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FOR OBSTETRICS & GYNECOLOGY

Date Completed:_____

PATIENT INFORMATION:

Name _____ Goes By: _____ DOB: _____ Age: _____

Address:_____ City: _____ State: _____ Zip: _____

Drivers License #: _____ Social Security #: _____ Marital Status: S M D W

Email Address (if you would like to have access to our patient portal): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

May we leave confidential messages on your voicemail? Yes / No If yes, which number: _____

Employer: _____ Occupation: _____

***Preferred Language:** English / Spanish / Chinese / Korean / Russian / French / Indian / Other _____

***Ethnicity:** Hispanic or Latino / Not Hispanic or Latino / Choose Not to Report

***Race:** American Indian or Alaska Native American / Asian / Native Hawaiian or Pacific Islander /

Black or African American / White / Hispanic / Choose Not to Report / Other _____

REFERRING INFORMATION:

Physician Referral: _____

Physician's Address: _____

_____

Patient Referral:

INSURANCE INFORMATION:

Name of ***Primary*** Insurance Co: _____ Copay Amt $_____ Effective Date: _____

Subscriber's Name:_____ DOB: _____ **Relationship** to patient: _____

ID #: _____ Group: _____ Employer: _____

Name of ***Secondary*** Insurance Co: _____ Copay Amt $_____ Effective Date: _____

Subscriber's Name:_____ DOB: _____ Relationship to patient: _____

ID #: _____ Group: _____ Employer: _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name: _____ Relationship: _____

Address:_____ City: _____ State:_____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PREFERRED PHARMACY INFORMATION:

Name: _____ Phone: _____

Address or Approximate Location:

Information requested to meet meaningful use criteria under the Health Information Technology for Economic and Clinical Health (HITECH) Act

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REVIEW OF SYSTEMS
QUESTIONNAIRE

DATE COMPLETED: _____

PATIENT NAME:_____ DATE of BIRTH: _____

	Please CIRCLE below ANY that apply to you TODAY:
GENERAL:	Headaches / Appetite Good / Appetite Poor / Chills / Fever / Fatigue / Weight Gain / Weight Loss / Frequent Colds / Vision Change
HEENT / NECK:	Nose / Sinus Problems
ENDOCRINE:	Hair Loss / Excessive Sweating / Excessive Thirst / Hirsutism / Hot Flashes
RESPIRATORY:	Cough / Hemoptysis / Asthma / COPD / Shortness of Breath / Wheezing
CARDIOVASCULAR:	Chest Pain / Murmurs
GASTROINTESTINAL:	Abdominal Pain / Blood in Stool / Diarrhea / Vomiting
HEMATOLOGY:	Anemia / Blood Transfusion
GYNECOLOGY:	Vaginal Discharge / Breast Lumps / Breast Discharge / Breast Pain / Heavy Periods / Irregular Menses
GENITOURINARY:	Recurrent Urinary Tract Infections / Blood in Urine / Burning with Urination / Difficulty Urinating / Urinary Frequency / Urinary Incontinence / Urinary Urgency
MUSCULOSKELETAL:	Muscle Pain / Joint Pain
DERMATOLOGY:	Rash / Skin Cancer
NEUROLOGIC:	Loss of Consciousness /Memory Loss / Seizures
PSYCHIATRIC:	Anxiety / Depression / Eating Disorders

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Today's Date: _____ Patient Name: _____ Birth Date:_____

Reason for Today's Visit: _____

GYNECOLOGICAL HISTORY

First Day of Last Period: _____

Are your periods (please circle): Normal / Heavy in flow, Regular / Irregular in length, Non-painful / Painful

At what age did your periods begin? _____

Are you currently sexually active? YES / NO Sexual partners are: MEN / WOMEN / BOTH

Your current method of birth control (please circle): IUD / OCP / Tubal Ligation / Condom / Other _____

When was your LAST PAP SMEAR? _____

HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR? . . . . . YES / NO

ARE YOU HPV POSITIVE? . . . . . YES / NO

Have you ever had a breast mass or lesion? . . . . . YES / NO

Have you ever had a MAMMOGRAM?. . . . . .YES / NO

MEDICAL HISTORY

HAVE YOU HAD ANY MEDICAL ILLNESSES (Please circle any that apply):

