TERRELL OB-GYN CLINIC
Marie Hollis, M.D.
Daphney Ayinde, DNP, FNP - C
109 Tejas Dr. Suite 100
Terrell TX 75160
Phone: 972-563-3334 Fax: 972-563-3339

PATIENT INTAKE INFORMATION/INFOMACION DE PACIENTE

Name:_____
First (Nombre de Pila) MI Last (Apellido)

SS# _____DOB: _____

Address/Direccion: _____City:_____Zip Code:_____

Home Phone# _____Cell:_____Work#_____

Email:_____Marital Status:_____
(Correo Electrónico) (Estado Civil)

Race: _____Ethnicity_____Perferred Language_____
(Carrera) (Etnicidad) (Idioma)

Employer:_____Occupation_____
(Lugar de empleo) (Ocupacion)

Emergency Contact:_____Phone:_____
(Contacto de emergencia) (Telefono)

Emergency contact relationship:_____
(Relación a paciente)

Spouse:_____DOB:_____Phone:_____
(Esposa) (Telefone)

Preferred Pharmacy:_____

INSURANCE INFORMATION

Insurance Co: _____

Policy# _____ Group# _____

Name of Insured: _____ DOB: _____
(Nombre de asegurado)

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Reason for Visit - Chief Complaint(s)

What brings you in today, and/or what concerns do you have?

_____
_____
_____
_____
_____
_____

Current Medications and/or over the counter medication along with any vitamins you may be taking: If you do not have enough space below please list on the back of the page.

Name	**Dose**	**How it is taken**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name: _____ Date: _____

Medical History

- ⬜ Alcoholism
- ⬜ Allergies
- ⬜ Anemia
- ⬜ Anxiety
- ⬜ Asthma
- ⬜ AIDS/HIV
- ⬜ Autoimmune Disorders
- ⬜ Back Problems
- ⬜ Bleeding
- ⬜ Blood Disorders
- ⬜ Blood Transfusion
- ⬜ Breast Cancer
- ⬜ Clotting Disorder
- ⬜ Colon Cancer
- ⬜ Diabetes
- ⬜ Depression
- ⬜ Eating Disorders
- ⬜ Ear Problems
- ⬜ Epilepsy/Seizures
- ⬜ Glaucoma
- ⬜ Gout
- ⬜ Heart Disease
- ⬜ Heart Defects
- ⬜ Hepatitis A,B,C
- ⬜ High Blood Pressure
- ⬜ High Cholesterol
- ⬜ Liver Disorder
- ⬜ Kidney Disorder
- ⬜ Joint Disorder
- ⬜ Lung Disorder
- ⬜ Measles
- ⬜ Migraines
- ⬜ Osteoporosis
- ⬜ Pneumonia
- ⬜ Polio
- ⬜ Psychiatric Illness
- ⬜ Rheumatic Fever
- ⬜ Stroke
- ⬜ Thyroid Disorder
- ⬜ Stomach Ulcer
- ⬜ Substance Abuse
- ⬜ Skin Disorder
- ⬜ Tuberculosis
- ⬜ Sexually Transmitted Disease

Other Details _____

OB/GYN History

- ⬜ Abnormal Vaginal Bleeding
- ⬜ Abnormal pap smear
- ⬜ Bleeding between periods
- ⬜ Breast Lump/mass
- ⬜ Breast Cancer
- ⬜ Breast Surgery
- ⬜ Cervical Cancer
- ⬜ Cervical Dysplasia
- ⬜ Herpes
- ⬜ HIV (Human Immunodeficiency Virus)
- ⬜ Chlamydia
- ⬜ Colposcopy
- ⬜ Cryosurgery
- ⬜ DES exposure
- ⬜ Fecal/Flatus Incontinence
- ⬜ Fibroids
- ⬜ Genital Warts
- ⬜ Gonorrhea
- ⬜ Painful intercourse
- ⬜ Hot Flashes
- ⬜ HPV (Human Papillomavirus)
- ⬜ Infertility
- ⬜ Irregular Periods
- ⬜ Nipple Discharge
- ⬜ Ovarian Cysts
- ⬜ Ovarian Cancer
- ⬜ Yeast
- ⬜ Pelvic/Inflammatory Disease
- ⬜ Menstrual Pain
- ⬜ Uterine Cancer
- ⬜ Uterine Hyperplasia
- ⬜ Urinary Incontinence
- ⬜ UTI - frequent
- ⬜ Vaginitis (BV)
- ⬜ RPR (syphilis)

