Woodus OBSTETRICS & GYNECOLOGY

918 E. Pleasant Run Rd., #110 Cedar Hill, TX 75104
Phone: 469-206-9080
frontdesk@woodusobgyn.com

New Patient Exam Information Sheet

Patient Name _____ Patient Date of Birth _____ Patient Social Security # _____

Street Address _____ City, State & Zip code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ Pharmacy Address/Phone: _____

Patient Employer _____ Address _____

Spouse Information

Spouse Name _____ Spouse Date of Birth _____ Spouse Social Security # _____

Spouse Employer _____ Spouse Address (if different) _____

Spouse Cell Phone _____ Spouse Work Phone _____

Emergency Contact Information

IN CASE OF EMERGENCY, NOTIFY: _____
Emergency Name (other than spouse)

Emergency Contact Address _____ Emergency Contact Phone _____

Referral

Who may we thank for your referral? _____

Insurance Information

Insurance Information Payment is requested at the time of service, unless prior arrangements have been made

Insurance Company _____ Name of Primary Insured _____

Authorization to Release Information and Assignment of Benefits

☐By checking the box on the left, I certify that information I have reported about my insurance is correct.
☐By checking the box on the left, I authorize the release of any medical information necessary to process this claim.
☐By checking the box on the left, I authorize my doctor to apply for benefits on my behalf for covered services rendered by him or her, or by his or her order. I request that payment from my insurance company be made directly to my doctor or to the party who accepts assignment.
☐By checking the box on the left, I permit a copy of this authorization to be used in place of the original. This authorization may be revoked in writing by either me or my insurance company.
☐By checking the box on the left, I understand that I am financially responsible for the charges not covered by my insurance.

Signature _____ Date _____

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Patient Medical History & Physical

_____ _____
Patient Name Date of Last Examination

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Education (circle highest grade completed) ☐ 6th ☐ 7th ☐ 8th ☐ 9th ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ or More
High School College

_____ _____ _____
Occupation How Long? Previous Occupation

Doctors Notes _____

_____

Are you legally disabled? ☐ Yes ☐ No _____
Describe Disability

Do you use tobacco now? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

_____ _____
Type and daily amount of tobacco use? How long have/did you use tobacco?

Do you use alcohol now? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

_____ _____
Type and daily amount of alcohol use? How long have/did you use alcohol?

Do you use recreational drugs? ☐ Yes ☐ No
Do you use exercise regularly? ☐ Yes ☐ No _____
Please describe your exercise routine

Do you use follow a special diet (e.g. low cholesterol)? ☐ Yes ☐ No _____
Please describe your diet regime

Are your periods regular? ☐ Yes ☐ No _____ _____
Date of last period Any problems with your periods?

Family History

Relationship	Living?	Age or age at death	Describe any health problems or cause of death
Father	☐ Yes ☐ No		
Mother	☐ Yes ☐ No		
Spouse	☐ Yes ☐ No		

_____ _____
Ages of Brothers/Sisters List of Sibling Health Problems

_____ _____
Ages of Children(s) List of Children(s) Health Problems

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_____

Patient Name

Please check illnesses which have occurred in your blood relatives

☐Diabetes ☐Heart Attacks ☐Nervous Illness ☐Breast Cancer ☐Stroke ☐High Blood Pressure ☐Thyroid Problems ☐Asthma/Hay Fever

_____

Allergies (to medications)

_____

Medications (include vitamins, oral contraceptives, dosages and any you recently discontinued)

_____

Medications continued

_____

What percentage of time do you take medications exactly as prescribed?

Health Maintenance (Please indicate the year you last had any of the following):

_____	_____	_____	_____	_____
TB Skin Test	Pap Smear	Immunizations	Hepatitis B	Rubella
_____	_____	_____	_____	_____
Eye Exam	Mammogram	Tetanus	Stool for Blood	Cholesterol
_____	_____	_____	_____	
Proctoscopy	Urine Test	Influenza	Pneumovax	

_____

Surgeries, list type and year (include appendix, hysterectomy, biopsies, etc.)