Asthma	Heart Disease	Migraines	Bleeding Disorder
High Cholesterol	Cancer	High Blood Pressure	Psychiatric Illness
Diabetes	Hypo/Hyperthyroid	Seizure Disorder	

STD (please list type): _____ Cancer (please list type):_____

Other: _____

OBSTETRICAL HISTORY

How many times have you been pregnant? (this includes miscarriages and abortions) _____

Have you ever had a C-Section?. . . . . YES / NO

If yes, how many C-sections?_____

How many live births have you had? . . . . . ._____

MEDICATION HISTORY

DO YOU HAVE ANY KNOWN DRUG ALLERGIES? . . . . . YES / NO

If yes, what is the drug? _____ If yes, what is the reaction? _____

Below, please list your CURRENT MEDICATIONS (both prescription and nonprescription):

DRUG NAME	DOSAGE	WHO PRESCRIBED?
1)		
2)		
3)		
4)		

SURGICAL HISTORY

HAVE YOU EVER HAD SURGERY? . . . . . YES / NO

If YES, what TYPE of surgery (please circle): Abdominal Hysterectomy, Vaginal Hysterectomy, Ovary(ies) Removed, Tonsillectomy, Gallbladder Removed (Cholecystectomy), Appendix Removed (Appendectomy), Laparoscopy, LEEP, Cryotherapy, Hysteroscopy with or w/o D&C, C-Section, Suction D&C, Tubal Ligation, Other_____

FAMILY HISTORY

MOTHER (Please circle): Living/Deceased FATHER (Please circle): Living/Deceased

Has your mother and/or sister had ovarian, breast, uterine, and/or cervical cancer? YES / NO

Please circle any below that are part of your immediate family history (mother, father, siblings):
Diabetes Cervical Cancer High Cholesterol Osteoporosis Ovarian Cancer
Heart Disease Pulmonary Embolus Uterine Cancer Hypertension Breast Cancer

SOCIAL HISTORY

Do you use any tobacco products? . . . . . YES / NO

Do you use alcohol? . . . . . YES / NO

Do you use illegal or street drugs? . . . . . YES / NO

Are you a victim of intimate partner violence? . . . . . YES / NO

Are you a victim of sexual abuse? . . . . . YES / NO

Are you around health hazards at work? . . . . . YES / NO

Do you use a seat belt? . . . . . YES / NO

Are you presently eating a healthy diet. . . . . YES / NO

Do you exercise? . . . . . YES / NO

Do you intake folic acid? . . . . . YES / NO

Do you have adequate calcium intake?. . . . . YES / NO

Do you intake caffeine?. . . . . YES / NO

Do you have an advance directive (living will)? . . . . . YES / NO
Are you an organ donor? . . . . . YES / NO

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SMOKING QUESTIONNAIRE

HAVE YOU EVER SMOKED? . . . . . YES / NO

ARE YOU A CURRENT SMOKER? . . . . . YES / NO

If YES:

- How often do you smoke cigarettes:
  - o every day
  - o some days, but not every day
- How many cigarettes a day do you smoke?
  - o 5 or less
  - o 6 -10
  - o 11-20
  - o 21-30
  - o 31 or more
- How soon after you wake up do you smoke your first cigarette?
  - o Within 5 minutes
  - o 6-30 minutes
  - o 31 – 60 minutes
  - o after 60 minutes
- Are you interested in quitting?
  - o Ready to quit
  - o Thinking about quitting
  - o Not ready to quit

ARE YOU A FORMER SMOKER? . . . . . YES / NO

If YES:

- How long has it been since you last smoked?
  - o Less than 1 month
  - o 1 – 3 months
  - o 3-6 months
  - o 6-12 months
  - o 1-5 years
  - o 5-10 years
  - o Greater than 10 years

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE.

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ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including private insurance and any other health plans to Chad Simmons, M.D., P.A. I transfer my title of reimbursement from my insurance company to Chad Simmons, M.D., P.A. I request that payment from my insurance company be made directly to Chad Simmons, M.D., P.A.

I hereby agree to pay any and all charges that exceed or are not covered by insurance. I hereby authorize said assignee to release all information necessary to secure payment.

