Please Note: So that we may maintain the most up to date and accurate information on our patients, we will request that your review and update this form at least once a year.

DATE_____

Patient Information

Patient Name: First_____ MI _____ Last _____ SS#_____

DOB:_____ Sex: [ ]male [ ] female Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed

Parent/Legal Guardian Name if patient is a minor Name:_____ DOB:_____

Race: [ ] White [ ] Black/African American [ ] Asian [ ] American Indian/Alaska Native [ ] Native Hawaiian/Pacific Islander

Ethnicity: [ ] Not Hispanic/Latino [ ] Hispanic/Latino [ ] Declined

Address:_____ Apt#_____ City_____ St_____ Zip_____

Phone: Cell_____ Home_____ Work_____

Email:_____ Best contact method to reach you:_____

Employment Status: [ ]Full-Time [ ] Part Time [ ] Unemployed [ ] Student [ ] Disabled [ ] Retired

Financial Responsibility

Name: First_____ MI_____ Last_____

Relationship: Spouse Parent Guardian Other (please specify): _____

Address:_____ Apt#_____ City_____ St_____ Zip_____

Phone: Cell_____ Home_____ Work_____

Emergency Notification

[ ] Check box if same as Guarantor. If different, please complete information below.

Name:_____ Relationship to Patient:_____

Phone: Home_____ Cell_____

Pharmacy Information

Pharmacy Name:_____ Address _____Zip Code_____

Please contact your pharmacy for medication refills. Your Pharmacy will fax us a medication refill request which the physician will review. Refill authorizations may take up to 72 hours. Please allow sufficient time for us to process you refill request.

Referral From

[ ] Friend/Family Member [ ] Insurance company [ ] Internet [ ] Magazine [ ] Practice Website [ ] Other_____

Referred from physician:_____

Patient Name:_____ Date:_____

Optional Authorization for Release of Medical Information

[ ] Do Not Release Information

I authorize Female Health Associates of North Texas, PLLC to use the contact information listed below to discuss and/or disclose information regarding any matter relating to my appointments, billing information, and/or medical care. This authorization will remain in effect until I provide written notification to Female Health Associates of North Texas, PLLC of changes or update. I authorize Female Health Associates of North Texas, PLLC to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

Name_____Relationship_____Phone_____

You may release the following information to the person named above: [ ] Appointments [ ] Billing [ ] Medical Care [ ] voicemail

Name_____Relationship_____Phone_____

You may release the following information to the person named above: [ ] Appointments [ ] Billing [ ] Medical Care [ ] voicemail

Name_____Relationship_____Phone_____

You may release the following information to the person named above: [ ] Appointments [ ] Billing [ ] Medical Care [ ] voicemail

Please Provide a Copy of all Insurance Cards and a Driver's License / Photo ID

Medicare Insurance Information

Medicare ID#_____

Do you have insurance primary to Medicare? [ ] Yes [ ] No If yes, please list:_____

Medicare Supplement:_____ ID#_____

Medicare Advantage Plan:_____ ID#_____

Medicaid#_____

Commercial Insurance

Primary Insurance_____ ID#_____Gp:_____

Policy Holder Name:_____ Relationship [ ]Self [ ]Spouse [ ]Parent [ ]other_____

SS#_____ Policy Holder's DOB_____ Employer_____

Secondary Insurance_____ ID#_____Gp:_____

Policy Holder Name:_____ Relationship [ ]Self [ ]Spouse [ ]Parent [ ]other_____

SS#_____ Policy Holder's DOB_____ Employer_____

Privacy Practices

Our office, physician and staff are committed to securing the privacy of your health information. We are making available to you a copy of our Notice of Privacy Practices.

Signature_____ Date_____

Consent for Treatment, Release of Information, Authorization & Assignment of Benefits

- I consent to treatment necessary to my care or discussed and directed by the provider
- I authorize release of all medical records to specialists and/or consulting physicians if applicable to my care
- I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or the party who accepts assignment. I understand it is mandatory to notify the health care provided of any party who may be responsible for paying my treatment.

Financial and Payment Guidelines

Payment is due at time of service. This includes all co-pays, deductibles and co-insurance. If your insurance company requires a referral, it is the patient's responsibility to obtain the referral prior to your appointment.

