South Texas Gynecologic Oncology
BHS PHYSICIANS NETWORK

PATIENT INFORMATION: **TODAY'S DATE**_____

Last Name: _____ First Name: _____ Middle Initial:_____

Date of Birth: _____ Sex: ____Male ____Female SS#:_____ Marital Status:_____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email: _____ Contact Preference: (Home Phone) (Work Phone) (Mobile Phone) (Mail) (Patient Portal)

AUTHORIZATION: I authorize you to leave automated reminder calls on my mobile device ____YES ____NO

Referring Provider: _____ Patient PCP: _____

Race: (Arab) (Asian) (Black or African American) (Other Race) (White) (Other) Preferred Language: English Other _____

Ethnicity: (Central American) (Cuban) (Dominican) (Hispanic or Latino/Spanish) (Latin American/Latin, Latino) (Mexican) (Not Hispanic or Latino) (Puerto Rican) (South American) (Spaniard)

How did you hear about us? (Physician) (Internet Search) (Newspaper) (Television) (Hospital Partner) (BHS Screening Bus) (Baptist Community Event) (Website) (Insurance Company) (Baptist Emergency Hospital) (Friend/Family) (Employer) (Other _____)

GUARDIAN INFORMATION:

Guardian Last Name: _____ Guardian First Name: _____ M. Name:_____

EMERGENCY CONTACT INFORMATION:

Last Name:_____ First Name:_____ Phone:_____ Relationship:_____

INSURANCE INFORMATION: *Please bring insurance card(s) to the visit*

Insurance Plan Name: _____ Policy Holder Name: _____ Policy Holder DOB: _____

EMPLOYER INFORMATION:

Employer Name: _____ Employer Phone: _____ Occupation:_____

CLINICAL INFORMATION:

Preferred Pharmacy: _____Phone: _____ Fax: _____

Preferred Laboratory: _____

Protected Health Information Authorization:

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

Name	**Relationship to Patient**	**Type of information**			
		All	**Schedule**	**Medical**	**Billing**
_____	_____	**Y/N**	**Y/N**	**Y/N**	**Y/N**
_____	_____	**Y/N**	**Y/N**	**Y/N**	**Y/N**
_____	_____	**Y/N**	**Y/N**	**Y/N**	**Y/N**
_____	_____	**Y/N**	**Y/N**	**Y/N**	**Y/N**

Specific Instructions or Limitations:_____

We will continue to rely on the information given here when communicating with family members or others involved in you care unless you request changes. Please promptly notify our office if you wish to alter the designations above.

Signature of Patient:_____ **Date:**_____

To revoke this authorization, please send a written request to our office.

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POLICY ACKNOWLEDGEMENTS AND RELEASES

Please read each of the following statements carefully and sign as your authorization, understanding, and agreement to each statement.

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to the physician. I also authorize the physician to release any information required to process this claim to my employer and/or any third party vendor.

Signed: _____ Date: _____

MEDICARE BENEFICIARY ASSIGNMENT AND RELEASE: I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by _____. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Signed: _____ Date: _____

FINANCIAL OBLIGATION: I hereby acknowledge that I understand there may be services provided that will not be covered by my insurance carrier, and fully understand that I am fully responsible for any and all charges not covered by my insurance carrier. I understand that payment may be requested at the time of service or I may be billed for such services subsequently.

Signed: _____ Date: _____

CONSENT FOR TREATMENT: I hereby authorize the physician, nurses, medical assistants and staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

Signed: _____ Date: _____

ADVANCED DIRECTIVE: Do you have an advance directive (living will/power of attorney)?

_____Yes _____No If yes, please provide a copy for our records.

MEDICATION HISTORY AUTHORITY: I authorize BHS Physicians Network and BHS Physicians Specialty to obtain Medication History Authority.

Signed: _____ Date: _____

NO SHOW POLICY

Patients who fail to present for a scheduled appointment will be considered a “no show”. Patients who fail to cancel the appointment 24 hours prior to the appointment will also be considered a “no show”.

A patient determined to be a “no-show” will be charged $25.00 for each episode.

Patients who have missed 3 appointments in a 12 month period will be considered a “chronic no show”. A patient determined to be a “chronic no show” may be discharged from the practice.

_____ has read and understand the above stated policy.
Patient Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: You may refuse to sign this acknowledgement.

I, _____, DOB, _____,

have received a copy of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

For Office Use Only:

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____Individual refused to _____accept Notice _____ sign Acknowledgment

_____Communications barriers prohibited obtaining the acknowledgment

_____An emergency situation prevented us from obtaining acknowledgment

Other (Please specify)_____

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We appreciate the opportunity to serve you. The following information and expectations are set forth in an effort to provide all our patients with the highest quality care:

____ **MEDICATION REFILL REQUESTS:** We request that you first contact your pharmacy for refills. We will not do same day refills. The pharmacy will work with us to process your requests. Refills should be requested at least 72 hours (3 business days) prior to your refill date. The practice is closed on weekends and refill requests will not be accepted. Please contact our office to confirm that we have received the refill request. If you have not been seen by our provider in the past year, we will not refill your medication without an appointment.