Patient Name: _____ Date: _____

Are you allergic to anything? ⬜ **Yes** ⬜ **No**

If yes, list all things allergic to below. If there is not enough room please list on the back of the page.

Name	**Reaction**
_____	_____
_____	_____

Surgical History

Surgery: _____ Date: _____ Where: _____

Surgery: _____ Date: _____ Where: _____

Surgery: _____ Date: _____ Where: _____

IF more surgeries please list on the back of the page.

Family Medical History

⬜ Alcoholism
⬜ Allergies
⬜ Anemia
⬜ Anxiety
⬜ Asthma
⬜ AIDS/HIV
⬜ Autoimmune Disorders
⬜ Back Problems
⬜ Bleeding
⬜ Blood Disorders
⬜ Blood Transfusion
⬜ Breast Cancer
⬜ Clotting Disorder
⬜ Colon Cancer
⬜ Diabetes
⬜ Depression
⬜ Eating Disorders
⬜ Ear Problems
⬜ Epilepsy
⬜ Glaucoma
⬜ Gout
⬜ Heart Disease
⬜ Heart Defects
⬜ Hepatitis A,B,C
⬜ High Blood Pressure
⬜ High Cholesterol
⬜ Liver Disorder
⬜ Kidney Disorder
⬜ Joint Disorder
⬜ Lung Disorder
⬜ Measles
⬜ Migraines
⬜ Osteoporosis
⬜ Pneumonia
⬜ Polio
⬜ Psychiatric Illness
⬜ Rheumatic Fever
⬜ Stroke
⬜ Thyroid Disorder
⬜ Stomach Ulcer
⬜ Substance Abuse
⬜ Skin Disorder
⬜ Tuberculosis
⬜ Sexually Transmitted Disease

Other Details _____

Patient Name: _____ Date: _____

Lifestyle - Social History

Are you sexually active? ⬜ Yes ⬜ No

How many partners? _____ Past Year _____ Total Lifetime _____

If not currently active, have you ever been sexually active? ⬜ Yes ⬜ No

Sexual Partner (s) is/are ⬜ Male ⬜ Female ⬜ Both

Would you like to be checked for sexually transmitted diseases? ⬜ Yes ⬜ No

Has anyone in your home physically or verbally hurt you? ⬜ Yes ⬜ No

Do you smoke? ⬜ Yes ⬜ No How many packs per day? _____

Have you ever smoked? ⬜ Yes ⬜ No Quit Date _____

Do you use recreational drugs? ⬜ Yes ⬜ No

If drugs are used, what type/frequency? _____

How much alcohol do you drink per week? _____

How much caffeine do you drink per day? _____

How many times per week do you exercise? _____

How tall are you? _____

Patient Name: _____ Date: _____

Gyn History: Menstrual/Health History

Age at first period? _____

Last pap smear? _____

Date of last period? _____

Last mammogram? _____

Frequency of periods? _____

Last bone density? _____

Length of period? _____

Last colonoscopy? _____

Are your periods regular? ⬜ Yes ⬜ No

Last general health check up? _____

Age at menopause? _____

Immunizations up to date? ⬜ Yes ⬜ No

OB/Pregnancy History:

Are you currently Pregnant? ⬜ Yes ⬜ No

Number of Pregnancies _____ Term Pregnancies _____

Preterm Pregnancies _____ Miscarriages _____ Abortions _____

Date: #weeks Type of Delivery M/F WT Living Complications

Are you trying to become pregnant? ⬜ Yes ⬜ No

What is your current method of birth control? ⬜ N/A ⬜ Abstinence ⬜ Condoms

⬜ Intrauterine Device ⬜ Implanon/Nexplanon ⬜ Vaginal Ring (NuvaRing)

⬜ Contraceptive Patch ⬜ Spermicide ⬜ Withdrawal

⬜ Natural Family Planning/Rhythm Method ⬜ Diaphragm/cervical cap

⬜ Oral Contraceptive pills: (name) _____ ⬜ Other: _____

Patient Name: _____ Date: _____

Social Security Number: _____

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for the future care or treatment.

