Oklahoma City Gynecology and Obstetrics, LLC

Permission for Disclosure of Protected Health Information.

I hereby acknowledge that I received a copy of this medical practice's *Notice of Privacy Practices*. I further acknowledge that I will be offered a copy of any amended *Notice of Privacy Practices* at each appointment.

I, ________________________, give my permission for Oklahoma City Gynecology and Obstetrics to give information to the people listed below about my medical care. This information may include lab results, medications being taken, appointment times, changes in appointments, x-ray results, doctor or nurse reports about me, and any other information that this office has about me. (Please do NOT include other physicians or your employer in this list.) It is my responsibility to keep the office updated on any changes in my personal information.

______________________________ Relationship __________________________

______________________________ Relationship __________________________

______________________________ Relationship __________________________

______________________________ Relationship __________________________

______________________________ Relationship __________________________

______________________________ ____________________

Signature of Patient Date

______________________________ ____________________

Witness Signature Date

OPPORTUNITY TO OBJECT

I, ___________________________, do not want any information given to anyone but myself regarding my healthcare status or other patient information.

______________________________ ____________________

Signature of Patient / Personal Representative Date

______________________________ ____________________

Witness Signature Date

CP375 Rev. 04152009

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.

OBSTETRICAL MEDICAL AND FAMILY HISTORY

Name:____Date:________________

Birthdate:______________________Age:___________Race:____________________

Marital Status: S M W D Sep Language:_________________

Occupation:_________________________Education:_________________________

Father of Baby:______________________Phone:___________________________

Total number of pregnancies: ______

Full-term births		Premature births		Induced abortions		Multiple births	
Spontaneous miscarriages		Ectopic (tubal) pregnancies		Number of living children		**Notes:**	

Menstrual History

1st day of last menstrual period:________________Certain: Yes No

Was this a normal period: Yes No Are periods monthly: Yes No

Interval of Periods (1st day of one to the 1st day of the next) ______________days

Age menstrual periods began:________

Were you using birth control when you became pregnant: Yes No

Was this a planned pregnancy: Yes No

Date of Pregnancy test:_________________ blood______ urine______

Past Pregnancies (Last 6)

DATE MO/YR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE OF DELIVERY	ANEST.	PLACE OF DELIVERY	PRETERM LABOR YES/NO	COMMENTS/COMPLICATIONS

Medical/Family History (Check all that apply)

	Personal History	Family History (IMMEDIATE FAMILY)
Diabetes		
High blood pressure		
Heart disease		
Autoimmune disease		
Kidney disease		
Neurologic disorder/Epilepsy		
Psychiatric		
Post Partum Depression		
Depression		
Hepatitis/Liver Disease		
Varicosities/Phlebitis		
Thyroid dysfunction		
Trauma/Violence		
History of blood transfusion		
Rh negative: YES NO	Did you receive Rhogam: YES NO	
Pulmonary (TB/Asthma)		
Seasonal Allergies		
Drug/Latex Allergies	LIST:	
Breast Problems		
GYN Surgery	LIST/DATES:	
Operations/Hospitalizations	LIST/DATES:	
Anesthetic Complications		
History abnormal pap	TREATMENT/DATES:	
Uterine anomaly (DES exposure)		
Infertility		
Other:		

Genetic History (Check all that apply)

	Personal History	Family History (IMMEDIATE FAMILY/FATHER OF THE BABY & HIS FAMILY))
Over age 35		
Thalassemia (Italian, Greek, Mediterranean, Asian)		
Neural tube defect (Meningomyelocele, spina bifida, anencephaly)		
Congenital heart defect		
Downs Syndrome		
Tay-sachs (Jewish, Cajun, French Canadian)		
Canavan Disease		
Sickle Cell disease or trait		
Hemophilia or other blood disorders		
Muscular Dystrophy		
Cystic Fibrosis (disease or carrier)		
Huntington's Chorea		
Mental Retardation/Autism. If yes:tested for Fragile X YES NO		
Other inherited genetic or chromosomal disorder		
Maternal metabolic disorder (Type 1 diabetes, PKU)		
Patient or father of baby with a child born with birth defects not listed		
Recurrent pregnancy loss or stillbirth		

Infection History

	YES	NO
Live with someone with TB or exposed to TB		
Patient or partner has history of genital herpes		
Rash or viral illness since last menstrual periods		
History of STD: Gonorrhea, Chlamydia, HPV, Syphilis		
Other:		

Social History

Medications (including supplements, vitamins, herbs, or OTC drugs/illicit/recreational drugs/alcohol since last menstrual period. If yes, list:

	Amount/Day Pre-pregnant	Amount/Day Pregnant	# Years Use
TOBACCO			
ALCOHOL			
ILLICIT/RECREATIONAL DRUGS			

Comments:____

Interviewed by:____________________