Patient Registration Form

Date of Appointment:________________________

Patient Information

Patient's First Name	Preferred Nickname	Middle Name	Last Name (as it appears on insurance card or ID)

Sex	Marital Status	Date of Birth	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Mobile Phone	Email Address

Referred by	Primary Care Physician	Primary Care Physician Phone

Pharmacy	Pharmacy Phone	Pharmacy Address

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School

Insured's Name (as it appears on insurance card or ID)	Patient	Insured's Phone Number

Insured's Address	City	State	Zip

Insured's Social Security Number	Insured's Birthdate

Secondary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient

Address	City	State	Zip

______________________________ Signature of Patient or Authorized Guardian

______________________________ Date

Name ______ Gender ______ Age ______ Date of Appointment: ______

Reason for Visit

What brings you to the office today?

- ☐ Well Woman Exam / Annual / Preventive Care
- ☐ Problem Visit
  - Anything addressed that is not preventive may be subject to copay.

Do you have any concerns you would like to address?

______

______

______

______

Current Medications

What medication are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

- ☐ Adhesive Tape
- ☐ Penicillin
- ☐ Latex
- ☐ NSAIDS (ibuprofen, Naproxen, etc.)
- ☐ Aspirin
- ☐ Iodine
- ☐ Codeine
- ☐ Sulfa
- ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Past Medical History

- ☐ Alcoholism
- ☐ Seasonal Allergies
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Disorder
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Stroke
- ☐ Stomach Ulcer
- ☐ Substance Abuse
- ☐ Thyroid Disorder

Post Surgical History

- ☐ Appendectomy
- ☐ Cholecystectomy
- ☐ Hysterectomy
  - ☐ Vaginal
  - ☐ Laparoscopic
- ☐ Abdominal
- ☐ Breast Augmentation
- ☐ LEEP / Cold Knife Cone
- ☐ Bilateral Tubal Ligation
- ☐ C-Section
- ☐ Tonsillectomy
- ☐ D&C
- ☐ Bariatric Surgery
- ☐ Knee Surgery

Please list any other surgeries:______

______

______

Family History

Has anyone in your family ever had any of the following conditions?

- ☐ Alcoholism
- ☐ Alzheimer's
- ☐ Anxiety
- ☐ Arthritis
- ☐ Bleeding Disorder
- ☐ Blood Disorder
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Genetic Disorder
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Psychiatric Disorders
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disorder

Details:______

______

______

______

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year:______

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years:______ # packs/day:______

Do you smoke now?

☐ Yes ☐ No # packs/day:______ year quit:______

Do you use or have you ever used recreational drugs?

☐ Yes ☐ No types?______ # times/week:______

How much alcohol do you drink per week?

drinks/week:______

How much caffeine do you drink per day?

drinks/day:______

How often do you exercise?

times/week:______

Name _______________ Gender _______ Age _______ Date of Appointment: _______________

OBGYN History

Have you ever had or do you currently have any of the following?

- ☐ Abnormal Vaginal Bleeding
- ☐ Abnormal Pap Smear
- ☐ Bleeding between Periods
- ☐ Breast Lump
- ☐ Breast Cancer
- ☐ Breast Surgery
- ☐ Cervical Cancer
- ☐ Colposcopy
- ☐ Cryosurgery
- ☐ DES Exposure
- ☐ Extreme Menstrual Pain
- ☐ Fibroids
- ☐ Hot Flashes
- ☐ Endometriosis
- ☐ Infertility
- ☐ Irregular Periods/Bleeding
- ☐ Nipple Discharge
- ☐ Ovarian Cysts
- ☐ Ovarian Cancer
- ☐ Painful Intercourse
- ☐ Pelvic inflammatory Disease
- ☐ Uterine Cancer
- ☐ Urinary Incontinence
- ☐ Yeast Infections - Frequent
- ☐ Polycystic Ovarian Syndrome

Sexually transmitted Infection History - Please check any current or prior infections

☐ Chlamydia ☐ Gonorrhea ☐ Genital Herpes ☐ HIV ☐ Hepatitis B ☐ Hepatitis C ☐ DHPV

☐ Trichomoniasis ☐ Genital Warts ☐ Syphilis ☐ Other: _______________

Pregnancy History

Please describe any pregnancies you have had.

_______ # of Pregnancies _______ #Births _______ # of Miscarriages _______ # of Abortions

Past Pregnancies

Date	Length of Pregnancy	Type of Delivery	Sex	Living

Were there any complications associated with any of your pregnancies?

____

____

____

____

Are you currently pregnant?

☐ Yes ☐ No

Are you trying to become pregnant?

☐ Yes ☐ No

Are you doing anything to prevent pregnancy?

☐ Yes ☐ No

If so what method?

☐ Condoms ☐ Withdrawal ☐ Pill ☐ Patch ☐ Nuvaring

☐ Nexplanon ☐ IUD ☐ Vasectomy

Do you need birth control or contraceptive advice?

☐ Yes ☐ No

Menstrual History

When was the first day of your last period?

____

How often does your period occur? (from first day to next)

☐ I am in Menopause: Year of last period___________

____

How many days does your period last?

