Premier Healthcare for Women

Jaime Middleton, M.D.

Please provider your Driver's License and Insurance Enrollment card upon checking in.

If you did not provide us with current insurance information when scheduling your appointment, you will be asked to pay for services provided today or your appointment may have to be rescheduled until coverage can be verified. We regret that time does not always allow us to verify your benefits or coverage on the day of your appointment.

Whom may we thank for referring you today?_____

Last Name_____ First Name_____ MI____

Address_____City_____State_____Zip_____

Date of Birth _____/_____/_____ Age_____ Gender: Male Female Martial Status: M____ S____ D____ W____

Home Phone # _____-_____-_____ Work Phone # _____-_____-_____ Cell Phone # _____-_____-_____

Email address: _____

Emergency Contact_____ Relationship_____ Phone # _____-_____-_____

Patient SS # _____ Patient Driver's License_____

Employer_____ Occupation_____

Insurance Company_____

Policy # _____ Group #_____

Guarantor/Policy Holder Name_____ Relationship to patient?_____

Date of Birth _____/_____/_____ Age_____ Gender: Male Female Martial Status: M____ S____ D____ W____

Guarantor/Policy Holder SS # _____ Driver's License #_____

Address (if different) _____City_____State_____Zip_____

Do we have your permission to:
Leave a message on your answering machine at home? ____yes ____no
On your cell phone? ____yes ____no
Leave a message on your answering machine at work? ____yes ____no
Discuss your medical condition with any member of your house hold? ____yes ____no
If yes, whom?_____ Relationship_____

- If your insurance company requires that you obtain referrals, you as the patient are responsible for contacting your primary care physician prior to your visit to obtain a referral. When a referral is necessary to render treatment and has not been provided, your appointment will have to be rescheduled until it can be obtained. It is the patient's responsibility, solely, to understand their individual benefits.
- As a courtesy to you, we verify insurance benefits and coverage. This is not a guarantee of coverage or payment. We encourage you to read your benefits handbook if you have any questions or call the 800 number on your insurance card. All charges not covered by insurance will be your financial responsibility. All in-network claims are submitted to insurance and paid directly to Premier Healthcare for Women. You will be asked to pay for any co-pay, deductible or out-of-pocket expenses at the time of service. Out of network insurance claims must be paid at the time of service but we will file the claim to get you reimbursed.
- It is your contractual responsibility to provide us with insurance information prior to services being rendered. By denying insurance coverage information, you may waive the right to have Premier Healthcare for Women file a claim at a later date and waive discounted fees that you might have otherwise been entitled to.
- By signing below, I authorize the release of any necessary information to my insurance company, which may be needed to process payment for my claim. I further acknowledge that I have been informed and agree with the above policies of Premier Healthcare for Women.

Patient Signature_____Date_____

Release and Assignment

I hereby authorize **Premier Healthcare for Women** to release my insurance carrier all information concerning my illness and treatment and hereby assign **Premier Healthcare for Women** all payments for medical services rendered to myself and/or my dependents. I understand that I am fully responsible for any amount NOT covered by my insurance carrier.

Patient Signature_____Date_____

Receipt of Notice of Privacy Practice
Written Acknowledgement Form

My signature confirms, I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services I have been informed of my provider's Notice of Privacy Practices containing a more complete description of the uses of disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my provider has the right to change the Notice of Privacy Practices and that I may contact the office to obtain the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of healthcare operations, and I understand that you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

Patient Signature_____Date_____

Authorization to Release Medical Records

I hereby authorize **Premier Healthcare for Women** to release any and all information related to my past and present medical history, diagnoses, and treatments to my referring physician and other PCP, or specialist that will be treating me during my illness and treatment. I understand that any records not related to my illness and treatment will not be released.

Patient Signature_____Date_____

Financial Responsibility

I understand that I am personally responsible for any medical fees I will incur at **Premier Healthcare for Women**. I also understand that I will be responsible for any charges incurred by not providing the most current, correct insurance information to **Premier Healthcare for Women**. I understand that my insurance benefits may have an "allowable amount" for each procedure that is determined by the benefit contract I have with the insurance company and does not always equal the doctor's fee. We are contracted with most insurance companies and would make the necessary allowable adjustments accordingly. My insurance may pay a percentage of the "allowable," and I understand that I am responsible for payment of the remaining allowable balance. This payment may include my deductible (if not already satisfied), any co-payments, and any remaining portion of the doctor's bill that is not covered. The portion estimated to be my responsibility will be due at the time of service. I understand that medical benefit policies may not pay for their entire treatment.

I understand I am financially responsible for services received from **Premier Healthcare for Women**.

