Seasons
OBSTETRICS
& GYNECOLOGY

Medical History Update

Patient Name _____ Date of Birth _____

1. Indicate any changes in your medical history, surgical history, family history, or social situation since your last visit.

   _____

2. When was the first day of your last menstrual cycle? _____

3. List all medications and dosages you are currently taking:

MEDICATION (INCLUDING OVER THE COUNTER)	DOSAGE	HOW OFTEN?

4. List all allergies/reactions to medications _____

5. Preferred Pharmacy _____ Location _____

6. Primary Care Physician First Name _____ Last Name _____

7. What is the reason for your visit today? _____

Please note: A "Well Woman Exam" is a preventative visit, which includes a Pap, pelvic, and breast exam. If you have any additional issues or concerns you would like addressed, you will be charged an office visit/copay if your provider can accommodate adding a problem visit to their schedule. If their schedule does not permit the additional time needed to address additional concerns, it may be necessary to schedule an appointment on a different day. We understand and regret the inconvenience this may cause, but these are the regulations of your insurance company and we are contractually obligated to follow them.

Patient/Guardian Signature _____ Date _____

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Patient Name: _____ **Date of Birth:** _____

PATIENT HEALTH QUESTIONNAIRE (PHQ9)

Use ✓ to indicate your answer

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than ½ the days**	**Nearly every day**
1. Little interest or pleasure in doing things				
2. Feeling down, depressed or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching T.V.				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead, or of hurting yourself in someway				
10. 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?				

Future Fall Risk and Plan of Care: If you are 65 years of age or older, it is recommended that you complete a fall risk assessment.

Have you had a fall(s) in the last year? Yes/No
If you answered yes , how many? _____ Did the fall(s) result in an injury? Yes/No

Please visit the American Geriatric's website for additional information to Fall Risk Assessment at www.americangeriatrics.org

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Patient Name: _____ **Date of Birth:** _____

BMI Screening: When your Height and Weight are entered into our Electronic Health Record, your Body Mass Index (BMI) is calculated automatically. If your BMI is considered above or below normal, we are required to give you information pertaining to a healthy lifestyle of diet and/or exercise. Please visit the Center for Disease Controls website for more information visit: http://www.cdc.gov/healthyweight/assessing/adultbmi/index.html

Pneumonia Vaccination Status: If you are 65 years of age or older, it is recommended that you get a Pneumococcal vaccination.

Have you had a Pneumonia Vaccination? Yes/No Approximate Date of your last vaccination?

If not, please talk with your Primary Care Physician about getting one. For more information on the Pneumococcal vaccine please visit the Center for Disease Control's website at:
http://www.cdc.gov/VACCINES/vpd-vac/pneumo/default.htm

Breast Cancer Screening: If you are a female 40-69 years of age, it is recommended that you get regular screenings for breast cancer. Although it is not necessarily related to your visit at our office, we are being required to ask if you have had these screening tests.

Have you had a mammogram? Yes/No Approximate date of your last mammogram: _____

If not, please talk to your Primary Care Physician or Gynecologist about ordering a mammogram. For more information on mammograms, please visit the American Cancer Society's website at: www.cancer.org

Colorectal Cancer Screening: If you are 50-75 years of age, it is recommended that you get regular screenings for colorectal cancer. Although it is not necessarily related to your visit at our office, we are being required to ask if you have had your screening test(s).

Have you had a colonoscopy? Yes/No Approximate date of your last colonoscopy: _____

If not, please talk to your Primary Care Physician about ordering a colonoscopy. For more information on colonoscopies, please visit the American Cancer Society's website at: www.cancer.org

Tobacco Use: If you are 18 years or older: Have you **ever** used any type of tobacco product (including smokeless products)?

Please circle: **NEVER** **CURRENT** **FORMER**

If **NEVER**, you are finished.
If CURRENT or FORMER, please answer the following questions to the best of your abilities:

1. Type of tobacco used: _____
2. How much per day: _____
3. Approximate age started: _____
4. Have you ever tried to stop? _____ If yes, approximate age: _____
5. What method did you use to try to stop (if applicable): _____
6. Approximate age stopped successfully (if applicable): _____

Please visit the Center for Disease Control's website for additional information onTobacco cessation at: www.cdc.gov/tobacco

MYRIAD myRisk Hereditary Cancer

Cancer Family History Questionnaire

Personal Information

Patient Name	Date of Birth	Healthcare Provider	Today's Date

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based upon your personal and family history of cancer. Leave blank what you do not know.
The following relatives should be considered: Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family.

