P. Ronen, M.D., P.A.,F.A.C.O.G.

OBSTETRICS • GYNECOLOGY ENDOCRINE INFERTILITY

CONFIDENTIAL PERSONAL HEALTH INFORMATION

TODAY'S DATE _____

NAME _____ AGE _____ DATE OF BIRTH _____

ADDRESS _____ HOME PHONE _____

Street, P.O.Box, City, State, Zip Code

S.S.NO. _____ DRIVER'S LICENSENO._____ WORK PHONE _____

HUSBAND'SNAME _____

RELIGIOUS PREFERENCE _____ HOMETOWN_____

PATIENTS EMPLOYER _____ OCCUPATION_____

BUSINESS ADDRESS _____

INSURANCE COMPANY _____

INSURANCE GROUP NO. AND ID# _____

MAIL CLAIMS TO _____

HUSBAND'S EMPLOYER _____ WORK PHONE _____

ARE YOU COVERED BY HUSBAND'S INSURANCE? YES____ NO____ HUSBAND'S S.S.# _____

INSURANCE COMPANY _____ DOB: _____

INSURANCE GROUP NO AND ID# _____

MAIL CLAIMS TO_____

PERSON TO NOTIFY IN EMERGENCY_____ PHONE_____

Other than Spouse

MEDICATION ALLERGIES _____

_____

REFERRED BY_____

Name Address Phone

Marital History:

Single _____ Married _____ Separated _____ Widowed _____ Divorced _____ No. Yrs Married _____

No. of Pregnancies _____ No. of Miscarriages _____ No. of Living Children _____

Contraception used? Yes ☐ No ☐

Check Method used: Diaphragm ☐ Condom ☐ Rhythm ☐ Withdrawal ☐ Birth Control Pills ☐ IUD ☐ Vasectomy ☐ BTL ☐

List Medications Taking (including hormones and birth control pills):

_____

_____

List Serious Illnesses, Hospitalizations and Major Surgery:

_____

_____

List Complaints or Reason for visit today:

_____

_____

Payment Requested with first visit.

Patient Name _____ Account # _____

Previous Pregnancies:

Please give all the information in regard to your previous pregnancies by filling in the spaces below. If information is unknown, leave space blank.

No.	Year of Birth	Length of Pregnancy In Months	Birth Weight of Infant	Sex	Number of Hours In Labor	Was Delivery Normal or Abnormal	Complications Yes	Complications No	Total Weight Gain During Pregnancy
1									
2									
3									
4									
5									
6									
7									
8									

Miscarriages:

No.	Year	How far along in Pregnancy (Months)	Cause	Was Curettage Performed Yes	Was Curettage Performed No	Complications Yes	Complications No
1							
2							
3							
4							

List Complications of Pregnancy _____

_____

_____

_____

_____

Medical Illnesses: Check (√) each of the following diseases that you have had. Insert year if known.

Yes	No		Year	Yes	No		Year
☐	☐	Measles	_____	☐	☐	Heart Disease	_____
☐	☐	Mumps	_____	☐	☐	Kidney Disease	_____
☐	☐	Chickenpox	_____	☐	☐	Epilepsy	_____
☐	☐	German Measles	_____	☐	☐	Mental Disease	_____
☐	☐	Poliomyelitis	_____	☐	☐	Venereal Disease	_____
☐	☐	Rheumatic Fever	_____	☐	☐	Diabetes	_____
☐	☐	Scarlet Fever	_____	☐	☐	Thyroid Disease	_____
☐	☐	Tuberculosis	_____	☐	☐	Operations or Injuries	_____
☐	☐	Allergies	_____	☐	☐	Blood Transfusions	_____
☐	☐	Drug Sensitivities	_____	☐	☐	High Blood Pressure	_____
☐	☐	Blood Disease	_____	☐	☐	Varicose Veins or Phlebitis	_____
☐	☐	Herpes	_____	☐	☐	Severe Depression	_____
☐	☐	Do you smoke?	_____	☐	☐	Other	_____

☐

Patient Name _____ Account # _____

Family History: Check (√) Yes, if applies.

