1. Allergies / hayfever ☐
2. Chronic runny nose ☐
3. Drainage into throat ☐
4. Itchy eyes ☐
5. Steroid use ☐
6. HIV disease ☐

O. Other

1. Any other problems ☐

2 I read these questions and I have no other medical problems. ☐

Patient Signature