

OB-GYN ASSOCIATES OF NORTH DALLAS

PATIENT INFORMATION RECORD

(PLEASE PRINT OR WRITE LEGIBLY)

C. EDWARD WELLS, M.D.
 DARRELL E. ROBINS, M.D.
 JOHN PAUL ROBERTS, M.D.
 STEVEN R. MacDONALD, M.D.
 RANDALL J. BURT, M.D.

PATIENT INFORMATION

DATE: _____

CHART NO.: _____

PATIENT'S NAME (LEGAL)		MARITAL STATUS S M W D SEP	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.
PATIENT'S ADDRESS		CITY AND STATE		ZIP CODE	HOME PHONE
TEXAS DRIVERS LICENSE NUMBER		E-MAIL ADDRESS			BUSINESS PHONE
PATIENT'S EMPLOYER		OCCUPATION (INDICATE IF STUDENT) HOW LONG?			CELL PHONE
EMPLOYER'S STREET ADDRESS		CITY	STATE	ZIP CODE	
PATIENT'S RACE (PLEASE CIRCLE) CAUCASIAN AFRICAN-AMERICAN HISPANIC ASIAN INDIAN OTHER:					
DRUG ALLERGIES					
SPOUSE'S NAME		SPOUSE'S DATE OF BIRTH	AGE	SOCIAL SECURITY NO	
SPOUSE'S TEXAS DRIVERS LICENSE NUMBER		NUMBER OF CHILDREN AND AGES			
SPOUSE'S EMPLOYER		OCCUPATION (INDICATE IF STUDENT) HOW LONG?			BUSINESS PHONE
SPOUSE'S EMPLOYER STREET ADDRESS		CITY AND STATE		ZIP CODE	
FOR EMERGENCY CONTACT NAME	STREET ADDRESS, CITY, STATE, AND ZIP CODE			HOME PHONE	
FOR EMERGENCY CONTACT NAME	STREET ADDRESS, CITY, STATE, AND ZIP CODE			HOME PHONE	
INSURANCE INFORMATION					
INSURANCE CO NAME (PRIMARY)		POLICYHOLDER'S CO NAME		POLICY NUMBER/GROUP NUMBER	
MAIL INSURANCE CLAIMS TO (STREET, CITY, STATE, ZIP CODE)					
INSURANCE CO. NAME (SECONDARY)		POLICYHOLDER'S CO NAME		POLICY NUMBER/GROUP NUMBER	
MAIL INSURANCE CLAIMS TO (STREET, CITY, STATE, ZIP CODE)					
REFERRED BY					

In order to control our costs of billing, we request that office visits be paid at the time service is rendered. We would rather control our billing costs than be forced to raise our fees.

My payment will be made for services rendered by: (please check one)

- Cash
 Check
 Master Card
 Visa
 American Express
 (Or)
 Previous arrangements made and approved by OB-GYN ASSOCIATES OF NORTH DALLAS Business Office.

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 plan to OB-GYN ASSOCIATES OF NORTH DALLAS. This assignment will remain in effect until revoked by me in writing. A photocopy of this statement is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signed: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

DATE: _____

NAME: _____

AGE: _____ MARITAL STATUS: Single / Married / Divorced / Widowed DATE OF BIRTH: _____

RELIGIOUS PREFERENCE: _____

Date of last Pap smear: _____

Have you ever had an abnormal Pap smear? Yes No

Have you ever had cryosurgery? Yes No
(freezing of the cervix)

How old were you when you first started
your period: _____

What was the first day of your last normal menstrual
period: _____

Are your periods: Regular Irregular

Do you often skip periods? Yes No

Do you have heavy bleeding with your period? Yes No

Do you have pain with your period? Yes No

Mild Moderate Severe

Do you have pain during or after intercourse? Yes No

Are you having any problems with sex? Yes No

Do you need birth control or contraceptive
advice? Yes No

Which of the following methods have you used in
the past:

Foam/Condoms/Diaphragm/Birth control pill/IUD

Vaginal sponge/Vasectomy/Tubal ligation

What form of birth control do you use at the present
time: _____

How many children: _____

How many miscarriages: _____

How many abortions: _____

Are you trying to become pregnant? Yes No

Did your mother take hormones during pregnancy? Yes No
(ie DES, diethylstilbesterol, etc.)