Have your grandparents, parents, brothers, sisters, uncles, aunts or children ever been treated for:

Yes	No		Year	Yes	No		Year
☐	☐	Cancer	_____	☐	☐	Epilepsy	_____
☐	☐	Diabetes	_____	☐	☐	Nervous Breakdown	_____
☐	☐	Tuberculosis	_____	☐	☐	Glaucoma	_____
☐	☐	Heart Disease	_____	☐	☐	Severe Deafness	_____
☐	☐	Kidney Disease	_____	☐	☐	Blood Disease	_____
☐	☐	High Blood Pressure	_____	☐	☐	Nervous Disorders	_____
☐	☐	Hay Fever or Asthma	_____	☐	☐	Muscular Disorders	_____
☐	☐	Is there any history of twins	_____	☐	☐	Is there any history of birth –defects	_____

Gynecological History: Check (√) Yes or No. Fill in blank spaces where appropriate.

Do you have menstrual periods? Yes ☐ No ☐ Date of last menstrual period _____

If you do not have menstrual periods, when did they stop? _____

Up to this time periods have been: Regular ☐ Somewhat Irregular ☐ Completely Irregular ☐

If periods have been regular, the interval from the first day of one period to the first day of the next period is usually _____ days.

If periods have been irregular, the interval between periods ranges in length from _____ to _____ days.

Menstrual flow usually lasts for a total of _____ days.

Menstrual flow usually is: Scant ☐ Moderate ☐ Heavy ☐ Excessive ☐

Yes	No	
☐	☐	Do you usually have clots with your periods?
☐	☐	Are your periods usually painful?
		If painful: Mild ☐ Moderate ☐ Severe ☐ Incapacitating ☐
☐	☐	Do you have back pain with your menstrual periods?
☐	☐	Any other symptoms associated with periods?
☐	☐	Do you have any bleeding or spotting between periods?
☐	☐	Do you have any bleeding or spotting following sexual intercourse?
		Do you have any significant pain with sexual intercourse?
		Do you have any vaginal discharge or itching?
		Have you ever had a pap smear made? Yes ☐ No ☐ Date _____
		If so, was it normal? Yes ☐ No ☐
☐	☐	Have you ever missed periods without being pregnant?
		Menstruated first time at age of _____
		At first periods were: Regular ☐ Irregular ☐
☐	☐	Do you have hot flashes?
☐	☐	Are you taking hormones? (excluding birth control pills)

Urological History:

Yes	No	
☐	☐	Do you lose urine when you cough, sneeze, or lift heavy objects?
☐	☐	Do you have burning or pain with urination?
☐	☐	Do you have to strain and push to get a urinary stream started?
☐	☐	Do you urinate frequently and feel as if you never empty your bladder completely?
☐	☐	Have you had numerous bladder and kidney infections in the past?
☐	☐	Have you ever had a cystoscopic examination of the bladder?

Patient Name _____ Account # _____

Comments

Patient Name _____ Account # _____

P. Ronen, MD, PA

Office Procedure Policy

- Patients must notify our office at least 24 hours prior to her appointment if she needs to cancel or reschedule. Not showing up to your appointment means there will be a charge as follows. These charges will be your responsibility as insurance will not pay for it.

  1. First no show, or call same day to cancel/reschedule = no charge
  2. Second no show, or call same day to cancel/reschedule = $25.00
  3. Third no show, or call same day to cancel/reschedule = $50.00

- Dr. Ronen asks that you do not bring small children to your appointments. Obstetrical patients cannot be exposed to many childhood illnesses, and we ask this as a courtesy for their well-being.

- If you have any changes in insurance (either policy benefits, telephone number, id number), you are required to provide us with that information prior to your appointment. If you arrive for your appointment and have new information, you will need to wait while your benefits are verified, prior to seeing the doctor, or you may be asked to reschedule your appointment. If you provide the information after you are seen by the doctor, then you may be responsible for the total cost of the day's charges.

- **To refill your medications, you must either call the pharmacy or our office 72 hours (3 days) prior to your medication running out.**

- If you require forms for disability, or insurance applications, there will be a $25 fee per form. This is required prior to the form being filled out.

- Should you require your records to be copied, we will be happy to make copies. However, if the number of pages is greater than 10, there will be a fee for copying of the records. These fees are set forth by the Texas State Board of Medical Examiners. The fee is $25 for the first 20 pages, and 15¢ for each additional page.

Financial/payment policy:

You are responsible for all charges incurred during your visits to our office. We are contracted with many insurance companies and will file the claims for you. However, after 60 days, you will be responsible for the charges if the insurance company has not paid. Co-payments, co-insurance, or deductibles are required to be paid at the time of service. We refer lab work to Laboratory Corporation of America (Lab Corp). If your insurance's preferred lab is Quest or Lab One, please notify the front office, otherwise you will be responsible for any lab charges. I have read and understand the above policy and also understand that I am responsible for timely payment of my account.

