To: RiverCity Women's Health, PLLC From: ______________________

Fax: (210) ____ - ______ Phone: ______________________

Thank you for choosing RiverCity Women's Health PLLC. In an effort to expedite your check-in process as a new patient, please complete the new patient forms before your appointment and either fax or bring them with you to your appointment.

Items to bring to your appointment:

1). New Patient Forms

2). Insurance Card(s)

3). Any and all recent Ultrasound, CT Scan, X-rays, and MRI's

4). Medications

Office Information: RiverCity Women's Health, PLLC
5534 Rogers Road
San Antonio, Texas 78251
Ph: (210) 684 - 1000
Fax: (210) 684 - 1003

Location: On Rogers Road
Two Blocks South of Culebra Road
In-Between Wiseman and Culebra Roads

Thank you for choosing RiverCity Women's Health, PLLC. If you have any questions please feel free to contact our office staff. We look forward to seeing you.

☐ New Patient ☐ Updated Information

RIVERCITY
WOMEN'S HEALTH

Patient Demographics

Patient Name:_______________________________________ Birth Date:_____/______/_____
LAST FIRST MI

Social Security No: _________-_________-___________ Gender: ☐ Male ☐ Female

Address: ____
STREET ADDRESS CITY STATE ZIP

Home #: _____-_______-______ Cell #: ______-______-________ Work #: _______-_______-_______

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Preferred Language: ________________

Race: ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic
☐ Native Hawaiian / Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic or Latin Decent ☐ Not Hispanic or Latin Decent ☐ Do Not Wish to Report

Emergency Contact Information

Name: ____ Phone: _______-________-_______

Release of Medical Information

(Medical Information may be released to the following individuals)

Name: _______________________ Relationship: _________________ Phone: ______________

Name: _______________________ Relationship: _________________ Phone: ______________

Payment Information

Form of Payment: ☐ Health Insurance ☐ Auto Insurance ☐ Workers Comp ☐ Self Pay ☐ Other

Primary Insurance:

Primary Company:_______________________________ Insured's Name:_______________________

Policy #:__________________ Group #:______________ Insured's Date of Birth: ________________

Secondary Insurance

Secondary Company:____________________________ Insured's Name:______________________

Policy #:__________________Group #:_______________ Insured's Date of Birth: ________________

Self-Pay Agreement

I agree to pay for medical services rendered from RiverCity Women's Health PLLC. I understand that payment must be made prior to establishing as a new patient.

Patient Signature: ______________________________________ Date: __________________

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION:

I authorize RiverCity Women's Health, PLLC and affiliated providers to release any medical information requested by insurance companies with whom I have coverage or any public agency that may be assisting in payment of my medical care.

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFIT:

I authorize the release of any medical information necessary to process any claim associated with RiverCity Women's Health, PLLC and affiliated providers with respect to my medical care. I permit a copy of this authorization to be used in the place of the original.

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize payment of benefits to be paid directly to the affiliated providers of RiverCity Women's Health, PLLC. I understand that I am financially responsible for charges not covered by this assignment. I authorize refunds of overpaid insurance benefits, when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs arising from the collection of payment, including attorney fees.

CONSENT FOR TREATMENT:

I hereby authorize the RiverCity Women's Health, PLLC and affiliated providers to perform a physical examination and to provide any medical treatment deemed necessary. This includes but not limited to all required medical examinations, echocardiograms, EKG, nuclear scans, x-rays, and/or medical and surgical procedures.

PATIENT PAYMENT RESPONSIBILITY:

I hereby agree that all applicable fees, deductibles, co-insurance, and co-payments are my responsibility and must be paid at the time services are rendered.

APPOINTMENT CANCELLATIONS:

I hereby agree to make every attempt to call the office at least 24 hours in advance of any appointment that needs to be cancelled or rescheduled.

CHANGE OF INFORMATION:

I hereby agree to provide the office any information regarding changes in my address, phone number, health benefits, or insurance information.

NOTICE OF PRIVACY PRACTICES:

RiverCity Women's Health, PLLC and affiliated providers are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Signing below indicated acknowledgement of receipt of our office's Notice of Privacy Practices.

