Dr. David DeShan
Dr. Ben Doke
Dr. Brady Locke
Dr. Gary Madden
Dr. Ronica McBrayer
Dr. Reagan Viney

MIDLAND WOMEN'S CLINIC
EXCELLENCE IN WOMEN'S HEALTHCARE
SINCE 1951

Dr. Beverly Yee
Dr. Rebecca Morton
James Struble, PA-C
Randal Morgan, PA-C
Courtney Luoma,CNM
Betsy Arreguin,CNM

2500 W. Illinois Ave, Suite 100 Midland, TX 79701
Phone 432-699-2370 * OB Coordinator ext 205
Fax 432-697-3524
MWCOB@UNIFIEDHC.COM

REMINDER

- Please fill out paperwork and return ASAP . You will know that your scheduling process has begun once you receive your confirmation email. The scheduling process takes 5-7 days from receiving confirmation email.

- PLEASE EMAIL TO MWCOB@UNIFIEDHC.COM OR
  - FAX TO 432-697-3524 ATTN: OB COORDINATOR
  - YOU MAY ALSO DROP IT OFF WITH OUR FRONT DESK STAFF

- All patients and attending parties must arrive **10 minutes before their appointment.** If you are late, you could be re- scheduled or moved to a different time. Visits that involve **Sonograms** will not wait for other parties to arrive.

- **Payment is required at check in. Your payment amount is based off of your benefits. Your appointment will be rescheduled if payment is not collected.**

- If you need to cancel or re-schedule your appointment, please call the office at least 24 hours prior to your appointment to avoid being billed a $50.00 no-show fee.

If you have any questions, please do not hesitate to call.

We look forward to starting your OB care with you!!

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NEW OB PAPERWORK

Name: ______________________________ Date of Birth: _______________________________

First Day of Last Period________________________on birth control?___________________________

How old were you when you first began menstruating?________________________

Are they predictable?_______________How often?____

Length of flow?____(days)

Date of Pregnancy test_________________

Pregnancy weight _____________________

Father of the baby's name____

Have you had any vaginal spotting with this pregnancy? __________________________

Have you had any nausea/vomiting?____

Date of last Pap smear:_________________Doctor who performed Pap smear: ___________

Medications currently taking: ____

Drug Allergies:____

OBSTETRIC HISTORY						
	Number		*Number*		*Number*	
Total # Pregnancies		Premature (<37 weeks)		Living Children		
Full Term		Abortions		Miscarriages		
Please List Each Pregnancy Below:						
No. Date	Sex	Weight	Weeks Pregnant	Anesthesia (Epidural)	Type of Delivery (Vaginal/C-Section	Complications
1.						
2.						
3.						
4.						
5.						

Have you/or the father of the baby been exposed to HIV, Herpes, or Tuberculosis? ________________________

Haveyou been sick or had a rash since your last period?____

Have you/or the father of the baby ever had an STD? ____

If yes,please explain:____

(for office use only) Received_______________

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If you have had any surgeries before, please describe below:		
	Date	*Type of Surgery*
1.		
2.		
3.		
4.		
5.		

PERSONAL MEDICAL HISTORY					
History	*Y/N*	*History*	*Y/N*	*History*	*Y/N*
Seasonal, Food, Environmental Allergies		Diabetes		Abuse, molested, raped, or assaulted	
Anemia		Heart Disease		Uterine Abnormalities	
Asthma		Hypertension		Blood Clots	
Autoimmune Disorders		Liver Problems		Abnormal Pap Smears	
Infertility		Blood Transfusions		Neurologic Problems	
Breast Disorders		Kidney Problems		Depression	
Psychiatric Disorder		Thyroid Problems			

Do you have cats at home? ____

Have you had the Chicken Pox? ____

Is the father of the baby in good health?____

Do you drink alcohol?____________ Amount per week?_________________________________

Do you smoke?____________Amount per day? _______________ How many years?____________

Has anyone in your family or the father of the baby's family had any of these?					
Disorder	*Y/N*	*Who?*	*Disorder*	*Y/N*	*Who?*
Spina Bifida			Autism		
Down Syndrome			Mental Retardation		
Congenital Heart Defects			Muscular Dystrophy		
Cystic Fibrosis			Sickle cell disease/trait		
Tay-Sachs			Type 1 Diabetes/PKU		
Thalassemia			Recurrent Pregnancy Loss/Stillbirth		
Canavan Syndrome			Hemophilia/Blood Disorder		
Huntington's Chore a			Other Genetic Screening/Birth Defects		

