

Women Of the Woodlands
 9200 Pinecroft Suite 400
 The Woodlands, Texas 77380
 (281)292-5774 / (281)292-5780

PATIENT INFORMATION FORM

Thank you for choosing our Clinic. Please completely fill out this form to ensure the fastest and best healthcare service. We may ask you to update your information from time to time to make sure it stays up to date.

Patient Name	Social Security Number
Date of Birth	Address: (street, city, state, zip)
Home phone	Work phone
Mobile	Emergency Name and Contact Number
Employer	Email Address
Spouse Name	Spouse Social Security Number
Spouse Date of Birth	Spouse Work Phone
Spouse Mobile	How did you hear about us?
Primary Care Physician	Primary Care Phone Number

RESPONSIBLE PARTY: Please fill out the following information for insurance and financial purposes.

Insured/Responsible Party Name	Relationship to Patient
Insured/Responsible Party SS Number	Date of Birth
Address (street, city, state, zip)	Home Phone
Work Phone	Mobile
Email address	Employer

*** Please be prepared to provide proof of insurance if applicable and photo identification upon submission of form***

FOR OFFICE USE ONLY
 Filled out:

Patient Name: _____ Date of Birth: _____

Medical History (circle all that apply or explain)

Allergies to medications?		
History of Asthma?	Eating Disorder?	Cancer? (Where? _____)
Diabetes?	Bowel Problems?	Thyroid Problems?
Tuberculosis?	Ulcer or Gastritis?	Liver Problems?
Blood Problem?	Kidney Problems?	Heart Failure?
Heart Attack?	Venereal Disease?	Blood Clots?
High Blood Pressure?	Abnormal Heart Rhythm?	Lupus?
Serious Illness? If yes, please explain...		
Hospitalization? If yes, please explain...		
Transfusion? If yes, please explain...		
Operations? If yes, list...		
Recent immunizations: Hepatitis B?		Tetanus?

Social History

Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Partner <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			
Tobacco: <input type="checkbox"/> Never smoked <input type="checkbox"/> Quit _____ years ago <input type="checkbox"/> years smoked <input type="checkbox"/> packs per day			
Alcohol: <input type="checkbox"/> Never <input type="checkbox"/> <1 week <input type="checkbox"/> 1-5 per week <input type="checkbox"/> Other			
	Yes	No	
Drug Use?			
Seat belt use?			
Regular exercise?			
Do you take calcium or dairy products?			
Have you been hurt by anyone?			
Do you have an advance directive (living will)?			

Family History

Has parent, sister, brother, child, or grandparent ever had?	
Stroke?	Heart Trouble?
Tuberculosis?	High Blood Pressure?
Diabetes?	Blood clots in lungs or legs?
Osteoporosis?	High cholesterol?
Has any blood relative ever had?	
Cancer? Type(s)	Bleeding Tendency?
	Sickle Cell or Thalassemia?
Mental Illness?	Hereditary Defects?
Arthritis or Gout?	Cystic Fibrosis?
What is your ancestry? (Eastern European etc.)	

Medications (include over the counter meds, herbal remedies, and vitamins)

Name	Dose	How many times per day?	When do you take it? (AM/PM)	Why do you take it?

Name of person completing form, if other than patient: _____

Relationship to patient: Patient Spouse Parent Other

Signature of Patient/Legal Guardian: _____

Patient Name: _____ Date of Birth: _____

Well Woman Exams

This office considers your annual exam to consist of the following services: pap-smear, pelvic exam, breast exam, and medication **refills**. If you meet the age criteria for a screening mammogram and bone density test, orders for these will also be given. Should you have a medical problem or concern that needs to be discussed; we ask that you schedule a separate “problem visit” appointment for this matter.

Signature of Patient/Legal Guardian: _____ Date: _____

Appointment Policy

Due to the nature of a busy obstetrical practice, if you are more than 15 minutes late you will be asked to reschedule.

Should you need to cancel your appointment, please give 24 hour prior notice in consideration to other patients who may need your appointment slot. Failure of notification will result in a \$25.00 fee.

Signature of Patient/Legal Guardian: _____ Date: _____

Financial Responsibility

Payment is due at time services are rendered unless other arrangements have been made in advance. Please call our billing department at (281) 292-5774 x102 for any questions. Accepted methods of payment are Visa, MasterCard, Discover, Amex, check, and cash. **Please make sure to read this document. It must be signed in order to receive services from Women of the Woodlands.** Thank you.

1. My right to payment for all procedures, tests, supplies and nursing/physician services including major medical benefits are hereby assigned to Women of the Woodlands. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Women of the Woodlands.
2. I understand that I am responsible for charges not covered or reimbursed by the above agents. I understand that payment from my insurance company can never be guaranteed as the insurance companies never guarantee payment to my provider. I understand that Women of the Woodlands will file my claim to my insurance company on my behalf as a courtesy to me but that ultimately I am always financially responsible for any services received from Women of the Woodlands. I also understand that I am responsible for ensuring my claims are paid in a timely manner and that any services not covered by my insurance, for any reason, I am financially responsible for. It is my responsibility to provide the office with current insurance information and to pay for any due co pays, co-insurance, deductibles, or past due amounts even in the event I am not asked by the office. I agree, in the event of non-payment, to assume the costs of interest, collection, and legal action (if required).

THIS AGREEMENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as the original.

Patient Signature: _____ Today's Date & Time _____ a.m / p.m.

Responsible Party Signature _____ Today's Date & Time _____ a.m./p.m.

Relationship to patient _____ Employee Initials _____ Date _____