AUTHORIZED SIGNATURE:

I authorize that I have read this document and will comply with the policies listed above. I also understand and agree that RiverCity Women's Health, PLLC and affiliated providers reserve the right to terminate the physician/patient relationship for non-compliance with any of the above policies.

Patient Name (Please Print)	Date	Patient Signature

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the office of RiverCity Women's Health, PLLC and affiliated providers to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). [The office's Notice of Privacy Practices provides a more complete description of such uses and disclosures.]

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of RiverCity Women's Health, PLLC and affiliated providers reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Administrator.

With this consent, the office of RiverCity Women's Health, PLLC and affiliated providers may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the office of RiverCity Women's Health, PLLC and affiliated providers may mail to my home or their alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, the office of RiverCity Women's Health, PLLC and affiliated providers may e-mail to my home or other alternative location any times that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the office of RiverCity Women's Health, PLLC and affiliated providers restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting that the office of RiverCity Women's Health, PLLC and affiliated providers may use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the office of RiverCity Women's Health, PLLC and affiliated providers may decline to provide treatment to me.

____

Signature of Patient or Legal Guardian

____

Print Patient's Name

____

Print Name Legal Guardian

____

Date

New Patient Health Questionnaire

NAME: ____ Birth Date: ____/____/____ Age: _____
LAST FIRST MI

Preferred Pharmacy: ____________________ **Phone #** ( ) - ____________________

Allergies / Sensitivity to Medications: ______________________________

Reason for Visit: ______________________________

____

____

______________________________.

Current Symptoms: *(Please check all that apply.)*

☐ Headaches	☐ Hoarseness	☐ Bowel Problems
☐ Vision Problems	☐ Throat Problems	☐ Bladder Problems
☐ Nasal Congestion	☐ Swallowing problems	☐ Sexual Difficulties
☐ Runny Nose	☐ Dizziness	☐ Weakness
☐ Ear Problems	☐ Breathing Problems	☐ Numbness
☐ Chest Pain	☐ Stomach Problems	☐ Weight Changes
☐ Abnormal Vagina Discharge	☐ Menopausal Problem	☐ Menstrual Problem

Past Medical History: *(Please check all that apply.)*

☐ Deafness/Decreased Hearing	☐ Epilepsy / Seizures	☐ Diabetes Mellitus
☐ Heart Problems	☐ Mental Illness	☐ Hemorrhoids
☐ Heart Attack	☐ Nervous Breakdown	☐ Stomach / Bowel Problems
☐ High Blood Pressure	☐ Mental Retardation	☐ Ulcers
☐ Blood Transfusion	☐ Cancer	☐ Migraines
☐ Anemia	☐ Stroke	☐ Arthritis
☐ Bleeding Disorder	☐ Blindness	☐ Hepatitis
☐ High Cholesterol	☐ Glaucoma	☐ Liver Problems
☐ Lung Problems	☐ Sinus Infection	☐ Gout
☐ Asthma	☐ Urine Infection	☐ Broken Bones
☐ Pneumonia	☐ Kidney Disease	☐ Joint Dislocation
☐ Rheumatic Fever	☐ Kidney Stone	☐ Birth Defects
☐ Scarlet Fever	☐ Thyroid Problems	☐ Amputations
☐ Tuberculosis	☐ Venereal Disease	☐ HIV
☐ Allergies		

New Patient Health Questionnaire

NAME: ____ Birth Date: ____/____/____ Age: _____
LAST FIRST MI

Current Medications:

List ALL medication that you are currently taking including Non-Prescriptions Medication & Herbal remedies.
(Please DO NOT Substitute a List. Please write medications: Over the counter & or Herbs below)

Medications	Dose	How Often	Approximately Start Date (Month/Year)

Obstetric and Gynecologic History:

