OKC Gynecology and Obstetrics
Patient Information / Disclosure Agreement

Doctor: ______________________

Patient Last Name: _________________________________First Name: ________________________Middle Init.: _________

Address: ____ City: _____________________State: _________Zip: ___________

Home #: __________________________Work#: ________________________Ext: ______Mobile: _______________________

Date of Birth: ___________________SS#: _________-_______-_________Marital Status: ______________________________

E-mail: ____Race: __________________________________

Pharmacy:____ Pharmacy Address: _______________________________________

Employer: ____Occupation: ____

Emergency Contact: _________________________________Relationship: ___________________Phone #: ________________

My Insurance requires lab/blood work to be sent to: ________________________________. (If no lab is identified, all Lab/blood work will be sent to the hospital's contracted lab.

REASON FOR TODAY'S VISIT

☐ **Routine Preventative Exam:** (I have no medical complaint or problem of which I am aware.) **Medicare will not cover.**

☐ **Routine Preventative Exam AND the Following Problem** that I wish to be evaluated/ treated:

____

☐ **I have a Problem/ Complaint** that I wish to have evaluated/ treated. My Chief Complaint Is:

____

Physicians of NW Oklahoma City, LLC (Susan L. Chambers, Deborah L. Huff, Laura L. Mackie, Jennifer K. Nelson, Valerie A. Engelbrecht, Virginia L. Vaughan, Dana G. Stone, Margaret A. Hall, Chris Davis, Jennifer McNeil, Lisa Wasemiller-Smith, and William Miller) are owners of Lakeside Women's Hospital. We refer patients there because it is convenient and efficient for patients, and the quality of care is excellent. We believe that patients have a choice in the selection of health care facilities. If you wish to use another facility, please let us know.

Lakeside Women's Hospital has arranged for one or more physicians to be on-site at the Hospital and available to respond for medical emergencies during most hours of operation. However, we cannot guarantee that a physician will be present at the Hospital at all times. The Hospital has taken certain measures to ensure that qualified and properly trained medical personnel are available to respond to any medical emergency that may arise when a physician is not present at the Hospital.

I hereby authorize the physicians of the Oklahoma City Gynecology and Obstetrics, LLC to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to Oklahoma City Gynecology and Obstetrics, LLC all payments for medical services rendered to myself or my dependents. I understand that the information authorized for release may include information, which may be considered a communicable, or venereal disease.

I agree to pay for any and all medical services I receive from the doctor that my insurance company refuses to pay, for whatever reason. This office will file a claim in my behalf (if contracted). I will pay these charges upon written/ verbal notice of their refusal. Failure of your insurance company to pay within 45 days of claim filing date will be considered a refusal to pay.

I further agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented in my medical records. Thus to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.

In the event I do not pay charges when due, for these or any other services provided me, I agree to pay all cost of collection, including reasonable attorney Fees.

I am aware that if laboratory (including pap smear, blood and urine testing, and biopsies) is obtained, there will be a separate charge from the pathology laboratory for this examination.

Patient Signature: ____Date: ________________

Parent Signature if Minor: ____Date: ________________

A photocopy of the authorization and assignment shall be considered as valid as the original.

OKC HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. **If you are uncomfortable with any question, do not answer it.** If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.

Name: ____ Date: ____

Main reason for today's visit: ______________________________ Other concerns: ________________________________

Primary Care Physician: ____

Age: ___________________________________

CURRENT MEDICATIONS ☐ **None**	
1.	**5.**
2.	**6.**
3.	**7.**
4.	**8.**

MEDICATION/ALLERGY SENSITIVITY **Name of medications you are allergic to:** ☐ **None**	**Reaction you had:**
1.	
2.	
3.	
4.	