- I understand that in the event I do not cancel my appointment within 24 hours of the scheduled appointment that the clinic will charge a cancellation fee.
- Insurance will be filed for services rendered. Any charges for services not covered by insurance will be the responsibility of the patient. I understand it is my responsibility to know my insurance benefits and whether or not the services rendered are covered benefits.
- Out of Network services not paid by the health insurance company will be the responsibility of the patient.
- Patient is responsible for notifying clinic of any changes in demographic and insurance.
- Female Health Associates or its authorized agent will provide medical information of the insurance company as required for payment claims for services rendered.
- All surgery pre-payments must be paid one week prior to surgery in order to hold the surgery date.

I have read, fully understand and agree to the above consent for treatment, financial responsibility statement, payment guidelines and release of medical information and insurance authorization, and medication refill policy. I also certify that all of the information provided is complete and accurate.

Patient Name_____ Signature_____ Date_____

FEMALE HEALTH ASSOCIATES OF NORTH TEXAS
A PROFESSIONAL ASSOCIATION

INITIAL HISTORY AND PHSYICAL DATE:_____

Appropriate sections to be completed by patient

Patient Name:_____ Preferred Phone Number:_____

Age:_____ Date of Birth: _____ Social Security:_____

Reason for Your Visit: _____

MEDICATION HISTORY

☐ **NONE**

Please list all current medications and dosages

_____

_____

_____

ALLERGIES

☐ NONE: NO KNOWN DRUG ALLERGIES

List allergies and type of reaction below

_____

_____

_____

MENSTRUAL HISTORY

Do you have menstrual periods? _____Yes _____No

Date of last menstrual period: _____

If you have periods, are they: regular Irregular heavy/moderate scant painful?

If irregular periods, for how long? _____Years _____Months

If you have painful periods, does the pain occur **before** or **during** or after **menses**? Circle one

If you no longer have menstrual periods:

Hysterectomy: Yes No Surgical removal of your ovaries Yes No

Do you take (or have you taken) hormone replacement therapy? Yes No

When was your last PAP smear? _____ Normal / Abnormal

Have you ever had an abnormal PAP smear in the past? Yes No

If yes, what year and treatment plan? _____

Are you experiencing any abnormal vaginal discharge or discomfort? Yes No

Do you have a feeling of vagina pressure or fullness? Yes No

Are you sexually active? Yes No

Are you currently taking a form of birth control? Yes No

If yes, which form are you taking? _____

Date of last mammogram? _____ results normal / abnormal

FEMALE HEALTH ASSOCIATES OF NORTH TEXAS
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PREGNANCY HISTORY

Total Number of Pregnancies: _____ Type of Deliveries: ____ vaginal ____Cesarean_____
Miscarriages:_____ Abortions:_____ Premature Births: _____ Living Children: _____
Problems with pregnancy? _____

BLADDER SYMPTOM QUESTIONNAIRE

☐ Skip this section. I have no bladder/kidney or urinary symptoms.

How often do you urinate: During the day? _____times
During the night? _____times

Do you leak urine (incontinence)? Yes No
Duration of incontinence? _____months _____years
Is it caused by **coughing, laughing, sneezing, running, sports,** etc? Yes No
Do you have difficulty starting your urinary flow? Yes No
Do you strain to void your urine? Yes No
Do you feel that you empty your bladder completely? Yes No
Do you notice dribbling of urine after voiding? Yes No
Do you need to wear protective pads for this type of incontinence? Yes No
If yes, how many pads do you wear on average per day _____?
Do you sometimes not make it to the bathroom in time (urgency) Yes No
What activities cause you to lose control of your urine?

- Sight, sound or feel of running water Yes No
- Standing up after being seated or lying down Yes No
- "key in the door" when you return home Yes No

Do you lose urine without any warning? Yes No
When urinating, can you usually stop your stream? Yes No
Do you have frequent urinary tract infections? Yes No
How often have these occurred in recent years? _____ per year
Do you ever see blood in your urine? Yes No
Has urine leakage limited your ability to:

- Do household chores Yes No
- Recreation such as walking, biking, exercise Yes No
- Travel more than 30 minutes from home Yes No
- Participate in social activities outside your home Yes No
- Participate in, enjoy or feel comfortable with sex Yes No

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PAST MEDICAL HISTORY/REVIEW OF SYMPTOMS (other current health problems):

☐ **Skip this section. I am completely healthy without any conditions mentioned below.**

Do you now or have you ever had in the past:

