

Steven A. Hoffman, M.D., F.A.C.O.G. • Shelley B. Ramos, M.D., F.A.C.O.G. • Jennifer L. Staud, M.D., F.A.C.O.G. • Rebecca Hardesty, PA-C

PATIENT REGISTRATION FORMOFFICE USE
ONLY:

Today's Date: _____ Who may we thank for referring you? _____

Emergency Contact: _____ Relation: _____ Phone#: _____

PATIENT INFORMATION - every line must be completed

Last Name: _____ First Name: _____ Middle Initial: _____

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

HM Phone: _____ WK Phone: _____ Cell: _____ Date of Birth: _____

Gender: Male Female Marital Status: _____ Email: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____

INSURED INFORMATION (person responsible for payment) - complete every line

Last Name: _____ First Name: _____ Middle Initial: _____

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

HM Phone: _____ WK Phone: _____ Cell: _____ Date of Birth: _____

Gender: Male Female

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Name on Policy: _____

Relationship to Patient: _____

Policy# _____ Group# _____

- Do you have an Advance Directive: **Y** or **N** - Directive to Physicians (Living Will)? **Y** or **N**- Durable Power of Attorney for Health Care? **Y** or **N** - A Do-not Resuscitate (DNR)? **Y** or **N**

If you have any of the above, please provide our office with a copy.

I hereby authorize payment of medical benefits to Shelley Ramos MD, Steve Hoffman MD, Jennifer Staud MD for services furnished. I further authorize the release of any medical information required to process any insurance claim on my behalf. I permit a copy of authorization to be as the original.

Patient's Legal Signature: _____ Date: _____

Date: _____

Patient Medical History

Tuscan OBGYN Associates

Name: _____

DOB: _____

Current medications: _____

Allergies: _____

Medical History: Please circle any of the following:

- | | | |
|-------------------|---------------------|-----------------|
| Anemia | Diabetes | Kidney disease |
| Asthma | Epilepsy | Liver disease |
| Arrhythmias | Heart attack | Stroke |
| Blood clots | Hemorrhoids | Thyroid disease |
| Blood transfusion | Hepatitis | Ulcers |
| Cancer | High blood pressure | Other |
| Depression | HIV | |

Surgeries: _____

Social History:

Do/did you smoke: Y N	How many per day: _____	Quit? _____
Do you drink alcohol: Y N	How much per week: _____	
Do you use street drugs: Y N	What kind: _____	
Ever had a blood transfusion? Y N		

Gynecologic History:

Have you ever had a pap smear: Y N

At what age did your menstrual cycles begin: _____

How many days between the first days of cycles: _____

Or are you irregular: Y N

How many days does bleeding last: _____

Is your menstrual flow: Light Moderate Heavy

Is your menstrual cramping: Mild Moderate Severe

Any specific concerns today: _____

When was your last pap smear: _____

Any abnormal paps before: Y N

Any treatment: _____

History of HPV? Y N

- Any history of sexually transmitted infections:
- Chlamydia
 - Genital warts
 - Gonorrhea
 - Herpes

Name: _____ Date: _____

OB History:

Have you ever been pregnant: Y N

How many times: _____

Term deliveries: _____ C-sections: _____ Vaginal del: _____

Preterm deliveries: _____

Miscarriages: _____

Terminations: _____

Any complications: _____

Family History:

Heart disease

Stroke

Blood clots

Breast cancer

Uterine cancer

Ovarian cancer

Colon cancer

Please circle any current or recent symptoms:

Unexpected weight gain

Dizziness

Blurry or double vision

Fatigue

Numbness or tingling

Fainting

Difficulty walking

Hearing loss

Coughing up blood

Chest pain

Shortness of breath

Irregular heart beat

Sudden urges to urinate

Frequent urination

Burning with urination

Leaking urine with coughing or sneezing

Fever/Chills

Joint swelling

Sore throat

Nose bleeds

Nasal drainage

Lumps on neck

Nausea

Vomiting

Diarrhea

Heartburn

Blood in stools

Change in bowel habits

Bleeding between periods

Unexpected bleeding

Vaginal discharge or odor

Vaginal itching or burning

Medical Records Release Form

To (Physician, Clinic, or Hospital name): _____
Street Address, City, State and Zip _____

Telephone and Fax Numbers: _____

This authorizes you to provide a copy, summary, or narrative of my medical records (as indicated by the checkmark(s) below) or otherwise release confidential information.

Patient Printed Name _____ Date of Birth _____

- Complete record
- Records of care from the following dates: _____ to _____
- Records concerning the following conditions: _____
- Other, please specify: _____
- Confer with person(s) listed below orally about my medical information:

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS/HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records **Initial:** _____ **Date:** _____

Release to the following person(s):

Tuscan OB/Gyn Associates
Steven A. Hoffman, M.D., Shelley B. Ramos, M.D.,
Jennifer Staud, M.D.
701 Tuscan Drive, Suite 200
Irving, Texas 75039
(972) 401-3200 fax (972) 401-3230

The reasons or purposes for this release of information are as follows:

Patient Signature: _____ **Date:** _____

I understand that you will provide this information within 30 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

PHYSICIAN ASSISTANT CONSENT FORM
Tuscan OBGYN Associates

This practice utilizes Physician Assistants (PAs) to provide healthcare. PAs are educated, licensed, and nationally certified providers that work in conjunction with a supervising Physician. There is on-going communication between the physician and the PA regarding patient care. If at any time a patient requests an appointment with the physician, this request will be granted at the first availability.

I have read the above information regarding Physician Assistants. I hereby give my consent for treatment.

Signature

Date

PATIENT RECORD OF DISCLOSURE

The HIPAA privacy rule allows for patients to request certain restrictions on uses and disclosure of PHI (personal health information).

I wish to be contacted in the following manner (CIRCLE your authorizations). If you do not circle an answer, you are giving permission to use that contact method.

Home Telephone:

Yes / No Leave a message with detailed Information.
Yes / No Leave name and a call back #.

Written Communication:

Yes / No Mail PHI to my home.
Yes / No Mail PHI to my work.
Yes / No Fax PHI to my work.
Yes / No Fax PHI to my home.

Work Telephone:

Yes / No Leave a message with detailed Information
Yes / No Leave name and a call back #.

Other:

I authorize release of my PHI to the following person(s) (*Example: Spouse, Parents, Friend etc.*): Length of release: Start date: _____ Ending date: _____

I understand it is my responsibility to provide this office with written changes to the release of my PHI.

Acknowledgement of Review of Privacy Practices for the Office of Tuscan OBGYN Associates

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 Guardian

Date

Description of Guardian or Representative

NOTICE OF PRIVACY POLICIES

Tuscan OBGYN Associates

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

Tuscan OBGYN Associates is committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective March 25, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit our office, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Tuscan OBGYN Associates the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations.
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Tuscan OBGYN Associates is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer. If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

PRINT NAME

SIGNATURE

DATE