How heavy are your periods? ☐ Light ☐ Normal ☐ Heavy

____

What age were you when you had your first period?

Health Exams

Please check and date all immunizations you have had.

	Month & Year	Results
☐ Flue		
☐ Shingles		
☐ Chicken Pox		
☐ Tetanus		
☐ Pneumonia		

Please check and date tests you have had

Test	Date		
☐ Blood Sugar-Fasting		☐ Normal	☐ Abnormal
☐ Cholesterol Test		☐ Normal	☐ Abnormal
☐ Colonoscopy		☐ Normal	☐ Abnormal
☐ CT/CAT Scan		☐ Normal	☐ Abnormal
☐ Dexascan (Bone Density)		☐ Normal	☐ Abnormal
☐ EKG		☐ Normal	☐ Abnormal
☐ Echocardiogram		☐ Normal	☐ Abnormal
☐ Mammogram		☐ Normal	☐ Abnormal
☐ MRI		☐ Normal	☐ Abnormal
☐ Pap Smear		☐ Normal	☐ Abnormal
☐ Cardiac Stress Test		☐ Normal	☐ Abnormal
☐ Ultrasound		☐ Normal	☐ Abnormal

Cancer Family History Questionnaire

PERSONAL INFORMATION

Patient Name	Date of Birth	Age

Gender (M/F)	Today's Date (MM/DD/YY)	Health Care Provider

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents,Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great-Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU Age of Diagnosis	PARENTS/SIBLINGS/ CHILDREN	Age of Diagnosis	RELATIVES on your MOTHER'S SIDE	Age of Diagnosis	RELATIVES on your FATHER'S SIDE	Age of Diagnosis
☒ Y ☐ N	***Example: Breast Cancer***	***45***	------	------	***Aunt Cousin***	***45 61***	***Grandmother***	***53***
☐ Y ☐ N	Breast cancer *(Female or Male)*							
☐ Y ☐ N	Ovarian cancer *(Peritoneal/Fallopian tube)*							
☐ Y ☐ N	Endometrial *(Uterine)* cancer							
☐ Y ☐ N	Colon/rectal cancer							
☐ Y ☐ N	10 or more Lifetime Colon/ Rectal Polyps *(Specify #)*							
☐ Y ☐ N	Pancreatic cancer							
☐ Y ☐ N	Prostate cancer							
☐ Y ☐ N	Other Cancer(s) *(Specify cancer type)*	Among others, consider the following cancers: Melanoma, Pancreatic, Stomach (Gastric), Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid, Prostate						
☐ Y ☐ N	Are you of Ashkenazi Jewish descent?							
☐ Y ☐ N	Are you concerned about your personal and/or family history of cancer?							
☐ Y ☐ N	Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? (Please explain/include a copy of result if possible) If Yes, Who? ______ What gene(s)? ______ What was the result? ______							

BREAST CANCER RISK MODEL INFORMATION

Your current height (ft/in) ______

Your current weight (lbs) ______

Your menopausal status:

☐ Pre-menopausal

☐ Peri-menopausal (time before menopause marked by irregular cycles)

☐ Post-menopausal (permanent cessation of period for 12 months or longer)

Age of onset ______

Your age at time of first menstrual period ______

Your age at time of first live birth: ______

Did you ever use Hormone Replacement Therapy? ☐ Yes ☐ No

If yes, type: ☐ Combined ☐ Estrogen only ☐ Progesterone only ☐ Don't know

If yes, are you a: ☐ Current user: How many years ago did you start? ______ How many more years do you intend to use? ______

☐ Past user: How many years ago did you stop using? ______

Have you ever had a breast biopsy? ☐ Yes ☐ No

If yes, do you know your diagnosis? ______

Number of daughters ______

Number of sisters ______

Number of maternal aunts (mother's sisters) ______

Number of paternal aunts (father's sisters) ______

CANCER RISK ASSESSMENT REVIEW (To be completed after discussion with your healthcare provider)

Patient's Signature	Date
Health Care Provider's Signature	Date

Office Use Only

Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

If yes and accepted, which test? ☐ BRAC*Analysis*® with Myriad myRisk® ☐ Multisite 3 BRAC*Analysis* REFLEX to BRAC*Analysis* with Myriad myRisk

☐ COLARIS®PLUS with Myriad myRisk ☐ COLARIS *AP*®PLUS with Myriad myRisk ☐ Single Site Testing ☐ Myriad myRisk Update

☐ Other: ______

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment: ______

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HEREDITARY CANCER RED FLAGS (To be completed with your healthcare provider - Check all that apply)

Hereditary Breast and Ovarian Cancer Syndrome - Red Flags*

Personal and/or Family history† of:

- ☐ *Breast cancer diagnosed at/under age 50*
- ☐ *Ovarian (peritoneal/fallopian tube) cancer at any age*
- ☐ *Two or more primary breast cancers≠*
- ☐ *Male breast cancer at any age*
- ☐ *Triple Negative Breast Cancer (ER-, PR-, HER2-Pathology)*
- ☐ *Ashkenazi Jewish ancestry with an HBOC-associated cancer≠§*
- ☐ *Three or more HBOC-associated cancers at any age≠§*
- ☐ *A previously identified HBOC syndrome mutation in the family*