Patient Signature_____Date_____

Date_____ Patient Name_____ Age_____

Reason for today's visit? Preventative or Problem

If problem, please describe _____

Gyn History

Are you currently pregnant?_____ Are you trying to get pregnant?_____

Last menstrual period (first day)_____ Are periods regular?_____

Any problems with periods?_____

Age periods began_____ Number of days bleeding_____ Number of days between periods_____

Any recent changes in periods?_____

Last pap smear_____ Result?_____

Abnormal pap/HPV in past? Y / N

Last mammogram_____ Abnormal mammograms/breast biopsies in the past? Y / N

Treatment?_____

Last colposcopy_____ Result?_____

Last bone density scan_____ Result?_____

Sexual orientation_____ Are you sexually active? Y / N

Any difficulties or discomfort?_____

Age at 1st intercourse_____ Total number of sexual partners_____ Number of current partners_____

Current birth control_____ Do you want to change?_____ To What?_____

Do you perform breast self exams? Y / N Any changes or concerns_____

Ob History

Pregnancies_____ Deliveries_____ Miscarriages_____ Abortions_____ Living children_____

Year	Sex	Baby's Weight	Hours in Labor	Anesthesia	Vaginal or C-section	Complications	Child's Name

Medications

Drug allergies_____

Medications list (include herbal and over-the-counter meds; include dosage for all)

_____

_____

_____

Surgical History (include approximate date)

_____

_____

_____

Social History

Occupation_____ Marital status: Single / Married _____# years / Divorced / Widowed

Do you smoke cirgarettes? Y / N _____Current _____Past _____Packs/day _____Years

Do you drink alcohol? Y / N _____#Drinks/day _____#Drinks/week

Do you use recreational drugs? Y / N Type & How much?_____

Do you exercise? Y / N How much?_____

Have you been sexually abused, threatened or hurt by anyone? Y / N Who?_____

Family History

Medical Condition	YES	NO	Who / Approx age of onset	Living Y/N
Birth defects				
Blood clots in legs/lungs				
CANCER				
Breast cancer				
Male breast cancer				
Multiple breast cancers same individual				
Ovarian cancer				
Colon cancer				
Multiple colon cancers same individual				
10+ more colon polyps same individual				
Uterine (endometrial) cancer				
Stomach cancer				
Kidney / urinary tract cancer				
Brain cancer				
Small bowel cancer				
Billiary cancer				
Melanoma				
Pancreatic cancer				
Cystic fibroids				
Diabetes				
Downs syndrome				
Heart disease				
High blood pressure				
High cholesterol				
Osteoporosis				
Sickle cell disease				
Stroke				
Tay Sachs disease				

List other significant medical problems or cancers in family members:_____

Personal Past Medical History

Have your been treated for any of the following medical conditions? (Past or current)

Medical Condition	YES	NO	Details (Date & Description)
Abnormal hair growth/hair loss			
Abnormal vaginal discharge			
Abnormally painful/heavy periods			
Arthritis/joint problems			
Asthma or lung disease			
Blood clots in legs or lungs			
Blood transfusion			
Bowel problems			
Cancer			
Depression/anxiety			
Diabetes			
Endometriosis			
Glaucoma			
Heart attack/angina			
Hepatitis – Type_____			
Herpes			
High blood pressure			
High cholesterol			
Infertility			
Involuntary loss of stool			
Involuntary loss of urine			
Irregular or absent periods			
Kidney infection/stones			
Lumps or pain in breasts			
Lupus/collagen vascular disease			
Menopause symptoms			
Migraines/Headaches			
Psychiatric problem			
Reflux/stomach ulcer			
Seizures			
Sexually transmitted diseases			
Skin problems			
Stroke			
Substance abuse			
Thyroid disease			
Tuberculosis			
Unexplained weight gain or loss			
Uterine fibroids			

Please explain items above or list other medical problems not listed:_____

_____

_____

Review of Systems

Are you currently experiencing any problems with the following body systems. Mark all that apply.

GENERAL	fatigue fever weight gain weight loss
HEAD/EARS/NOSE/THROAT	headaches sore throat decreased hearing
BREAST	breast lumps breast tenderness nipple discharge
CARDIOVASCULAR	chest pain irregular heartbeat
RESPIRATORY	shortness of breath cough wheezing
GASTROINTESTINAL	nausea vomiting diarrhea constipation abdominal pain
SKIN	rashes skin lesions
NEUROLOGIC	seizures tingling numbness
MUSCULOSKELETAL	joint pain joint swelling
ENDOCRINE	hair loss temperature intolerance abnormal hair growth

Please provide name and number of all other treating physicians and their specialty:

Provider Name	Phone Number	Specialty

Do you allow us to discuss your results with them? Yes / No (circle one)

Pharmacy Information

Pharmacy Name:_____

Pharmacy Address:_____

Pharmacy Phone number:_____

Premier Healthcare for Women
Jaime Middleton, M.D.
10970 Shadow Creek Parkway, Suite 250
Pearland, TX 77584
Phone (832) 615-1109 | Fax (832) 615-1110

Consent / Authorization for Release of Information

Patient Name_____ DOB_____

Address_____

Home Phone_____ Cell Phone_____

Email_____

I hereby authorize the following individual or organization to disclose the above named individual's health information:

Name_____

Address_____

Phone_____ Fax_____

This information may be disclosed to and used by the following individual or organization:

Name Premier Healthcare for Women

Address 10970 Shadow Creek Parkway, Suite 250; Pearland, TX 77584

Phone (832) 615-1109 Fax (832) 615-1110

For the purpose of transfer of care

Please release any the entire record including diagnostic tests, records of any examination rendered to me while under your care.

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____.

I understand the information in my health records may include information relating to sexually transmitted disease, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ Yes, I consent to the release of this information.

_____ No, I do not consent to the release of this information.

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient

_____ _____
Witness Date