_____

Surgeries continued

_____

Medical illnesses (e.g. diabetes, cancer, asthma, heart or kidney trouble, nervous disorder)

_____

Medical illnesses continued

_____

Main reason you are here

_____

Main symptom(s)

Doctor's Notes: _____

_____

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HRT Checklist For Women

_____ _____
Patient Name Date

_____
Email Address

Symptom(s) (please check)

Depressive Mood	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Memory Loss	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Mental Confusion	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Decreased Sex Drive / Libido	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Sleep Problems	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Changes / Irritability	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Tension	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Migraine / Severe Headaches	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Difficult To Climax Sexually	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Bloating	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Weight Gain	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Vaginal Dryness	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Hot Flashes	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Sweats	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Dry and Wrinkled Skin	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Hair is Falling Out	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Cold All The Time	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Swelling All Over The Body	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Joint Pain	☐ Never	☐ Mild	☐ Moderate	☐ Severe

Family History

Heart Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No
Breast Cancer	☐ Yes	☐ No

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Acknowledgement for Consent to Use and Disclosure of Protected Health Information (PHI)

Use and Disclose of your Protected Health Information (PHI)

Your Protected Health Information will be used by Dr. Tiffany Woodus or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day heath care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information (PHI) may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information. This office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Authorization To Retrieve Medication Records

I authorize Woodus Obstetrics and Gynecology to retrieve my complete medication profile from my insurance, pharmacy, or other third party source. I understand this information will be kept confidential and used only to aid in my ongoing treatment.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

☐ Agree ☐ Deny

Please list others we may release your PHI to: _____

Phone Calls

By providing contact information, I authorize Woodus Obstetrics & Gynecology, its assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/employment telephone; leave detailed voice or text messages; and use pre-recorded /artificial/ voice messages and/or auto-dialing devices in connection with any communication to me.

Signature _____ Date _____

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General Consent for Treatment

General consent to Treatment: By signing below, I, (or my authorized representative on my behalf) authorize Dr. Tiffany Woodus and her staff to conduct any diagnostic examinations, tests, and procedures deemed necessary in my care. I authorize the provision of any medications, treatment or therapy necessary to effectively assess and maintain my health or diagnose and treat my illness or injury. I understand that it is the responsibility of Dr. Woodus to explain the rationale for diagnostic tests or procedures, the available treatment options, common risks and benefits or procedures, and alternative treatment options.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended by Dr. Woodus. I also understand that the practice of medicine is not an exact science and no guarantees have been made regarding the results of my evaluation and/or treatment.

_____ _____

Signature Date

Photo Release: I understand that I choose to send correspondence such as family photographs or birth announcements to the office of Dr. Tiffany Woodus, the photos contained in these items may be displayed in public areas in the office. I understand that I have the right to request the photographs be kept private and will include a request of privacy with the correspondence if privacy is desired.

I hereby give permission for images of me, captured during the Woodus Obstetrics & Gynecology event through video, photo, and digital camera, to be used solely for the purposes of Woodus Obstetrics & Gynecology promotional material and publications, and waive any rights of compensation or ownership thereto.

_____ _____

Signature Date

These consents remain active unless revoked in writing by patient or authorized representative.

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Disability & FMLA Fee Schedule

Dr. Tiffany Woodus charges an administrative fee for the completion of certain work-related documents presented by patients. These documents include Disability Insurance Benefits Forms, Family and Medical Leave Act (FMLA) forms and return to work forms.

Typically, your employer or insurance company requires these forms when a medical condition prevents you from reporting to work. A licensed medical professional must sign these documents verifying that the information is correct. In the event that you need Dr. Tiffany Woodus to complete one or more of these forms, we will be happy to assist you. The fee for this service is $30.00 per patient.

Please follow these steps to ensure the timely completion of your forms:

- Obtain a copy of the forms from your employer or insurance company.
- Complete and sign all parts of the form that are to be completed by the employee.
- Mail or drop off the form(s) at our office and pay the required fee either in person, by credit card over the phone or you may also mail a check.
- Please allow 10 business days for the completion. We will notify you as soon as your forms are available for pick up.

By signing below, I state that I have read and understand all office protocol for disability and FMLA forms.

_____ _____
Patient Name Date

_____
Signature