† Close blood relatives include first-, second-, or third-degree in the maternal or paternal lineage
≠ In the same individual or on the same side of the family
§ HBOC-associated cancers include breast (including DCIS), ovarian, pancreatic, and aggressive prostate cancer (Gleason Score ≥ 7)

Lynch Syndrome - Red Flags*

An individual with a personal history of any of the following:

- ☐ *Colon/rectal and/or endometrial cancer before age 50*
- ☐ *MSI High histology on a colon/rectal or endometrial tumor before age 60¶*
- ☐ *Abnormal MSI/IHC tumor test result (colon/rectal/endometrial)*
- ☐ *Two or more Lynch syndrome cancers** at any age*
- ☐ *Lynch syndrome cancer** with one or more relatives with a Lynch syndrome cancer^*
- ☐ *A previously identified Lynch syndrome or MAP syndrome mutation in the family*

An individual with a family history of any of the following:

- ☐ *A first-or second-degree relative with colon/rectal or endometrial cancer before age 50*
- ☐ *Two or more relatives with a Lynch syndrome cancer**, one before the age of 50^*
- ☐ *Three or more relatives with a Lynch syndrome cancer** at any age^*
- ☐ *A previously identified Lynch syndrome or MAP syndrome mutation in the family*

¶ MSI High histology includes: Mucinous, signet ring, tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, or medullary growth pattern
*** Lynch syndrome-associated cancers include colorectal, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas*
^Cancer history should be on the same side of the family

• Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com

BAY AREA OBSTETRICS & GYNECOLOGY, P.A.

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MARY POAG, M.D., F.A.C.O.G.
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MELANIE CHRISTOFFERSON, D.O.

Diplomates of The American Board of Obstetrics and Gynecology

#17 PROFESSIONAL PARK
WEBSTER, TX 77598
TELEPHONE (281) 332-9511
FAX (281) 332-6685

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I am personally obligated to pay all physician bills from Bay Area Ob-Gyn for services rendered to me. I understand that the physician bills are separate from and do not include charges made by the hospital, outside laboratories and other physicians. The fact that I may be covered by insurance does not relieve my personal obligation to pay all my physician bills; including bills for non-covered services and any amounts applied to co-pays, deductibles and co-insurance.

I authorize the release of any medical or other information necessary to process my insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.

I authorize payment of medical benefits to the provider of any services for Bay Area Ob-Gyn.

I agree to pay at Webster, Harris County, Texas the charges of Bay Area Ob-Gyn.

Patient_________________

Date___________________

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WEBSTER, TX 77598
TELEPHONE (281) 332-9511
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Medical Treatment Consent Form

This will verify that I hereby authorize any and all physicians at Bay Area Ob-Gyn or those designated by them including ancillary personnel to evaluate, diagnose, treat and otherwise care for including all necessary tests or procedures, whether in our office or elsewhere.

This permission is valid until revoked by written notice to Bay Area Ob-Gyn.

Signed_________________________________ Date___________________________

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Dear Patient,

Your physician may order lab work as part of your routine exam. Your insurance company may or may not cover the labs under your Well Woman exam diagnosis. You have the option to contact your insurance company prior to your exam to verify which tests are covered on your Well Woman exam. If you prefer to have your labs drawn at your visit without verifying coverage first please understand you may receive a bill from the lab.

By signing below, you are authorizing the ordered tests and understand you may receive a bill.

Patient signature_______________________________________Date______________________________

Thank you,

Bay Area Ob-Gyn

Bay Area Obstetrics & Gynecology, PA, Inc
17 Professional Park Dr
Webster, Texas 77598
281-332-9511
www.baobgyn.com

Privacy Officer: Reata Baker
Office Manager
rabaker@baobgyn.com

*Date*________________

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

The undersigned understands that Bay Area Obstetrics and Gynecology, PA, Inc. is required by law to maintain privacy of protected health information and has provided the patient/patient's representative with a notice of its privacy practices regarding health information.

Patient's name__________________________ Date of birth____

Patient signature____

Patient's representative (if applicable) ______________________Relationship to patient___________________

Please list below the person(s) we can release your health information to. (Please note: In an emergency or other situation outlined in our Notice of Privacy Practices, we may share information with others who are not specifically listed on this form.)

____________________________ ______________________________

____________________________ ______________________________

____________________________ ______________________________

What is the best phone number for us to contact you? ____

From time to time we will leave a message for you (as stated in our Notice of Privacy practices) on an answering machine, voice mail, or with another individual in your absence. (Such as diagnosis and medication).
Is it ok to leave a ***detailed message on*** the above phone number? ________________________________

For Bay Area Ob-Gyn office use only:

An attempt was made to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained due to:

The individual refused to sign____________
Communication barriers prevented us from obtaining the acknowledgement____________
An emergency situation prevented us from receiving the acknowledgment_____________
Other (please specify)__________________________________

Bay Area Obstetrics and Gynecology Privacy Notice
Effective 7/23/2019

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.