____ **PAYMENTS:** All applicable fees, deductibles, coinsurance, co-pays or outstanding balances must be paid at the time of your appointment. We accept cash, checks, Visa, MasterCard, Discover and American Express. There is a $25 charge for all returned checks.

____ **CHANGES OF INFORMATION:** Please provide us with any changes regarding your address, phone number or insurance information as soon as possible. Failure to notify us of any updates may result in you being financially responsible for the services rendered.

____ **FMLA & OTHER FORMS:** Should you require our office to complete FMLA or other applicable forms, there is a fee starting at $35. Fees are due when forms are completed. Please allow 7 business days for us to complete forms. Please inquire with the staff regarding forms that need to be completed and applicable fees.

____ **APPOINTMENT TIME:** We ask that you arrive on time for your appointments. Arrivals later than 15 minutes will require appointment rescheduling.

____ **CELL PHONES:** We ask you to please have your cell phone off during your office visit.

____ **CANCELLATION/NO SHOWS:** If you need to cancel your appointment, we ask that you give us 24 hours notice. If you fail to notify us and miss your appointment, there will be a $25 fee and possible termination from the office if excessive. There will also be a fee of $25 if you cancel your appointment on the same day.

____ **Office Visits:** At the time of scheduling, please notify the staff of all the reasons for which you are requesting an appointment. In respect to all our patients' time and to maintain the efficiency of the practice, only complaints for which the visit was scheduled will be addressed. We will address all your healthcare needs, but it may require multiple visits.

We ask that you initial each area and sign below. By signing below, you acknowledge having read, understood and are in agreement with the above information and expectations.

_____ _____ _____

Patient Signature **Printed Name** **Date**

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What problem brings you to our clinic today? When did it start? Are you having symptoms? Have you started medications / treatment for this problem?

_____
_____
_____
_____

Please list any known drug allergies and the reaction:_____
_____

List Medications / Herbals / Over the counter drugs / Vitamins Taken on a regular basis:

_____
_____

GYNECOLOGICAL HISTORY:
When did you first menstruate ____
When did you stop menstruating? ____
Cycle-Every ___ days. Last MP___
Have you ever been treated for an abnormal pap smear? [] yes [] no
Current birth control method ____
Do you have any hair loss or abnormal growth? [] yes [] no
Age at Menopause_____
Lifetime number of partners_____
Age at first sexual activity_____
Do you have pain with intercourse? [] yes [] no

Loss of sex drive? [] yes [] no
Have you ever had a pelvic infection? [] yes [] no
Have you ever had a sexual transmitted disease? [] yes [] no
Have you had hormone replacement? [] yes [] no

FAMILY HISTORY OF CANCER:
[] I am adopted and have no record of family history
[] I have no sisters and my mother has no sisters
[] I have no family history

Family member #1_____(ie: aunt, mother, uncle)
Type of Cancer _____(ie: colon, breast, brain)
[] Maternal or [] Paternal
[] alive and well [] alive with disease
[] deceased of disease [] deceased of other cause

Family member #2_____
Type of Cancer _____
[] Maternal or [] Paternal
[] alive and well [] alive with disease
[] deceased of disease [] deceased of other cause

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FAMILY ILLNESSES:

[] Diabetes
[] Kidney disease
[] High blood pressure
[] Rheumatic fever
[] Bleeding tendency
[] Tuberculosis
[] Arthritis and/or gout
[] Heart attacks
[] Asthma
[] Stroke
[] Alcoholism
[] Nervous breakdown

Social History:

Smoking status: _____ Years of use/How much: _____

Education: _____

What is your occupation: _____

Do you have a support person? (Yes/No)

Exercise Level: None/Occasional/ Moderate/ Heavy

Do you have a specific diet? Regular/Vegetarian/ Vegan/Gluten Free/ Cardiac/ Diabetic

What is your alcohol intake? None/Occasional/ Moderate/ Heavy

What is your caffeine intake? None/Occasional/ Moderate/ Heavy

Do you use illicit drugs? Yes/No

Do you have an advance directive? _____

Operations / Hospitalizations / Procedures

Problem	YEAR

Have you ever had a problem with general anesthesia? [] yes [] no
If yes, please describe:_____

Prior history of cancer: [] Yes [] No if yes, describe: _____
Prior radiation therapy: [] Yes [] No if yes, describe: _____

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Past Medical History: (circle those that apply to you)

__ Allergies
__ Anemia
__ Anxiety
__ Arthritis and/or Gout
__ Asthma
__ Bowel Disease
__ CAD
__ Cardiac Bypass
__ Chest Pain
__ Convulsions/ Seizures
__ Depression
__ Diabetes
__ Dyslipidemia
__ Gastric Ulcer
__ HIV/AIDS
__ Headaches
__ Hepatitis
__ High Blood Pressure
__ Kidney Disease/ Stones
__ Prior History of Cancer
__ Prior Radiation Therapy
__ Problems with general anesthesia
__ Sexually Transmitted Disease
__ Stroke
__ Thyroid Disease
__ Tuberculosis
__ Upper Respiratory Problems

Are there any other medical problems not listed above that you feel we should know about??

_____

_____

If there is additional information you think we should know about you, please describe below: