PINEY POINT Women's CENTER

REGISTRATION INFORMATION

NAME: _____ AGE: _____ DATE OF BIRTH: _____

SOCIAL SEC. NUMBER: _____ HOME ADDRESS: _____

APT#: _____ CITY/STATE/ZIP: _____

TELEPHONE: HOME (____) _____ WORK (____) _____ CELL (____) _____

PHARMACY NUMBER **(IMPORTANT):** _____ EMAIL ADDRESS:_____

EMPLOYER: _____

EMERGENCY CONTACT: _____ TELEPHONE#: _____

HOW WERE YOU REFERRED TO PPWC? _____ PRIMARY PHYSICIAN: _____

ARE YOU? ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ OTHER

RACE: _____ ETHNICITY: _____ PRIMARY LANGUAGE: _____

PRIMARY INSURANCE INFORMATION

NAME OF POLICYHOLDER: _____ DATE OF BIRTH:_____

POLICYHOLDER'S SSN: _____ EMPLOYER: _____

INSURANCE COMPANY: _____ PHONE #: _____

ID#: _____ GROUP#: _____ RELATION: SELF/SPOUSE/CHILD/PARENT

SECONDARY INSURANCE INFORMATION

NAME OF POLICYHOLDER: _____ DATE OF BIRTH:_____

POLICYHOLDER'S SSN: _____ EMPLOYER: _____

INSURANCE COMPANY: _____ PHONE #: _____

ID#: _____ GROUP#: _____ RELATION: SELF/SPOUSE/CHILD/PARENT

PERSONAL HISTORY

DATE OF LAST PAP SMEAR: _____RESULT: _____ CLINIC/DOCTOR NAME: _____

DATE OF LAST MAMMOGRAM: _____RESULT:_____ LOCATION: _____

OBSTETRIC HISTORY (Please list pregnancy information in chronological order):

YEAR	SEX	WEIGHT	C-SEC OR VAGINAL DELIVERY	COMPLICATIONS	MD/HOSPITAL
_____	___	_____	_____	_____	_____
_____	___	_____	_____	_____	_____
_____	___	_____	_____	_____	_____

MISCARRIAGE: _____ ELECTIVE TERMINATION: _____

CURRENT MEDICATIONS AND DOSES (INCLUDE BIRTH CONTROL)

_____ _____

_____ _____

_____ _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? CIRCLE **NO/YES**_____

DO YOU SMOKE?_____IF YES, HOW MUCH?_____

DO YOU HAVE A HISTORY OF?

YES	**NO**	**EXPLAIN**
___	___	ABNORMAL PAP SMEAR_____
___	___	SEXUALLY TRANSMITTED DISEASE_____
___	___	UTERINE FIBROIDS_____
___	___	ENDOMETRIOSIS_____
___	___	HORMONE REPLACEMENT THERAPY_____
___	___	HIGH BLOOD PRESSURE_____
___	___	DIABETES_____
___	___	THYROID PROBLEMS_____
___	___	BLOOD CLOTS OR BLEEDING DISORDER_____
___	___	MITRAL VALVE PROLAPSE_____
___	___	SICKLE CELL DISEASE OR TRAIT_____
___	___	DRUG OR ALCOHOL ABUSE/ADDICTION_____
___	___	PSYCHIATRIC DISORDER/TREATMENT_____
___	___	SURGICAL PROCEDURES: _____

_____

_____

DO YOU HAVE A FAMILY HISTORY OF?

YES	**NO**	**EXPLAIN**
___	___	BREAST CANCER_____
___	___	CERVICAL, UTERINE OR OVARIAN CANCER_____
___	___	HIGH BLOOD PRESSURE_____
___	___	DIABETES_____
___	___	OTHER CANCER OR MEDICAL ILLNESS_____

_____

Patient Information Consent Form

I have read and fully understand PPWC Privacy Notification. I understand that PPWC may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice in writing. I also understand that PPWC will consider requests for restrictions on a case-by-case basis, but does not have to agree to the restriction request.

