Seasons OBSTETRICS & GYNECOLOGY

Confidential Health History

Updated 9/24/2019

Name	Age	Date of Birth	Today's Date
Primary Phone Number	E-mail Address		
Referring Physician / Person	Primary Care Provider		
Preferred Pharmacy Name	Pharmacy Phone Number		
Pharmacy Address	Pharmacy Cross Streets		
Reason for visit			

PREVENTIVE HEALTH

	Date of last		Date of last		Date of last
Pap		Blood Work		Bone Density	
Mammogram		Colonoscopy			
History of abnormal pap? ☐ Yes ☐ No		Would you accept blood products? ☐ Yes ☐ No			

MEDICAL HISTORY

Please check any past or current medical problems for yourself or immediate, blood relatives

X = Yourself; M = Mother; F = Father; S = Sister; B = Brother; Maternal Grandparents = MGM or MGF; Paternal Grandparents = PGM or PGF

	You	Family		You	Family
Autoimmune Disease (Lupus, MS, etc.)			Heart Disease		
Alzheimer's			Hemorrhoids		
Anemia			Hepatitis		
Arthritis			High Blood Pressure		
Bleeding Disorder			Irritable Bowel Syndrome		
Blood Clots in legs			Kidney Disease		
Blood Clots in lungs			Lung Disease, Asthma		
Blood Disorders			Mental Illness, Depression		
Cancer Breast			Migraine Headache		
Cancer Colon			Osteoporosis		
Cancer Ovarian			Seizure Disorder		
Cancers Other			Skin Disorders		
Diabetes			Stroke		
Drug/Alcohol Abuse			Thyroid Disorder		
Frequent Bladder Infections			Tuberculosis		
Gallbladder Disease or Gallstones			Ulcers		
Hearing Problems			Other		

SURGERIES

Date	Surgery	Date	Surgery

CURRENT MEDICATION

List any MEDICATIONS you are taking, to include birth control pills, Tylenol, Advil, Aspirin, other non-prescription medicine, vitamins, herbs.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Do you take Calcium?	☐ Yes	☐ No	If yes, amount
Do you take Vitamin D?	☐ Yes	☐ No	If yes, amount
Do you take Multiple Vitamin or Prenatal Vitamin?	☐ Yes	☐ No	

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MEDICATION ALLERGIES

Do you have any medication allergies? ☐ Yes ☐ No	If yes, to what?	What type of reaction do you have?

FOOD ALLERGIES

Do you have any food allergies? ☐ Yes ☐ No	If yes, to what?	What type of reaction do you have?

ENVIRONMENTAL / LATEX ALLERGIES

Do you have any environmental / latex allergies? ☐ Yes ☐ No	If yes, to what?	What type of reaction do you have?

MENSTRUAL HISTORY

First day of last normal menstrual period - Date	Is menstrual pain or cramping a problem for you? ☐ Yes ☐ No
Age period began	Do you ever have spotting or bleeding in between your periods? ☐ Yes ☐ No
Number of days between periods	
Length of periods (# of days of bleeding)	Is PMS a problem for you? ☐ Yes ☐ No
Menstrual flow: ☐ Light ☐ Medium ☐ Heavy	Do you perform self-breast exams? ☐ Yes ☐ No

How often do you change pads / tampons on your heaviest day of menses? Every _____ hours

Do your periods regularly affect your life in a negative way? ☐ Yes ☐ No

Method of birth control

☐ Condoms	☐ Diaphragm	☐ Implanon	☐ Nuva Ring	☐ Post Menopause	☐ Vasectomy
☐ Contraceptive Pills	☐ Essure	☐ IUD	☐ Foam, Jelly, etc.	☐ Same Sex Partner	☐ Other:
☐ Depo Provera	☐ Hystectomy	☐ Not Sexually Active	☐ Patch	☐ Tubal Ligation	☐ None

Are you interested in a different method of birth control? ☐ Yes ☐ No

REPRODUCTIVE PREGNANCY HISTORY

# of times pregnant	# of term deliveries	# of deliveries prior to 37 weeks	# of elective abortions
# of miscarriages	**# of ectopic pregnancies**	**# of multiple births**	**# of living children**

PREGNANCY DETAILS #1

Date	Type of delivery	Complications
# weeks at delivery	☐ Vaginal	
Birth weight	☐ C-section	
Sex of child	☐ Elective abortion	
Name	☐ Miscarriage	

PREGNANCY DETAILS #2

Date	Type of delivery	Complications
# weeks at delivery	☐ Vaginal	
Birth weight	☐ C-section	
Sex of child	☐ Elective abortion	
Name	☐ Miscarriage	

PREGNANCY DETAILS #3

Date	Type of delivery	Complications
# weeks at delivery	☐ Vaginal	
Birth weight	☐ C-section	
Sex of child	☐ Elective abortion	
Name	☐ Miscarriage	

PREGNANCY DETAILS #4

Date	Type of delivery	Complications
# weeks at delivery	☐ Vaginal	
Birth weight	☐ C-section	
Sex of child	☐ Elective abortion	
Name	☐ Miscarriage	

SOCIAL HISTORY

Marital Status ☐ Divorced ☐ Engaged ☐ Married ☐ Partnered ☐ Separated ☐ Single ☐ Widowed	Race ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other
Patient Occupation	Husband / Partner's Occupation

Do you exercise? ☐ Yes ☐ No	If yes, # of times per week	Number of children living at home

Do you / did you ever drink alcohol? ☐ Yes ☐ No	How much per week?	How many drinks a day?	Is alcohol or drug use a problem for you? ☐ Yes ☐ No

Do you / did you ever use tobacco? ☐ Yes ☐ No	If yes, what type? ☐ Chewing Tobacco ☐ Smoking/Cigarettes	How many years?	How much per day?	When did you stop?

Do you / did you ever use any recreational drugs or abuse prescription drugs? ☐ Yes ☐ No	If yes, what type?
Have you ever been sexually abused? ☐ Yes ☐ No	If you have experienced abuse, have you received counseling? ☐ Yes ☐ No
Have you ever been physically abused? ☐ Yes ☐ No	
Have you ever been emotionally abused by anyone important to you? ☐ Yes ☐ No	Is this something you would like to discuss today? ☐ Yes ☐ No

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REPRODUCTIVE PREGNANCY HISTORY (continued)

PREGNANCY DETAILS #5			**PREGNANCY DETAILS #6**		
Date	Type of delivery	Complications	Date	Type of delivery	Complications
# weeks at delivery	☐ Vaginal		# weeks at delivery	☐ Vaginal	
Birth weight	☐ C-section		Birth weight	☐ C-section	
Sex of child	☐ Elective abortion		Sex of child	☐ Elective abortion	
Name	☐ Miscarriage		Name	☐ Miscarriage	
PREGNANCY DETAILS #7			**PREGNANCY DETAILS #8**		
Date	Type of delivery	Complications	Date	Type of delivery	Complications
# weeks at delivery	☐ Vaginal		# weeks at delivery	☐ Vaginal	
Birth weight	☐ C-section		Birth weight	☐ C-section	
Sex of child	☐ Elective abortion		Sex of child	☐ Elective abortion	
Name	☐ Miscarriage		Name	☐ Miscarriage	
PREGNANCY DETAILS #9			**PREGNANCY DETAILS #10**		
Date	Type of delivery	Complications	Date	Type of delivery	Complications
# weeks at delivery	☐ Vaginal		# weeks at delivery	☐ Vaginal	
Birth weight	☐ C-section		Birth weight	☐ C-section	
Sex of child	☐ Elective abortion		Sex of child	☐ Elective abortion	
Name	☐ Miscarriage		Name	☐ Miscarriage	
PREGNANCY DETAILS #11			**PREGNANCY DETAILS #12**		
Date	Type of delivery	Complications	Date	Type of delivery	Complications
# weeks at delivery	☐ Vaginal		# weeks at delivery	☐ Vaginal	
Birth weight	☐ C-section		Birth weight	☐ C-section	
Sex of child	☐ Elective abortion		Sex of child	☐ Elective abortion	
Name	☐ Miscarriage		Name	☐ Miscarriage	

PRIVIA MEDICAL GROUP NORTH TEXAS

PHYSICIAN: _____ BEING SEEN TODAY

LOCATION: _____ DATE: _____

PATIENT REGISTRATION INFORMATION

If Patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.

Social Security #: _____ Driver's License # _____ State: _____

Name: _____ ___ ___ ___/___/___ ___ S M D W O
LAST FIRST MI SEX DATE OF BIRTH (MM/DD/YY) AGE MARITAL STATUS

Address: _____ _____ ___ _____ (___) _____
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

Alt/Cell Phone: (___) _____ Day Phone: (___) _____ Email: _____

Race _____ Language _____ Ethnicity ☐ Hispanic/Latin ☐ Non Hispanic/Latin

Full-Time Part-Time Retired Unemployed Student Employer's Name: _____
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School

Employer's Address: _____ _____ ___ _____
MAILING ADDRESS CITY ST ZIP

Occupation: _____

Emergency Contact: *(Please indicate a friend or relative not living at the same address.)*

_____ _____ (___) _____
NAME RELATIONSHIP EMERGENCY CONTACT #

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient is responsible unless a minor child or guardian. RESPONSIBLE PARTY SECTION must be completed.

Patient Relationship to Responsible Party: Child ____ Other _____ Resp. Party SS #: _____
SPECIFY

Name: _____ ___ ___ ___/___/___ ___ S M D W O
LAST FIRST MI SEX DATE OF BIRTH (MM/DD/YY) AGE MARITAL STATUS

Address: _____ _____ ___ _____ (___) _____
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

Full-Time Part-Time Retired Unemployed Student Employer's Name: _____
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School

Employer's Address: _____ _____ ___ _____
MAILING ADDRESS CITY ST ZIP

Occupation: _____ (___) _____ (___)
WORK PHONE EXT

OTHER PATIENT INFORMATION

Spouse's Name: _____ Employer: _____

___/___/___ Spouse's Work Phone: (___) _____ (_____) Occupation: _____
DATE OF BIRTH EXT

PRIMARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (___) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ _____ ___ _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ ___ ___ ___/___/___ _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other _____
(SPECIFY)

Employer's Name: _____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Address: _____ _____ _____ _____
STREET CITY ST ZIP

SECONDARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (____) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ _____ _____ _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ ___ ___ ____/____/____ _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other_____
(SPECIFY)

Employer's Name: _____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Employer's Address: _____ _____ _____ _____
STREET CITY ST ZIP

WORKER'S COMPENSATION

Worker's Compensation Insurance Name: _____ Adj. _____

Address: _____ City: _____ State _____ Zip _____ Phone _____

Claim #: _____ DOI _____

What Employer: _____

ACCIDENT INFORMATION

Was this the result of an accident? ___Yes ___No Where did it occur? ___At Work ___Auto Accident ___Other

Date of Accident_____Have you reported this injury to your employer? ___Yes ___No When _____

Describe accident briefly: _____

Do you have an attorney representing you? ___Yes ___No Who is the attorney? _____

REFERRAL INFORMATION

Who referred you? _____ Address: _____ Phone: _____

Family Physician _____ Address: _____ Phone: _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ

Privia Medical Group North Texas (PMG), and its physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that PMG has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to PMG, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint PMG to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

_____ _____ _____ _____
PATIENT SIGNATURE DATE WITNESS SIGNATURE DATE

Privia Medical Group North Texas

HIPAA Authorization for Release of Patient Health Information

In general, HIPAA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. This information will remain in effect until revoked in writing, except to the extent that action has already been taken.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home or Cell Phone: _____
  - ☐ OK to leave a message with detailed information
  - ☐ Leave name and doctor with call back number only
- ☐ Work Telephone: _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave name & doctor with call back number only
- ☐ When unable to contact me by phone, a written communication may be sent to my home address.
- ☐ Other: _____

I consent and authorize the release of NORMAL test results to the following:

- ☐ Only Myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize the release of ABNORMAL test results to the following:

- ☐ Only myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize your office or a facility on my behalf, to conduct benefit verification services.

☐ Yes ☐ No

I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

☐ Yes ☐ No

Do you have an advanced directive (Living Will)?

☐ Yes ☐ No

I consent and authorize your office or facility to make calls and/or send text messages containing important information about my account including marketing information and past-due notifications through an automated telephone dialing system.

☐ Yes ☐ No

_____

Patient Signature (Must be an adult 18 yrs or older) Date

_____

Print Name Birthdate

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician(s) and/or order another person to perform all exams, tests, procedures, injections, phlebotomy and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Dr. Lungren/Osborn, with Privia Medical Group North Texas unless revoked by me in writing.

_____

Patient Name/Legal Representative

_____

Date of Birth

_____

Date