[ ] Anemia
[ ] Asthma/Bronchitis
[ ] Blood/Black Bowel Movement
[ ] Cancer _____
[ ] Depression
[ ] Diabetes
[ ] Gallstones
[ ] Headaches
[ ] Heart Disease
[ ] Hearing Problems
[ ] Hepatitis _____
[ ] Hernia
[ ] High Blood Pressure
[ ] Kidney Stones
[ ] Osteoporosis
[ ] Other_____
[ ] Problems with muscles, bones, nerves/joints
[ ] Psychiatric Problems_____
[ ] Seizure Disorder
[ ] STD_____
[ ] Stomach Disorder
[ ] Stroke
[ ] Thrombophlebitis/Blood Clot
[ ] Thyroid Disorder
[ ] Visual Problems
[ ] Vomited Blood
[ ] Comments_____
[ ] Comments_____

PAST SURGERIES OR HOSPITALIZATIONS

☐ **NONE**

Please list with date(s):

_____

_____

_____

FAMILY HISTORY (check illness which has occurred in any blood relative and their relation to you):

☐ Negative Family History ☐ Adopted, Family History Unknown

Birth Defect:_____
Breast Cancer:_____
Cancer, other:_____
Diabetes:_____
Heart Disease:_____
High Blood Pressure:_____
Kidney Problems:_____
Other:_____
Lung Problems:_____
Osteoarthritis:_____
Ovarian Cancer:_____
Rheumatoid Arthritis:_____
Seizure Disorder:_____
Skin Disease:_____
Stroke:_____
Thrombophlebitis:_____

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SOCIAL HISTORY

Marital status: married single divorced widowed separated

Alcohol Use: Yes No Daily / Weekly amount_____

Caffeine Use: Yes No Daily / Weekly amount_____

Drug Use: Yes No Daily / Weekly amount_____

Exercise: Yes No How many times per week _____

Tobacco Use: Yes No Daily / Weekly amount_____

Have you ever smoked? Yes No When did you quit?_____

Other: _____

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Confidential Patient Questionnaire

Please take a few moments to answer the questions below. Your feedback will help us to determine whether to offer our valued patients several of the country's most popular aesthetic and medical procedures. ***Please return to front desk after completing.***

Patient Name:_____ **Date of Birth:**_____

Email Address:_____ **Telephone:**_____

Are you interested in a new minimally invasive liposuction procedure that can be done in the office with minimal discomfort or downtime? Yes_____ No_____

Would you be interested in receiving CO_2 Fractional Laser Skin Resurfacing for the treatment of age spots, sun damage, enlarged pores, fine lines, wrinkles, stretch marks and acne scars? Yes_____ No_____

Would you be interested in an Incisionless Vaginal Rejuvenation procedure that uses a laser to create a smaller, tighter, more youthful vagina with normal anatomic contours? Yes____ No____ This procedure will help to restore the structure of the vagina which has been damaged from childbirth, aging, and/or previous gynecology surgery.

Are you interested in a physician directed weight-loss program that can help you lose 1 – 3 pounds per day? Yes_____ No_____

Would you be interested in Botox Cosmetic wrinkle removing therapy? Yes_____ No_____ If yes, which facial areas would you be interested in treating? Forehead _____ Crow's Feet _____ Frown Lines_____

Would you be interested in Juvederm treatments? Yes_____ No_____ If yes, which facial areas would you be interested in having treated? Smile Lines_____ Vertical Lip Lines_____ Lip Borders_____ Marionette Lines (lines at the corner of the mouth)_____ Other_____

Would you be interested in a permanent form of birth control that is gentle, hormone-free and can be done without cutting or the risks of getting your tubes tied? Yes_____ No_____

Do you suffer from heavy periods? Yes_____ No_____ If yes, would you be interested in learning more about an in-office procedure that can stop or significantly reduce heavy bleeding? Yes_____ No_____

Do you suffer from a loss of bladder control during physical activity such as coughing, laughing, sneezing or lifting? Yes_____ No_____ If so, would you be interested in learning more about a minimally invasive approach to treating this condition? Yes_____ No_____

Do you suffer from an overactive bladder? Yes_____ No_____ If you are waking up several times a night to use the bathroom, avoiding shopping trips and long walks or even scoping out public bathrooms whenever you leave home, then we have several treatment options available to you.

Do you experience pressure or discomfort in the vaginal or pelvic area, often made worse with physical activities such as prolonged standing, jogging or bicycling? Yes_____ No_____ If so, would you like to learn more about non-surgical and surgical options available to you? Yes_____ No_____

Would you be interested in Bio-Identical Hormone Replacement therapy to treat the symptoms of menopause including: hot flashes, weight gain, irritability, vaginal dryness, sleep disturbances and low libido? Yes____ No____