WELCOME TO

1st CHOICE OBSTETRICS & GYNECOLOGY

Thank you for taking the time to complete this form. It will assist us in providing you with the best possible medical care during your visit today.

Name: _____ Date: _____

Are you here for your annual exam, or is there another reason for your visit today?

_____

Personal History:

Last Menstrual Period _____

How many days between your periods? _____ How long do they last? _____

Marital status (circle one): single, engaged, married, separated, divorced, widowed

Are you sexually active? YES / NO Any problems? _____

What are you using for birth control? _____

How many times have you been pregnant? _____

Number of children _____ Number of miscarriages _____ Number of abortions _____

Number of C-sections _____ Number of preterm deliveries _____

Any history of sexually transmitted diseases? YES / NO

When was your last pap smear? _____

Have you ever had an abnormal pap? YES / NO

Any problems with your breasts? YES / NO Last mammogram date/result? _____

Have you had a hysterectomy? YES / NO

Are you on hormone replacement therapy? YES / NO If yes, what: _____

Major Medical Problems: _____

Prior Surgeries: _____

Current Medications and dosages: _____

_____

Drug Allergies: _____

Family History:

Cancer, Heart Attacks, Diabetes, High Blood Pressure, etc. YES / NO

If yes, please explain: _____

Race/Ethnic Background: _____

Habits:

Smoking: YES / NO If yes, how much? _____

Alcohol: YES / NO If yes, how much? _____

Drug Use: YES / NO If yes, how much? _____

Exercise : YES / NO If yes, how much? _____

Are you currently experiencing any of the following problems? (Please circle all that apply)

Chest Pain Abdominal Pain Trouble Breathing Headaches Vision problems
Swelling Dizziness Nausea/Vomiting Weight Gain/Loss Skin Problems
Numbness/Weakness Constipation/Diarrhea Urinary Problems

History of sexual abuse? YES / NO

History of physical abuse? YES / NO

If you are over age 50, please answer the following:

Have you ever had a colonoscopy? YES / NO If yes, when? _____ Was it normal? YES / NO

Have you ever had a bone density? YES / NO If yes, when? _____ Was it normal? YES / NO

Do you take any medication to prevent osteoporosis? YES / NO If yes, what? _____

Do you take Calcium? YES / NO If yes, amount taken each day _____

Do you take Vitamin D? YES / NO If yes, amount taken each day _____

1st Choice Obstetrics & Gynecology

Shelby L. Hampton, MD • Tracy L. Turner, MD, FACOG

920 Medical Plaza Drive, Suite 400 • The Woodlands, TX 77380

Our Financial Policy

1st Choice OBGYN is committed to providing you with the best possible care. Your clear understanding of our Financial Policy is important to our professional relationship. If you have any questions about our fees, financial policy, or your responsibility, please let us know.

Account Responsibility: You are responsible for all changes incurred on your account. It is also your responsibility to make sure all information on your account is current and accurate. Accounts with incorrect information can cause payment delays.

Insurance: Payment of co-pays/deductibles and co-insurance are all due at the time of service. Our office will file an insurance claim for services rendered. Please be aware your insurance plan my change your copay periodically. It is your responsibility to know what your current plan is.

Self-Pay: full payment is expected at the time of service.

Account with Overdue Balance: All overdue balances must be paid in full before your next office visit. If your balance is not paid in full within 90 days, your account will be turned over to an outside collection agency. If your account has been turned over to a collection agency, all future charges incurred must be paid in full before the service is rendered.

Returned Checks: A $30 service charge will be assessed on all returned checks. Non-payment of returned checks may be referred to the District Attorney for legal action in some cases.

Missed Appointments: A **$25 charge** will be assessed if you do not show up for your appointment, or if you fail to cancel less than 24 hours. Please understand that your appointment time could have been offered to another patient if we had known in advance that you would have not been able to make it your appointment.

Family Medical Leave Act (FMLA), Disability Forms and Medical Records:
There will be a **$25 charge** for completion of all (1 fee per pregnancy and or surgery) Disability and or FMLA forms. These forms require a physician to review so please allow 7-10 business days.

There will be a **$25 charge** for a hard copy of Medical Records. Please allow 7-10 business days to process this request.

Methods of Payment:
1st Choice accepts exact cash, personal checks, Visa, Mastercard, AMEX, and Discover cards. Payments can be in made in person, by mail, or by phone when paying by credit card.

I understand and agree to the terms of 1st Choice OBGYN's Financial Policy.

I also have been informed regarding of 1st Choice OBGYN's privacy practices.

This notice is posted in the reception area, and copy is available upon request.

_____ _____

Signature of Patient or Legal Guardian Date

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Dear Patient:
In accordance with the Health Insurance Portability Act of 1996 (HIPAA), Public Law 104-91, the physicians and/or staff of 1st Choice Obstetrics & Gynecology are unable to release any information pertaining to your condition, treatment and/or care without your specific written consent.

I hereby authorize the physicians and/or staff of 1st Choice Obstetrics & Gynecology to release information pertaining to my condition and/or care to the individuals listed below:

_____
Name Relationship

_____
Name Relationship

_____
Name Relationship

Expiration Date of Authorization
This authorization is effective indefinitely as of the date of signing this document unless revoked or terminated by the patient of patient's representative. It is your responsibility to inform our office if you would like to make changes to this form.

Right to Terminate of Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to 1st Choice Obstetrics & Gynecology.

How I wish to be contacted (the primary number I want to be reached at):

_____ ( ) O.K. to leave a message with detailed information

_____ _____
Authorized Signature Date

_____
Patient's Name (please print)

If signature above is not patient, please indicate relationship
( ) Parent or guardian of minor patient
( ) Guardian or conservator of incompetent patient

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Medicaid Consent Form

I understand that 1st Choice Obstetrics & Gynecology is accepting me as an insured/cash pay patient.

This means either:

1. I do not have insurance and will be cash pay.
2. I have private medical insurance that they do accept.

I will be responsible for paying my portion for any services I receive.

I understand that 1st Choice Obstetrics & Gynecology does **NOT** accept Medicaid.

If I choose to get on Medicaid, I can use it to pay for my labs and my hospital stay, but not for services provided at/by this practice.

If I want to be able to use Medicaid as my primary insurance, then I will have to transfer care to another practice.

Patient Name: _____ Date: _____

Signature: _____

T: 281.882.8050 • F: 281.882.2057