Do you have any history of the following:

Herpes Infection	Yes	No
Tubal/Ovarian Infection	Yes	No
Gonorrhea	Yes	No
Syphilis	Yes	No
Chlamydia	Yes	No
Condyloma (HPV)	Yes	No

Do you have cyclic breast pain? Yes No

Do you have a history of breast lumps or tumors? Yes No

Do you have any milk or discharge from your
breasts? Yes No

Do you perform self breast examination? Yes No

Do you have a family history of breast cancer? Yes No

Have you ever had a mammogram? Yes No

Do you lose urine when lifting heavy objects
or coughing? Yes No

Do you have involuntary loss of urine? Yes No

Do you experience bladder symptoms of urgency,
frequency, or pain? Yes No

Do you smoke? Yes No

If so, _____ packs a day.

How much alcohol do you consume weekly?
_____ drinks per week

How many cups of coffee, cokes or glasses of tea do you
consume daily? _____

Are you allergic to any drugs or medications? Yes No

If so, please list them:

FAMILY HISTORY

Has any blood relative ever had any of the following: (if yes, please circle)
CANCER, LEUKEMIA, DIABETES, HEART DISEASE, HIGH BLOOD PRESSURE, STROKE

Have you or your husband, or anyone in either of your families, ever had one of the following: (if yes, please circle) CLEFT LIP/PALATE,
DOWNS SYNDROME (MONGOLISM), HEMOPHELIA, MUSCULAR DYSTROPHY, DEFECTS OF THE SPINE (SPINA BIFIDA),
HYDROCEPHALUS (WATER ON THE BRAIN), MENTAL RETARDATION, SICKLE CELL DISEASE, STILLBORN BABY,
CHROMOSOMAL ABNORMALITIES, INHERITED OR GENETIC DEFECTS, CONGENITAL ABNORMALITIES, BIRTH DEFECTS.

Are there any diseases which tend to run or recur in your family?

If yes, please explain: _____

REVIEW OF MEDICAL HISTORY

Have you ever experienced any of the following diseases, illnesses, surgical procedures? (If yes, please circle)

Depression
Nervous breakdown/Mental Problems
Seizure disorder/Convulsions
Concussion/Head injury
Migraine Headaches
Thyroid problem/Goiter
Asthma
Emphysema/Bronchitis
Heart problems/Angina
Hypertension/High blood pressure
Heart Murmur
Rheumatic fever
Phlebitis/Thrombophlebitis
Stomach ulcers
Colitis
Hepatitis/Yellow jaundice
Gallbladder disease/stones
Kidney disease/stones/infection
Diabetes
Arthritis/Bone disease
Broken bones
Cancer or leukemia

Blood transfusions
Anemia
Tonsillectomy
Head/Neck surgery
Heart/Lung surgery
Appendectomy
Gallbladder surgery
Other abdominal surgery
Bone surgery
Bladder surgery
C-Section
Laparoscopy
Hysterectomy
Surgery of fallopian tubes or ovaries
Cryosurgery
D & C
Treatment of abnormal Pap smear
Abnormal mammogram
Breast Surgery (augmentation implants or reduction)
Hysterosalpingogram
Hysteroscopy
Colposcopy

List any other medical illnesses or surgical procedures: _____

List all present medications: _____

List all allergies: _____

HEALTH DATA

Date of last pelvic examination: _____

Date of last physical examination: _____

Date of last blood count: _____

Chest X-ray/EKG: _____

Name of Internal Medicine Specialist/Family Doctor: _____

DATE: _____ PATIENT'S SIGNATURE: _____

OB-GYN ASSOCIATES OF NORTH DALLAS

C. Edward Wells, M.D.
Darrell E. Robins, M.D.
John Paul Roberts, M.D.
Steven R. MacDonald, M.D.
Randall J. Burt, M.D.

OFFICE POLICIES

We want your experience with our office to be a positive one. Below you will find our office policies. Please read each one carefully. We hope this information will be helpful to you when accessing our office and making decisions about your health.

OFFICE HOURS:

Our office offers appointments Monday – Friday between the hours of 9:00 and 4:00.

APPOINTMENTS:

Office visits are by appointment only. We strive to see our patients as close to their appointment times as possible. As you know, emergencies do arise and can cause an increase in waiting time. Patients who arrive late for an appointment may be asked to reschedule.