I understand that this information serves as:

1. **A basis for planning my care and treatment.**
2. **A means of communication among the many healthcare professionals who contribute to my care.**
3. **A source of information for applying my diagnosis and surgical information to my bill were actually provided.**
4. **A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.**

I understand that I have the right:

1. **To object to the use of my health information for directory purposes.**
2. **To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested.**
3. **To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.**

I request the following names mentioned to the use of disclosure of my health information:

_____

_____

_____

I further authorize payment to be made directly to Dr. Marie Hollis M.D. for medical or surgical benefits. I will be responsible for payment of any medical or surgical fees not covered by my Insurance company.

_____ _____

Signature of patient or Legal representative. **Date**

_____ _____

Witness Signature Date

Patient Name: _____ Date: _____

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I authorize and direct _____to examine me and perform those procedures necessary for prenatal and/or family planning care and/or women's healthcare and/or general medical care. Procedures that may be performed Include, but are not limited to:

- Medical history and physical examination, Including pelvic and breast examination
- Blood draws to screen for syphilis, anemia, rubella, diabetes, hepatitis, and AIDS OR HIV, and other blood work determined to be necessary.
- Urinalysis, urine pregnancy test, urine culture, and drug screens.
- Gonorrhea/Chlamydia culture and pap smear.
- Any other appropriate lab work
- Ultrasound(s)
- Necessary Immunizations.

The nature of the procedures has been explained to me and no warranty or guarantee has been made to me as to the result.

I understand that medical providers of the OB-GYN Clinic who will be examining me Include physicians, certified nurse midwives, advanced nurse practitioners and physician assistants.
Advanced nurse practitioners are professional nurses educated to provide the full range of primary care services in the community and hospital settings. They are certified by the American Nurses Association or by nursing specialty organizations. They hold licenses from the state as Registered Professional Nurse Practitioners. Physician Assistants are skilled members of the healthcare team who are educated to work Independently with physicians and under their supervision provide diagnostic and therapeutic patient care. Certified Nurse Midwives are individuals educated in the two disciplines of nursing and midwifery, who possess certification according to the requirements of the American College of Nurse Midwives. In addition, In the state of Texas, they hold licenses as Registered Nurses and Advanced Nurse Practitioners.

I understand that I may request to be seen by a physician.

Additionally, the OB-GYN Clinic employs and contracts with other professionals to provide some of the services offered as part of our treatment team. These Individuals provide ancillary or allied health services such as sonography, phlebotomy, and psychotherapy. I understand that as part of my assessment or treatment at the OB-GYN Clinic, a qualified professional may provide, at the request of my medical practitioner, ancillary or allied health services important to my care.

I authorized the release of any medical information required for payment of my provider (including ancillary or allied health services) and/or hospital charges for services rendered by the OB-GYN Clinic or by one of its providers allied health practitioners. I further authorized the release of information to any hospital or medical facility I present myself to for medical care.

Patient Printed Name: _____

Patient's Signature: _____ Date: _____

Patient Name: _____ Date: _____

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ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical Information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____
Signature of Patient or Personal Representative **Date**

_____ _____
Description of Personal Representative's Authority **Date**

Patient Name: _____ Date: _____

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PHONE RELEASE FORM

This Phone release form will remain in effect until terminated by me in writing.