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NEW PATIENT PAPERWORK

First Name: ____________________ Middle: __________________ Last Name:_______________________

Former Last Name: ___________________ Sex: Preferred Name: ________________________

Social Security: _______________________ DOB _______________ Marital Status:____________________

Address: ____ Apt/Unit:_________

City: __________________ State: _________________ Zip: _______________

Home #: ______________________ Cell #: _____________________ Work#: _______________________

Consent to SMS (text messages): Yes No Contact Preference:

Patient Email: ____________________________________Consent to Email: Yes No

How did you hear about us: _______________________Patient Care Summary: Portal Paper

Language: ________________________ Race: _____________________ Ethnicity: ____________________

Pharmacy: ____ Provider: ____________________________

Guarantor (Responsible Party)

_____ Self

_____ Other than patient Relationship to patient: _______________________

First Name: ___________________________ Last Name: _________________________

Middle Name: ______________________________DOB: ____

Mailing Address: (if different from patient)

____

City, State, Zip: ____

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Emergency Contact

Last Name: _______________________________ First Name: ______________________________

Home#: _____________________ Cell#: ________________________ Relationship: ________________

Insurance

Primary Insurance **Secondary Insurance**

Insurance Company:_________________________ Insurance Company:_________________________

Claims Address:_____________________________ Claims Address:_____________________________

ID:____ ID:____

Group:______________________________________ Group:______________________________________

Copay:____________ Coinsurance__________ Copay:____________ Coinsurance__________

Policy Holder Information: Policy Holder Information:

Last Name:__________________________________ Last Name:__________________________________

First Name:_________________________________ First Name:_________________________________

DOB: _________ Relationship to Patient:_________ DOB: ______Relationship to Patient:____________

SEX: SEX:

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Name: ____ **DOB:** _________________

Please check all that apply:

Systemic symptoms
- Weight change
- Chills
- Fever
- Night sweats
- Fatigue

Head symptoms
- Headache
- Facial pain
- Sinus pain

Eye symptoms
- Eyesight problems
- Light sensitivity
- Eye pain
- Eye itching

Ears/mouth/throat symptoms
- Earache
- Hearing loss
- Ringing in ears
- Nosebleeds
- Nasal discharge
- Mouth sores
- Bleeding gums
- Hoarseness
- Throat pain

Neck symptoms
- Neck pain
- Neck stiffness
- Swelling in the neck

Breast symptoms
- Breast pain·
- Nipple discharge
- Breast lump

Cardiovascular symptoms
- Chest pain
- Fast heart beat
- Palpitations

Pulmonary symptoms
- Shortness of breath
- Cough
- Coughing up blood
- Wheezing

GI symptoms
- Change in appetite
- Difficulty swallowing
- Heartburn
- Nausea
- Vomiting
- Abdominal pain
- Diarrhea
- Blood in bowel movements

Genitourinary symptoms
- Burning with urination
- Frequent urination
- Blood in urine
- Genital lesions

Skin symptoms
- Itching
- Skin lesions
- Rashes

Endocrine symptoms
- Excessive sweating
- Excessive thirst
- Change in libido

Musculoskeletal symptoms
- Joint pain
- Joint stiffness
- Muscle aches

Neurological symptoms
- Dizziness
- Vertigo
- Fainting
- Weakness
- Numbness

Other symptoms
- Trouble sleeping
- Anxiety
- Depression

Comment:

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Name ________________________________ Day Phone _______________________________

Date of Birth ___________________________ Last menstrual period _____________________

Primary Provider:____ Martial Status:

History and Physical

Surgical Procedure Date Notes

Current Medication Dosage

Default Pharmacy ___________________________ Phone ____

Address____

Allergies/ Adverse Reactions

Drug/Allergen Reaction

Personal History. **Please List Type & Describe**

Cancer History **Yes** **No**

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Cardiac History (Heart) Yes No

Endocrinology History (Diabetes, Osteoporosis, Thyroid etc.) Yes No

Gastrointestinal History (Crohn's, gallbladder, hemorrhoids, liver etc.) Yes No

Hematology History (Bleeding disorders) Yes No

Neurology History (Headaches, seizures, strokes etc.) Yes No

Psychological History (Anxiety, Bipolar, Depression etc.) Yes No

Pulmonary (lung)/Rheumatology/Urology Yes No

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Social History

Do you drink alcohol? ____Yes___ No If so, how many drinks per week ____ Wine____ Beer____ Other
Tobacco years of use _____________ Packs per day _________________