_____ _____

Signature of patient (or legal guardian) Date

Patient Name _____ Account # _____

Acknowledgement of Review of Notice of Privacy Practices
Consent for Medical Treatment

I have reviewed this office's notice of Privacy Practices (copies in the waiting room), which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request. I also consent for medical services and treatment from the physicians and staff of P. Ronen, MD, PA.

_____ _____

Signature of patient (or legal guardian) Name of patient or legal guardian

_____ _____

Date Relation of guardian to patient

DO WE HAVE PERMISSION TO:

YES NO Leave a detailed message on your answering machine at home?
YES NO Leave a detailed message at your place of employment?
YES NO Leave a detailed message on your cell phone?
YES NO Discuss your medical condition with a family member?
YES NO Discuss your account with any person answering you home phone?

PLEASE LIST ALL PERSONS WITH WHOM WE CAN DISCUSS YOUR CARE OR ACCOUNT. THESE PEOPLE MAY ALSO BE CONTACTED IN THE CASE OF A MEDICAL EMERGENCY.

NAME	PHONE #	RELATIONSHIP
NAME	PHONE #	RELATIONSHIP
NAME	PHONE #	RELATIONSHIP

Family History Questionaire for Commom Hereditary Cancer Syndromes

Patient Name: _____ **Date of Birth:** _____ **Age:** _____ **Doctor's Name:** _____

Please mark below if there is a **personal or family history** of any of the following cancers. If yes, then **indicate family relationship** AND **age at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, & cousins.

COLON AND UTERINE CANCER (Colaris)

			You (age at diagnosis)	Siblings / Children (age at diagnosis) *Ex: Brother 36 yrs*	Mother's Side (Who + age at diagnosis) *Ex: Aunt 44 yrs*	Father's Side (Who + age at diagnosis) *Ex: Grandfather 65 yrs*
Y	N	Uterine (endometrial) cancer				
Y	N	Colon cancer				
Y	N	Ovarian, stomach, kidney/urinary tract, pancreatic, brain OR small bowel cancer				
Y	N	10 or more colon polyps found in a lifetime				

BREAST AND OVARIAN CANCER (BRCA)

Y	N	Breast cancer				
Y	N	Breast cancer in both breasts OR multiple primary breast cancers				
Y	N	Ovarian cancer				
Y	N	Pancreatic cancer				
Y	N	Male breast cancer				
Y	N	Prostate Cancer				
Y	N	Are you of Ashkenazi Jewish descent?				
Y	N	Breast Cancer diagnosis with Triple Negative Receptors: ER-, PR-, and HER2-				

Patient's Signature: _____ **Date:** _____

For Office Use Only: Patient offered hereditary cancer testing? YES NO
If YES ACCEPTED DECLINED *Patient Signature for Declining Testing* _____

Health Care Provider's Signature: _____ Date: _____

BRCA – Personal or Fam. History

One person with (out to 2nd degree)
- Breast Cancer at 45 or younger
- Ovarian Cancer at any age
- Male breast cancer any age
- Breast, Ovarian or Pancreatic + AJ Heritage
- Bilateral Breast at 50 or younger
- Triple Neg Br.Ca. at 60 or younger

BRCA – Personal or Fam. History

Two persons with (out to 3rd Degree)
- 2 Breast Cancers, w/1 ≤ 50 or younger
- Breast & Ovarian (any age)

Three Persons with (out to 3rd degree)
- Breast and/or Ovarian and/or Pancreatic Prostate – *any age / any combination*

Lynch Syndrome (Colon/ Endometrial)
Personally Affected with:
- Colon or Endometrial at ≤ 50 or younger

Family History: Two persons with (out to 2nd degree)
- Colon or Endometrial, + another Lynch Cancer (gastric, ovarian, brain, kidney, small bowel)
- 1 needs to be dx ≤ 50

Patient Name: _____ **Account #** _____

We recently upgraded our system and our new version requires some information required by the new government healthcare regulations that we have never needed before. Please indicate your answers on the following questions and return to the receptionist. Thank you for your understanding.

Ethnic Group:

- Decline to answer
- Hispanic or Latino
- Not Hispanic or Latino

Race:

- American Indian or Alaska Native
- Asian
- Black or African American
- Middle Eastern
- Other
- Pacific Islander
- White or Caucasian

Email address:

_____

Pharmacy Name: _____

Pharmacy location: _____

Pharmacy Phone #: _____