Please call: ( ) My home ( ) My Work ( ) My Cell Phone

Number to call: _____

IF UNABLE TO REACH ME:

( ) You may leave a detailed message

( ) Please leave a message asking me to return your call

The best time to reach me is _____

_____
Patient printed name:

_____ _____
Patient Signature: Date:

_____ _____
Witness: Date:

Patient Name: _____ Date: _____

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MISSED APPOINTMENT / NO SHOW POLICY

Dear Patient:

Our goal is to provide quality medical care in a timely manner. In order to achieve this, we implemented a missed appointment / no show policy. This allows us to better utilize available appointments for patients who need medical care.

Please be respectful and call our office if you need to cancel or reschedule an appointment at least 24 hours in advance. You may leave a message if you can't reach us. Be sure to leave your contact information and the best time to return your call if you wish to reschedule. Note that all voice mails are returned within 24hrs.

A "no show" is someone who misses an appointment without canceling or rescheduling in a timely manner. No show appointments are inconvenient to both patients who need medical care and our office.

If you do not give a 24 hour notice, or you do not show an appointment, you will be charged a $10.00 fee.

If you do not give a 24 hour notice or you no show for an office procedure, you will be charged a $25.00 fee.

By signing below you are acknowledging that you have read and understand our missed appointments/no show policy.

_____
Printed Name

_____ _____
Signature Date

_____ _____
Witness Signature Date

Patient Name: _____ Date: _____

NOTICE OF MEDICAL INSURANCE POLICIES

Anyone that has Medicaid Insurance and is seen here and has other commercial insurance and doesn't provide this information to us will be responsible for payment when Medicaid doesn't pay for your visits.

If you have commercial insurance this just means it has to be listed as a primary insurance and then medicaid will be your secondary insurance. You **DO NOT** have to pay anything. We just have to file with your primary insurance first and then what they do not pay medicaid will pick up the rest. Even if you canceled the primary recently we will need that information so we can file with them to get the denial letter to send to medicaid so they will pay for your visits. If you have already received the cancellation or termination of benefits letter please give to us so we can attach to your chart. If the commercial insurance is not provided then **you will be responsible for payment at time of visit or you will not be able to be seen**.

There is no refund!

If the commercial insurance is not provided at the time of your first visit you will be charged a 35.00 refiling fee.

Patient printed name: _____

Patient Signature: _____

Patient Name: _____ Date: _____

NOTICE OF SICKNESS

DO NOT COME IN HERE IF YOU ARE SICK WITH THE FOLLOWING SYSTEMS:

FEVER/CHILLS
COUGH
SORE THROAT

IF YOU HAVE AN APPOINTMENT PLEASE CALL AHEAD TO NOTIFY US OF YOUR ILLNESS. WE WILL LET YOU KNOW IF YOU NEED TO COME IN ANYWAYS OR REBOOK APPOINTMENT. IF YOU HAVE THESE SYMPTOMS YOU CAN GO TO THE URGENT CARE OR ER TO GET TESTED. WE DO NOT HAVE THE TEST HERE. THEN CALL US WITH YOUR RESULTS.

Patient Name: _____ Date: _____

Genetic Screening / Teratology Counseling	YES OR NO	RELATION TO YOU
Thalassemia (Italian, Greek, Mediterranean or Asian): MCV <80		
Neural Tube defect		
Congenital heart defect		
Down Syndrome		
Tay-Sachs		
Canavan disease		
Sickle cell disease or trait		
Hemophilia or other blood disorders		
Muscular dystrophy		
Cystic Fibrosis		
Mental Retardation / Autism		
If yes, was person tested for fragile X		
Other inherited genetic or chromosomal disorder		
Maternal metabolic disorder		
Patient or baby's father had a child with birth defects not listed		
Recurrent pregnancy loss or a stillbirth		

Patient Name: _____ Date: _____

Medications/illicit/recreational drugs/alcohol/ since last menstrual period		
If yes, Agent(s) and strength/dosage		
Any other (see comments)		

INFECTION HISTORY

Do you live with someone with TB or exposed to TB?		
Do you or your partner have genital herpes?		
Have you had a rash or viral illness since the last menstrual period?		
Do you have a history of STD, Gonorrhea,		
Other (see comments)		

Comments:_____

_____

_____

_____

_____

_____

Patient Name: _____ Date: _____