Family history Relation (Breast, Cervical, Colon etc.) Onset Age Died Maternal/Paternal

Gynecological History Date Notes

Last Mammogram____

Last Colonoscopy____

Last DXA (Bone Scan) ____

Last Pelvic ultrasound____

Last Pap Smear ____

Last HPV test____

HPV Vaccination ____

History of abnormal PAP____

History of Cervical Dysplasia____

Are you sexually active? ____Yes_____ No

Current birth controlmethod____

How old were you when you began menstruating? ____

How old were you when you began menopause? ____

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Post menopause hormonal use? ____

History of endometriosis ____

History of fibroids ____

History of infertility ____

History of ovarian problems ____

History of PCOS ____

Past Pregnancies

Delivery __________ Gestation ________ Weight ______ Sex: Type: Anesthesia:

Delivery __________ Gestation ________ Weight ______ Sex: Type: Anesthesia:

Delivery___________Gestation ________Weight _______Sex: Type: Anesthesia:

Delivery___________Gestation ________Weight _______Sex: Type: Anesthesia:

How many total pregnancies have you had? ____

How many were born premature? ____

How many were miscarriages? ____

How many were abortions? ____

Have you had any complications with your pregnancies? Explain:

Anything else you would like to discuss?

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Cancellation/No Show &

New Patient Paperwork Policy

1. **Cancellation/No Show Policy**
   We understand that there are times when you must miss an appointment due to an emergency or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit because the schedule seems "full".

   If an appointment is not cancelled at least 24 hrs. in advance, you will be charged a fifty-dollar ($50) no show fee; this will not be covered by your insurance company. A patient who no-shows more than three times is dismissed from the practice.

2. **Scheduled Appointments**
   We understand delays can happen however, we must try to keep the other patients and doctors on time; although sometimes our doctors do run behind, your timely arrival helps from adding to the delay.

   If a patient is 15 minutes late past their appointment time, we reserve the right to reschedule the appointment(s).

3. **New Patient Paperwork**
   We ask that all new patients have our new patient paperwork filled out and in our office at least one business day (24 hrs) prior to your appointment. Having this information ahead of time allows our staff to be able to give you the best care during your appointment.

   If our clinic does not have your new patient paperwork at least one business day (24 hrs) before your appointment, we may have to reschedule your appointment.

I understand all the above policies and procedures

_______________________________________ ______________________

Signature **Date**

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Privacy Consent & Financial Agreement Form

Privacy Consent

In reference to the HIPAA Law, I ______________________________________, Date of Birth:_____________________ as a patient of Midland Women's Clinic.

_____ I DO NOT authorize the discussion or release of my medical records to anyone other than myself

_____ I DO authorize the discussion or release of my medical records to the following people:

Name: _____________________________ Relationship:___________________

Name: _____________________________ Relationship: __________________

Name: _____________________________ Relationship: __________________

I am also aware of this office's Notice of Privacy Practice and HIPAA/Privacy policy which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

Signed ______________________________ Date _________________________

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Financial Agreement

Insurance is filed as a courtesy to our patients**. I understand that I am responsible for charges not covered or reimbursed by my insurance carrier**. Payment is expected within 30 days of the receipt of notification of denial. 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 record. 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. I understand every year it is my responsibility to update any changes to my insurance to prevent denied claims.

Signed ___________________________ Date _______________

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Release of Billing Information & Assignment of Benefits

Please take a few minutes to read the paragraphs below and sign in the indicated spaces:

1. I authorize my insurance carrier to release information regarding my coverage to Midland Women's Clinic. I also authorize agents of any hospital, treatment center or previous physicians to furnish Midland Women's Clinic copies of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits and quality assurance reviews within Midland Women's Clinic

Signed:____Date:____________
(Patient's signature or Parent or Legal Guardian if Patient is a Minor – Under 18)

2. My right to payment for all pharmaceuticals, procedures, tests, supplies and nursing/physician services including major medical benefits, are hereby assigned to Midland Women's Clinic. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Midland Women's Clinic within five business days.

Signed:______________________________________Date:_______________
(Patient's signature or Parent or Legal Guardian if Patient is a Minor – Under 18)

3. I authorize Midland Women's Clinic to obtain/have access to my medication history.

Signed:______________________________________Date:_______________