CONTACT INFORMATION

Name: _____

DOB: _____

Mailing Address: _____
City _____ **State** _____ **Zip Code** _____

Best Contact Phone #: _____

Marital Status: _____

Email Address: _____

Pharmacy Name: _____
Pharmacy Phone #: _____
Pharmacy Address: _____
City _____ **State** _____ **Zip Code** _____

PATIENT HISTORY

Name _____ Age _____ Marital Status_____
Family Doctor _____
Current health problems _____
Current medications and doses
_____
Allergies _____
Surgeries & Date _____
Smoking (cigs/day) _____ Alcohol (drinks/week) _____ Street drugs _____
Exercise (type & frequency) _____

Past Medical / Family History

(S=self & F=family; Explain)

___ Asthma _____
___ Breast Cancer _____
___ Colon Cancer _____
___ Ovarian Cancer _____
___ Diabetes _____
___ Depression _____
___ Blood Transfusion _____
___ Osteoporosis _____
___ Hepatitis _____
___ Heart Disease _____
___ High Blood Pressure _____
___ Kidney Problems _____
___ Phlebitis _____
___ Thyroid Problems _____
___ Reaction to Anesthesia _____
___ STD(s) _____

Gynecological History

Age at first period _____ Date last period began _____ Period starts every _____ days
Bleeding lasts _____ days Pads/tampons used per day _____ Cramps: __ none __ mild __ severe
Menstrual/premenstrual problems: _____
Present birth control _____
Last pap smear ___/___/___ Result _____ Abnormal pap requiring treatment Y or N
If yes, explain _____
Last mammogram ___/___/___ Result _____

Bladder Problems

Frequency: going to the toilet often	__ A little __ Moderate __ Alot
Nocturia: getting up at night to void	__ A little __ Moderate __ Alot
Urge Incontinence: urinary leakage with strong desire to urinate	__ A little __ Moderate __ Alot
Stress Incontinence: urinary leakage with activity (cough,sneeze,run)	__ A little __ Moderate __ Alot
Nocturnal Enuresis: wetting the bed at night	__ A little __ Moderate __ Alot
Intercourse Incontinence: urinary leakage with intercourse	__ A little __ Moderate __ Alot
Waterworks	__ A little __ Moderate __ Alot
Bladder Pain	__ A little __ Moderate __ Alot
Infections	__ Frequent __ Infrequent

Do these bladder problems limit you physically or socially?	__ Yes __ No
Do these bladder problems affect your personal relationships?	__ Yes __ No
Do you wear pads to keep dry?	__ Yes __ No
Do you limit your fluid intake due to your bladder problems?	__ Yes __ No
Do you have to change your clothes due to bladder incidents?	__ Yes __ No

- ☐ I have had difficult vaginal births
- ☐ My labia are larger/looser than I want
- ☐ My vagina feels too loose inside
- ☐ I do not like the way my labia look
- ☐ I have decreased sensations
- ☐ I have a difficult time achieving an orgasm
- ☐ My labia rub, tug and pull on my clothing
- ☐ I feel pelvic heaviness and/or pressure
- ☐ I am unable to wear the type of clothing I want (swim suits, yoga pants, etc.)
- ☐ Sex is uncomfortable/unpleasant
- ☐ My vagina is dry and uncomfortable

Obstetrical History

Number of pregnancies _____ Living children _____

Problems in pregnancies _____

_____ _____

Signature Date

Nathan T. Thomas, MD, FACOG
Board Certified in Obstetrics & Gynecology

Medical Information Release Form

(HIPAA Form)

Name: _____ Date of Birth: ___/___/___

Release of Information

☐ I authorize the release of information including examinations rendered to me, medical diagnosis and billing information. This information may be released to:

Name: _____ Relationship: _____

☐ Information is not to be released to anyone.

Messages

If unable to reach me (select all that apply):

☐ You may leave a detailed message
☐ Please leave a message asking for me to return your call
☐ You may text me to contact the office

Emergency Contact

Name: _____ Relationship: _____

Phone Number: _____

This **Release of Information** will remain in effect until terminated by me in writing.

_____ _____

Signature Date

Nathan T. Thomas, MD, FACOG
Board Certified in Obstetrics & Gynecology

Patient Financial Responsibility & HIPAA Form

Thank you for choosing Dr. Nathan Thomas for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays, deductibles and coinsurance charges are due at the time of service.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
    - Charge for returned checks - $30.00

By my signature below, I hereby authorize the assignment of financial benefits directly to Dr. Nathan Thomas and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient HIPAA Acknowledgement and Authorization

- We respect patient confidentiality and only release personal health information about you in accordance with the State and Federal law. The attached notice describes our policies related to the use of the records of your care and how you may get access to this information. Please review this policy carefully.
- Your signature below signifies your consent to the use and disclosure of your PHI by our office during treatment, billing, reimbursement and medical office operations as outlined in our Notice. You agree and consent that your PHI may be communicated to you via telephone, text messaging, postal service or email (encrypted or unencrypted).

By my signature below, I acknowledge that I have received and read the privacy notice provided by Dr. Nathan Thomas. I hereby authorize Dr. Nathan Thomas, staff and hospitals associated with this office to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.

Patient Name _____ **Date** _____

Patient/Guardian Signature _____

Nathan T. Thomas, MD, FACOG
Board Certified in Obstetrics & Gynecology

Cancellation, Reschedule and No Show Policy

This office requires a 24 hour notice for all scheduled appointments. Failure to do so will result in a $50 fee, which must be paid prior to rescheduling the missed appointment or scheduling any future appointment.

Any appointment that is a No Show will also result in a $50 fee.

By signing this form, you are acknowledging the new cancellation, reschedule and no show policy and accepting responsibility.

_____ _____

Signature Date