We understand that there are times when it will be necessary for you to cancel or reschedule your appointment. In order for us to be available to as many patients as needed, we ask that you kindly provide our office with at least 24-hour notice of these changes.

Minors cannot be seen without prior written authorization by a parent or legal guardian.

TELEPHONE CALLS:

We ask that you make all non-emergency calls and prescription refills during our regular office hours when your patient chart is readily available. We will return your call as quickly as possible. Prescription refills will not be completed after normal office hours. Calls made after 4:00 pm might not be returned until the next business morning.

Patients that call after office hours can either leave a message for a return call the next business morning, or for urgent medical emergencies, they can call the answering service to have the physician on-call paged. If a life-threatening situation arises, call 911.

PATIENT / INSURANCE PAYMENTS:

Payment is expected at the time services are rendered. Payment will be accepted in the form of cash, check, MasterCard or Visa. We require that you present accurate insurance information and that you complete a registration form on the *initial appointment and update on a semi-annual basis, or when your insurance coverage changes*. We will keep a copy of your insurance card on file in your chart. Our goal is to help you utilize your insurance benefits in every way. If you have insurance coverage with a health plan that our office participates with, we will collect the portion you are responsible for and file the claim. While this office will attempt to negotiate disputed claims with the insurance carrier, the ultimate obligation for services rests with the patient. Please be aware that most insurance plans do not cover 100% of the services provided. After the insurance company has paid your claim, if you still have a balance (even though you paid your co-pay at the time of service), you will receive a

statement from our office. We ask that you pay the balance upon receipt of this statement. Account balances exceeding 60+ days without payment arrangements will be accessed a monthly \$10.00 late fee until the balance is paid in full. Please do not hesitate to contact our billing office to assist you with any insurance or account questions.

PHYSICIAN SELECTION:

We have 5 physicians in our group, although all of our physicians take call and cover for each other in their absence.

MEDICAL RECORDS:

All medical record requests require written release of information. The Texas State Board of Medical Examiners allows *2 weeks* for the processing of all medical records. There is a fee for patients that request medical records which must be paid prior to the records being copied and mailed. Our office follows the fee schedule put forth by the Texas State Board of Medical Examiners. The fee is \$25.00 for the first twenty pages and \$0.15 for each additional page plus the cost of postage.

There will also be a fee for all forms that need to be completed by your physician. This fee is the patient's responsibility. This includes Family Medical Leave, disability, medical leave, etc. Please allow at least *2 weeks* for completion of all forms.

TELEPHONE NUMBERS:

Please keep our office number and fax number for your records

Office 972-981-7777

Fax 972-981-7750

I have read and understand the office policies related to care provided by OB-GYN Associates of North Dallas.

Signature

Date

OB-GYN ASSOCIATES OF NORTH DALLAS

OBSTETRICS, GYNECOLOGY & INFERTILITY

C. EDWARD WELLS, M.D., P.A.

DARRELL E. ROBINS, M.D., P.A.

JOHN PAUL ROBERTS, M.D., P.A.

STEVEN R. MACDONALD, M.D., P.A.

RANDALL J. BURT, M.D., P.A.

**Notice to Patients
of Financial Interests**

You have been referred to Presbyterian Center for Diagnostics & Surgery (the "Hospital"). You are informed that your physician holds a financial interest in the Hospital. You have the option, at you discretion, to use an alternate health care facility.

Please indicate your receipt of this Notice by your signature below.

Date: ___/___/___

Patient Signature

Patient Printed Name

OB-GYN Associates of N Dallas

NOTICE OF PRIVACY PRACTICES

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

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At OB-GYN Associates of N Dallas (hereinafter referred to as "the Practice"), privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this information to provide service to you, to process your claims and to bring you health information that might be of interest to you.

Keeping information accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write us at the telephone numbers or addresses listed below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How - and why - information is shared

We limit who receives information and what type of information is shared.

- *Sharing information within the Practice.* We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.
- *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.
- *Other.* Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

Count on our commitment to your privacy

You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us – whether it's at our office, over the phone or through the Internet.

OB-GYN Associates of N Dallas

6124 W Parker Rd Ste 134

Plano, TX 75093

972-981-7777

OB-GYN Associates of N Dallas

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, OB-GYN Associates of N Dallas creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

_____ (PATIENT'S NAME PRINTED)	_____ DATE
_____ PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR)	_____ SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)
_____ WITNESS (Optional)	_____ DATE