I have a right to receive the notice of privacy practices available at the front desk and understand that the staff of PPWC is available to answer any questions I may have about the privacy practices. I hereby consent to the use and discloser of my personal health information for purposes as outlined in PWCC Privacy Notice. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

With my consent PPWC may call my home or any other designated location and leave a message on my voice mail or in person for the purpose of carrying out treatment, payment and healthcare operations. PPWC may send appointment reminders, insurance items, lab or diagnostic results and clinical care to my home address.

With my consent PPWC can mail information to my home or any other designated location in reference to appointment reminder cards, patient statements, and test results as long as they are marked “Personal” and or “Confidential”.

With my consent PPWC can send emails through my email address or other designated location and send information that assist the practice in carrying out treatment, payment and healthcare operations. PPWC may send appointment reminders, patient statements and test results to my email address.

Patient’s Name _____ Signature of Patient/Guardian _____ Date _____

Designated Individuals Authorization

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Authorization for Treatment

I hereby consent to medical treatment, diagnostic procedures and injections by the providers and staff of PPWC. I understand diagnostic procedures may include, but not limited to lab tests on blood, urine and tissue. I understand I may be asked to undergo diagnostic radiology procedures including, but not limited to, ultrasound. I understand I have the right to ask questions about my treatment and/ or procedures and I agree to notify my provider of my concerns.

I have read the above and agree to treatment to their content.

Patient Signature _____ Date _____

I give Piney Point Women's Center permission to contact me regarding the indicated items in the following manner:

List numbers we can call, circle yes or no if we may leave detailed message, and indicate type of information we can leave on voicemail.

Home# _____ **Leave Message Yes or No**

☐ Appointments ☐ Scheduling ☐ Results ☐ Billing ☐ RX

Work# _____ **Leave Message Yes or No**

☐ Appointments ☐ Scheduling ☐ Results ☐ Billing ☐ RX

Cell# _____ **Leave Message Yes or No**

☐ Appointments ☐ Scheduling ☐ Results ☐ Billing ☐ RX

Email: _____ **Leave Message Yes or No**

☐ Appointments ☐ Scheduling ☐ Billing

Ok to leave messages and discuss information with: _____
(Individual's name/relationship)

☐ Appointments ☐ Scheduling ☐ Results ☐ Billing ☐ RX

I give my permission as above, and I understand that these will remain in force until such time I request a change in writing.

Signature: _____

Date: _____

PHYSICIAN DISCLOSURE
OF FINANCIAL INTEREST

The physicians and staff at **PINEY POINT WOMEN'S CENTER, PLLC** provide the highest quality, complete women's health care services including normal and high risk obstetrics, gynecology, infertility, adolescent care and menopausal management. The ability to provide patient access to high quality obstetrical and gynecological providers and services is an essential component to any quality-based women's health practice. Ownership interests in the following entities reflect our commitment to providing the highest standard of patient care in the office, laboratory, surgery settings, and enhances our ability to direct the manner in which your care is delivered.

Victory Medical Center Houston
Gala Histology Laboratory
Memorial Hermann Ambulatory Surgery Center
VitaMedMD

The entities listed above are not contracted with insurance companies and will be considered "out of network" when claims are processed. If you obtain services from these entities, and the service is covered under your benefit plan, the costs of their service will be covered under the "out of network" portion of your benefit plan. If your benefit plan does not have out of network benefits, it is possible that you may not have coverage for the service and will be required to pay the costs yourself. Further, your physician may receive a benefit from the referral.

If you have any concerns regarding your referral to any of the above-indicated entities, please do not hesitate to contact our office to request additional information, including an alternative referral. Please be aware of your right to request a referral to an alternative facility.

Sincerely,

Paul Cook, MD
Catherine Gabel, MD
Roz Nanda, MD
Ziad Melhem, MD
Noelle Niemand, MD
Vida Esfandiari, MD

PATIENT ACKNOWLEDGEMENT

I hereby acknowledge receipt of a copy of the foregoing Physician's Disclosure of Financial Interest.

_____ _____
Patient Signature Date

_____
Print Name