I authorize my insurance claim form to be sent via electronic claim filing. I authorize the release of my medical records or insurance claims to be sent via fax.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

_____ _____

PATIENT SIGNATURE (Parent or Guardian if patient a minor) **DATE**

_____

PRINTED NAME

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NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Protecting your privacy and maintaining the security of your protected health information is one of the most important responsibilities of this office. If you have any questions about this notice, please contact our Privacy Officer at 12890 Hillcrest Road, Suite 203, Dallas, Texas 75230.

Our Obligations

We are required by law to:

- Maintain the privacy of protected health information, hereinafter, designated "PHI."
- Give you this notice of our legal duties and privacy practices regarding your PHI.
- Follow the terms of our notice that is currently in effect.

How We May Use and Disclose Health Information

Except for the following, we will use and disclose health information only with your written permission:

- Treatment – We may use and disclose PHI for your treatment and to provide you with treatment-related services. For example, we may disclose PHI to doctors, nurses, technicians, pharmacists, including personnel outside our office who are involved in your care and need to provide you with care.
- Payment - We may use and disclose PHI so that we or others may bill and receive payment from you, from an insurance company, or a third party for the treatment and services you received.
- Operations – We may use and disclose PHI for operational purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care, and to operate and manage our office.
- Appointment Reminders - We may use and disclose PHI to contact you and remind you of your appointment with our office.
- Individuals Involved in Your Care or Payment for Your Care - We may use and disclose PHI with a person involved in your care such as your family or a close friend.
- Research - We may use your PHI for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI has approved the research.

Special Situations

- As Required by Law - We may disclose PHI when required to do so by international, federal, state, or local law.
- To Avert a Serious Threat to Health or Safety - We may disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.
- Business Associates - We may disclose PHI to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. All of our business

associates are obligated to protect the privacy of your PHI and are not allowed to disclose any information other than as specified in our contract.

- Lawsuits and Disputes – We may disclose PHI in response to a court order or subpoena only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- Law Enforcement - We may release PHI if requested by law enforcement official if the information is in response to a court order, subpoena, warrant, or summons.

Your Rights

You have the following rights regarding your protected health information ("PHI"):

- Right to Inspect and Copy – your medical and billing records except for psychotherapy notes. You must make this request in writing. The charges for copying are in accordance with the Texas Medical Practice Act.
- Right to Amend – you may ask to amend the information when the information is in our office.
- Right to Accounting of Disclosures – you have the right to request a list of certain disclosures we made of your PHI other than for treatment, payment, operations, or disclosures with your written authorization. You must make this request in writing.
- Right to Request Restrictions – you have the right to request a restriction or limitation on the PHI we disclose for purposes of treatment, payment, operations, or to someone involved in your care or the payment of your care, like a family member or friend. For example, you may request that we not share information about a particular diagnosis or treatment with your spouse. This request must be made in writing. We are not required to agree to your request.
- Right to Request Confidential Communications - you have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. Your request must be in writing and must specify how or where you wish to be contacted. We will accommodate reasonable requests.
- Right to a Paper Copy of This Notice - You may ask us to provide you with a copy of this notice at any time.

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to PHI we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. This notice will contain the effective date on the top of the first page.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the Department of Health and Human Services, 200 Independence Ave., SW, Washington, DC 20201. A complaint must be filed within 180 days of when the complainant knew or should have known that the act or omission complained of occurred. Filing a complaint will not interfere with your health care at this practice.

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Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____ , have received a copy of the privacy practices of Chad Simmons, M.D., P.A.

_____ _____
Signature of Patient Date

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DISCLOSURE OF PATIENT INFORMATION

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

_____

_____

_____

_____

Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name_____ Phone #_____

Name_____ Phone #_____

Please print the telephone number where you want to receive calls about your appointments, lab, and x-ray results, or other health care information:

_____

*I am fully aware that a cell phone is not a secure and private line.

Please Print:

Patient Name_____

Patient/Guardian Signature:

_____ Date_____

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E-PRESCRIBING CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program. These include:

- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.

- **Medication history transactions** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

- **Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up or partially filled.

By signing this consent form, you are agreeing that Chad Simmons, M.D., P.A. can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Chad Simmons, M.D., P.A. to enroll me in the E-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Print Patient Name Patient's Date of Birth

_____ _____

Signature of Patient or Guardian Relationship to Patient