GYN & PREGNANCY HISTORY	
1st day of last menstrual period:	Date and result of last mammogram:
Frequency of Cycle (Days):	Abnormal Mammogram (Y/N):
Periods Monthly (Y/N):	Monthly breast exams (Y/N):
Flow (Light/Moderate/Heavy):	Changes in breast exam (Y/N):
Duration of Flow (Days):	Date and result of last pap:
If Post Menopausal, Age at Menopause:	Abnormal Pap (Y/N)
Age at first period:	Date and result of last Bone Density:
Cramps (Y/N):	Date and result of last Colonoscopy:

# of pregnancies:	#of full term births:	#of pre-term births:	#of pregnancy losses:	#Living Children:

Birth Date	# fetuses	Weeks Pregnant (Term=40 wks)	Labor Length (hrs)	Birth Weight (Lbs./oz.)	Sex (M/F)	Delivery Type	Healthy?	Anesthesia Type

PAST MEDICAL HISTORY ☐ **None**		
☐ AIDS/ HIV	☐ Diabetes	
☐ Anemia/Blood Disorder	☐ Endometriosis	
☐ Anesthesia complications	☐ Female/Sexual Problems	☐ Ovarian Cancer
☐ Anxiety Disorder	☐ Headaches or Migraines	☐ Psychiatric Illness
☐ Arthritis/Lupus	☐ Heart Conditions	☐ Rheumatic Fever
☐ Asthma	☐ Hepatitis	☐ Seasonal Allergies
☐ Birth Defects or Inherited Disease	☐ Herpes (HSV)	☐ Sexual Abuse/Domestic Violence
☐ Blood Transfusion	☐ High Blood Pressure	☐ Stomach/Bowel/Gall Bladder Problems
☐ Breast Cancer	☐ High Cholesterol	☐ Syphilis
☐ Breast Problem	☐ Infertility	☐ Thyroid Problems
☐ Cancer	☐ Kidney or Bladder Problems	☐ Tuberculosis
☐ Chlamydia/Gonorrhea	☐ Liver Disease	☐ Varicosities
☐ Depression	☐ Lung Disease	☐ Other:

SOCIAL HISTORY/LIFESTYLE	
Occupation:	Is sexual intercourse painful? (Y/N):
Religion:	History of sexually transmitted infection:
General Stress Level (Low/Medium/High):	Current Birth Control Method:
Diet (Regular/Vegetarian/etc.):	Smoking Status (Never/Former/etc.):
Exercise Level (Occasional/Moderate/Heavy):	Smoking (How much per day/week?):
Marital Status: (S / M / D / W)	Alcohol Intake- (#Drinks per week?): None, 0-5, 6-14, >14
Sexual Orientation: (Heterosexual/ Homosexual/ Bisexual)	Caffeine Intake (None/Occasional/Moderate/Heavy):
Sexually Active (Y/N):	Illicit Drugs:
How many years have you been sexually active?	Hours of sleep each night? (approx.):

HOSPITALIZATIONS/SURGICAL PROCEDURES		☐ **None**
Month/Year	Illness/Operation	Complication (Y/N)

VACCINE HISTORY: LIST RECENT VACCINATIONS	☐ **None**
Name of vaccine:	**Date:**
Tdap/Tetanus (Last 10 years?) Y/N	
Pneumonia: Y/N	
Gardasil (HPV): Y/N	
Shingles: Y/N	
Flu: Y/N	

FAMILY HISTORY: (IF YOU CHECK YES PLEASE LIST RELATION)		☐ **None**
☐ AIDS (HIV)	☐ Diabetes	☐ Osteoporosis
☐ Anemia/Blood Disorder	☐ Heart Disease	☐ Ovarian Cancer
☐ Anesthesia complications	☐ High Blood Pressure	☐ Rheumatoid Arthritis/Lupus
☐ Birth Defects	☐ High Cholesterol	☐ Stroke
☐ Breast Cancer	☐ Kidney Disease	☐ Uterine Cancer
☐ Colon Cancer	☐ Lung Cancer	☐ Other: