PATIENT REGISTRATION

Please print clearly so that we can process your information quickly and efficiently. Thank you!

Name (*First, M.I., Last*)____

Date of Birth ______________ Age __________ Male / Female Marital Status: S M W D

Address ____

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Email: ______________________________ Social Security # ______________

Employer ____________________________________ Full-Time / Part-Time

Employer Address ____

Referring Physician ______________________________ Phone ______________

If Student, School Name ______________________________ Full-Time / Part-Time

Responsible Party

Name ______________________________ Relationship to Patient ______________

Address____

Phone Number ______________ Social Security # ______________ Date of Birth ______________

Employer ______________________________ Phone Number ______________

Emergency Contact ______________________________ **Phone Number** ______________

Insurance Information

Insurance Company ______________________________ Phone Number ______________

ID # ______________________________ Group # ______________________________

Insured's Name ______________________________ Relationship to Patient: Self / Spouse / Dependent

Insured's Employer ______________________________ Phone Number ______________

Insured's Social Security # ______________ Date of Birth ______________ Male / Female

I hereby assign, transfer, and set over to PROGRESSIVE WOMEN'S CARE 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. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature ______________________________ Date ______________

CONSENT FOR CARE AND TREATMENT

Patient Name (Please Print) ____

I, the undersigned, do hereby agree and give my consent for Progressive Women's Care to furnish medical care and treatment to ___________________________, considered necessary and proper in diagnosing or treating my/his/her physical and mental condition.

_________________________________ _______________________________

Patient/Guardian Signature *Date*

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 45 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed to us, you recognize an obligation to promptly remit same payment to Progressive Women's Care. This does not apply for those patients that are on an HMO plan or considered Worker's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges rendered to you.

When you pay by check, you expressly authorize the physicians of Progressive Women's Care, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit (plus any applicable sales taxes). Please note: The above language authorizes an electronic debit to your account for the state-allowed recovery fee. In accordance with the rules of the National Automated Clearing House Association, you may call (888) 235-4635 to revoke the authorization for the electronic transaction. This does not mean, however, that Progressive Women's Care cannot collect a return check fee by other methods.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

The above information has been read an explained to me. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

____ _____________________________

Signature: Patient/Guardian/Responsible Party *Date*

____

Practice Representative

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

Patient Name (Please Print) ____

I, the undersigned, do hereby confirm that I have been given access to and have reviewed a copy of Progressive Women's Care Notice of Privacy Practices. ☐ *I would like a copy of this statement.*

____ _____________________________

Signature of Patient/Guardian *Date*

Ann Bertles, M.D.
23232 Kingsland Blvd Suite E
Katy, TX 77494
Phone: 832-437-9690 Fax: 832-437-9694

AUTHORIZATION FOR RELEASE OF INFORMATION TO DESIGNATED PERSON(S)

Patient Name: ____ Date of Birth: ___________________

This form is part of the Federal Health Insurance Portability and Accessibility Act of 1966 (HIPAA) requirements for patient privacy. Signing this form and naming a person(s) who can receive your health information allows the staff of Progressive Women's Care to release all information regarding your healthcare.

Person(s) who can receive information for you:

Name: ___________________________________ Relationship: _______________ Date of Birth: __________

Name: ___________________________________ Relationship: _______________ Date of Birth: __________

Name: ___________________________________ Relationship: _______________ Date of Birth: __________

I hereby authorize the staff of Progressive Women's Care to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary and that I may revoke this authorization at any time by notifying Progressive Women's Care in writing. I understand that once this information is disclosed, the released information may no longer be protected by federal privacy regulations.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing this authorization.

This authorization shall be in force until revoked by the patient or representatives signing the authorization.

____ ________________________
Signature of the patient or patient's guardian/representative Date

____
Practice Representative

Progressive
WOMEN'S CARE

Ann Bertles, M.D.
23232 Kingsland Blvd Suite E
Katy, TX 77494
Phone: 832-437-9690 Fax: 832-437-9694

NEW PATIENT HISTORY

DATE ______________________

PERSONAL PROFILE

NAME	NAME YOU WOULD LIKE US TO USE:
AGE	OCCUPATION
BIRTH DATE	MARITAL STATUS

RACE:	ETHNICITY:	LANGUAGE:

GYNECOLOGICAL HISTORY

ARE YOU CURRENTLY PREGNANT?	CURRENT BIRTH CONTROL:
LAST MENSTRUAL PERIOD (FIRST DAY):	LAST PAP SMEAR: RESULT:
AGE PERIODS BEGAN:	ABNORMAL PAP IN PAST? ___ NO___ YES DATE_______
NUMBER OF DAYS BLEEDING:	LAST MAMMOGRAM
NUMBER OF DAYS BETWEEN PERIODS:	ABNORMAL MAMMOGRAMS/BREAST BOIPSIES IN THE PAST?
ANY RECENT CHANGES IN PERIODS?	_____NO _____YES DATE _______________
ARE YOU CURRENTLY SEXUALLY ACTIVE?	LAST COLONOSCOPY RESULT:
SEXUAL ORIENTATION:	LAST BONE DENSITY EXAM RESULT:

OBSTESTRIC HISTORY

TOTAL PREGNANCIES:	FULL TERM	ABORTIONS	ECTOPIC	MISCARRIAGES	PREMATURE (<37 WKS)	LIVING CHILDREN

PLEASE LIST EACH PREGNANCY BELOW:

DATE	WEIGHT OF BABY	SEX M OR F	WEEKS PREGNANT	COMPLICATIONS	VAGINAL OR C-SECTION DELIVERY
1.					
2.					
3.					
4.					
5.					

MEDICATIONS (INCLUDE OVER THE COUNTER)

	DRUG NAME/DOSE		DRUG NAME/DOSE
1		4	
2		5	
3		6	

MEDICATION ALLERGIES

1	
2	
3	
4	

SOCIAL HISTORY

CIGARETTES: ____NEVER ____ CURRENT ____ PAST _____PACKS PER DAY _____ YEARS

ALCOHOL: NONE _____# DRINKS PER DAY _____ #DRINKS PER WEEK

RECREATIONAL DRUGS (DESCRIBE) _____ CURRENT _____ PAST _____ NEVER

HAVE YOU BEEN SEXUALLY ABUSED, THREATENED OR HURT BY ANYONE? ____ NO ____ YES

PERSONAL AND FAMILY MEDICAL HISTORY			
HAVE YOU OR A FAMILY MEMBER HAD ANY OF THE FOLLOWING CONDITIONS (PAST OR CURRENT)			
	SELF	FAMILY MEMBER	DETAILS (DATE/DESCRIPTION)
ABNORMAL HAIR GROWTH/HAIR LOSS			
ABNORMAL VAGINAL DISCHARGE			
ABNORMALLY PAINFUL/HEAVY PERIODS			
ARTHRITIS/JOINT PROBLEMS			
ASTHMA OR LUNG DISEASE			
BIRTH DEFECTS			
BLOOD CLOTS IN LEGS OR LUNGS			
BLOOD TRANSFUSION			
BOWEL PROBLEMS			
CANCER			
CYSTIC FIBROSIS			
DEPRESSION/ANXIETY			
DIABETES			
DOWNS SYNDROME			
ENDOMETRIOSIS			
HEART PROBLEMS			
HERPES			
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
INFERTILITY			
INVOLUNTARY LOSS OF STOOL			
INVOLUNTARY LOSS OF URINE			
IRREGULAR OR ABSENT PERIODS			
KIDNEY INFECTIONS/STONES			
LUMPS OR BREAST PAIN			
LUPUS/RHEUMATOID DISEASE			
MENOPAUSE SYMPTOMS			
MIGRAINES/HEADACHES			
REFLUX/STOMACH ULCER			
SEIZURES			
SEXUALLY TRANSMITTED DISEASES			
SICKLE CELL DISEASE			
STROKE			
SUBSTANCE ABUSE			
THYROID DISEASE			
UNEXPLAINED WEIGHT LOSS OR GAIN			
UTERINE FIBROIDS			
OTHER FAMILY HISTORY			

FAMILY HISTORY

MOTHER: _____ LIVING _____ DECEASED – AGE/CAUSE OF DEATH

FATHER: _____LIVING _____ DECEASED – AGE/CAUSE OF DEATH

SIBLINGS: #LIVING______ #DECEASED______ AGES/CAUSES OF DEATH

OPERATIONS/HOSPITALIZATONS

PROCEDURE/REASON HOSPITALIZED	DATE	HOSPITAL	COMPLICATIONS
1			
2			
3			
4			
5			
6			

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 congestion

BREASTS breast lumps breast tenderness nipple discharge

CARDIOVASCULAR chest pain irregular heart beat

RESPIRATORY shortness of breath cough wheezing

GASTROINTESTINAL nausea vomiting diarrhea constipation abdominal pain

SKIN rashes skin lesions

NEUROLOGICAL seizures tingling numbness

MUSCULOSKELETAL joint pain joint swelling

ENDOCRINE hair loss temperature intolerance abnormal hair growth

GENERAL INFORMATION

PRIMARY CARE PHYSICIAN:

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE:

ARE YOU HERE TODAY FOR A _____ ROUTINE ANNUAL EXAM OR A _____ PROBLEM?

IF YOUR VISIT IS FOR A PROBLEM, PLEASE DESCRIBE:

HAVE YOU RECEIVED A FLU SHOT? YES NO

PHARMACY NAME & PHONE NUMBER: ____

THANK YOU!!

NAME: ____ DATE OF BIRTH: _____________

ARE YOU EXPERIENCING PAIN?

Over the last 2 weeks, how often have you been bothered by the following problems? Circle the number in the appropriate column.	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? Check the appropriate answer on the right please.	Not difficult at all __________ Somewhat difficult _________ Very difficult _________ Extremely difficult __________