Total Pregnancies: __________ Premature: __________ Stillborn: Miscarriages: __________
Total Living Children: __________ Pregnancy Complications: __________
First Day of your last Menstrual Cycle: ____/____/____ Age at first Menstruation: __________
How long does your Menstrual Cycle last: __________
How often does Menstruation occur: (e.g., monthly, every six weeks) __________
On the heaviest day, how many pads or tampons do you use: __________ Any Cramps: __________
Any PMS symptoms: __________ If so, describe: __________
Do you spot or bleed between cycles or after intercourse: __________ if so, describe: __________
Is this your first GYN exam: __________ Any history of STD's: __________ If yes, which one(s): __________
Date of your last Pap smear: __________ Have you ever had an abnormal Pap smear: __________
Any Breasts Problems: __________ Do you examine your breasts regularly: __________
Have you had a Mammogram recently: __________ If Yes, Date: ____/____/____ Outcome: __________

Sexual History:

Have you had sex with: ☐ Male ☐ Female ☐ Both How old were you when you first had sex: __________
Have you had more than one partner in the past year: __________
Do you have any pain with intercourse: __________
If you use contraception, what form(s) do you use: __________
Do you wish to continue with this method: __________
Have you ever experienced sexual assault or incest: __________
Is there any violence in any of your relationships: __________

New Patient Health Questionnaire

NAME: ____ Birth Date: ____/____/____ Age: _____

LAST FIRST MI

Periodic Examinations:

(Please Check Exam and State when.)

☐ *Pap Smear:* ____/____/____ ☐ *Mammogram:* ____/____/____

☐ *Bone Density:* ____/____/____ ☐ *Colonoscopy Exam:* ____/____/____

☐ *Lipid:* ____/____/____

Immunizations:

Description	Last Known Date	Description	Last Known Date
☐ PNEUMONIA	/ /	☐ FLU	/ /
☐ TETANUS	/ /	☐ RUBELLA	/ /
☐ HPV	/ /	☐ OTHER	/ /
☐ HEPATITIS B	/ /		/ /

Surgical History:

Have you ever had any surgery (including oral surgery, tonsils, abdominal surgery, etc.)

If yes, Date: ____/____/____ Type: ____________________ Complications: ____________________

If yes, Date: ____/____/____ Type: ____________________ Complications: ____________________

If yes, Date: ____/____/____ Type: ____________________ Complications: ____________________

Social History:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Domestic Violence: ☐ ____.

Employment: ☐ Employed ☐ Unemployed ☐ Retired Occupation: ____________________.

Living Situation: ☐ Lives alone ☐ Lives with family ☐ Lives with others

Smoking: ☐ Current Smoker, everyday ☐ Current Smoker, some days ☐ Former Smoker

☐ Never Smoker ☐ _______ packs/day ☐ _______ years smoked

Alcohol Use: ☐ YES ☐ NO

☐ Heavy drinker (1-5 drinks/day) ☐ Moderate Drinker (1-5 drinks/week)

☐ Occasional Drinker

Seat Belt Use: ☐ YES ☐ NO

Recreational Drug Use:

☐ YES ☐ NO

☐ Heavy User (daily to weekly) ☐ Moderate User (monthly) ☐ Occasional User

List Recreational drugs used: ____.

New Patient Health Questionnaire

NAME: ____ Birth Date: ____/____/____ Age: _____
LAST FIRST MI

Exercise: ☐ YES ☐ NO If Yes, Please explain: ____________________________________

____

____

____.

Family Medical History: *(Please check all that Apply.)*

Conditions	Father	Mother	Brother(s)	Sister(s)	Children
Diabetes:	☐	☐	☐	☐	☐
High Blood Pressure:	☐	☐	☐	☐	☐
Cancer/Type:	☐	☐	☐	☐	☐
Heart Disease:	☐	☐	☐	☐	☐
Glaucoma:	☐	☐	☐	☐	☐
Anemia:	☐	☐	☐	☐	☐
Osteoporosis:	☐	☐	☐	☐	☐
High Cholesterol:	☐	☐	☐	☐	☐
Breast Cancer:	☐	☐	☐	☐	☐
Uterine Cancer:	☐	☐	☐	☐	☐
Ovarian Cancer:	☐	☐	☐	☐	☐
Others:	☐	☐	☐	☐	☐