Do you have a personal history of:	Yes (Y) or No (N)?	Which cancer?	Age at diagnosis?
Breast, **ovarian**, or **pancreatic cancer** at any age	☐ Y ☐ N		
Colorectal or **uterine cancer** at 64 or younger	☐ Y ☐ N		

Do you have a family history of:	Yes (Y) or No (N)?	Which relative?	Maternal (M) or Paternal (P) side of the family?	Age at diagnosis?
Breast cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Two **breast cancers** (bilateral) in one relative at any age	☐ Y ☐ N		☐ M ☐ P	
Three **breast cancers** in relatives on the same side of the family at any age	☐ Y ☐ N		☐ M ☐ P	
Ovarian cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Pancreatic cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Male breast cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Metastatic prostate cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Colon cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Uterine cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Ashkenazi Jewish ancestry with **breast cancer** at any age	☐ Y ☐ N		☐ M ☐ P	
Do you have a family history of **other cancers**?	☐ Y ☐ N	**List them here:**		
Have you or anyone in your family had genetic testing for hereditary cancer?	☐ Y ☐ N	**Who?**	**What gene(s)?**	**What was the result?**

Cancer Risk Assessment Review (to be completed after discussion with your healthcare provider)

Patient Signature _____ Date _____

Healthcare Provider Signature _____ Date _____

Office Use Only Patient offered hereditary cancer genetic testing? ☐ Yes ☐ No ☐ Accepted ☐ Declined

If yes, which test? ☐ BRAC*Analysis*® with Myriad myRisk® ☐ Multisite 3 BRAC*Analysis*® REFLEX to BRAC*Analysis*® with Myriad myRisk®
☐ COLARIS®PLUS with Myriad myRisk® ☐ COLARIS *AP*®PLUS with Myriad myRisk® ☐ Single Site Testing ☐ Myriad myRisk® Update
☐ Other: _____

Follow-up appointment scheduled? ☐ Yes ☐ No Date of next appointment: _____

PRIVIA MEDICAL GROUP NORTH TEXAS

PHYSICIAN: _____ BEING SEEN TODAY

LOCATION: _____ DATE: _____

PATIENT REGISTRATION INFORMATION

If Patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.

Social Security #: _____ Driver's License # _____ State: _____

Name: _____ ___ ___ ___/___/___ ___ S M D W O
LAST FIRST MI SEX DATE OF BIRTH (MM DD YY) AGE MARITAL STATUS

Address: _____ _____ _____ ___ _____ (___) _____
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

Alt/Cell Phone: (___)_____ Day Phone: (___)_____ Email: _____

Race_____ Language_____ Ethnicity ☐ Hispanic/Latin ☐ Non Hispanic/Latin

Full-Time Part-Time Retired Unemployed Student Employer's Name: _____
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School

Employer's Address: _____ _____ ___ _____
MAILING ADDRESS CITY ST ZIP

Occupation: _____

Emergency Contact: *(Please indicate a friend or relative not living at the same address.)*

_____ _____ (___) _____
NAME RELATIONSHIP EMERGENCY CONTACT #

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient is responsible unless a minor child or guardian. RESPONSIBLE PARTY SECTION must be completed.

Patient Relationship to Responsible Party: Child ____ Other _____ Resp. Party SS #: _____
SPECIFY

Name: _____ ___ ___ ___/___/___ ___ S M D W O
LAST FIRST MI SEX DATE OF BIRTH (MM DD YY) AGE MARITAL STATUS

Address: _____ _____ _____ ___ _____ (___) _____
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

Full-Time Part-Time Retired Unemployed Student Employer's Name: _____
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School

Employer's Address: _____ _____ ___ _____
MAILING ADDRESS CITY ST ZIP

Occupation: _____ (___) _____ (___)
WORK PHONE EXT

OTHER PATIENT INFORMATION

Spouse's Name: _____ Employer: _____

___/___/___ Spouse's Work Phone: (___) _____ (_____) Occupation: _____
DATE OF BIRTH EXT

PRIMARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (___) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ _____ _____ _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ ___ ___ ___/___/___ _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other_____
(SPECIFY)

Employer's Name: _____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Address: _____ _____ ___ _____
STREET CITY ST ZIP

SECONDARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (____) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ _____ _____ _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ ___ ____ ____/____/____ _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other _____
(SPECIFY)

Employer's Name: _____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Employer's Address: _____ _____ _____ _____
STREET CITY ST ZIP

WORKER'S COMPENSATION

Worker's Compensation Insurance Name: _____ Adj. _____

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

Claim #: _____ DOI _____

What Employer: _____

ACCIDENT INFORMATION

Was this the result of an accident? ___Yes ___No Where did it occur? ___At Work ___Auto Accident ___Other

Date of Accident_____Have you reported this injury to your employer? ___Yes ___No When _____

Describe accident briefly: _____

Do you have an attorney representing you? ___Yes ___No Who is the attorney? _____

REFERRAL INFORMATION

Who referred you? _____ Address: _____ Phone: _____

Family Physician _____ Address: _____ Phone: _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ

Privia Medical Group North Texas (PMG), and its physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that PMG has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to PMG, 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, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint PMG to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

_____ _____ _____ _____
PATIENT SIGNATURE DATE WITNESS SIGNATURE DATE

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician(s) and/or order another person to perform all exams, tests, procedures, injections, phlebotomy and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Dr. Lungren/Osborn, with Privia Medical Group North Texas unless revoked by me in writing.

_____

Patient Name/Legal Representative

_____

Date of Birth

_____

Date

Acknowledgement of Review of Notice of Privacy Practices

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 Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Privia Medical Group North Texas

HIPAA Authorization for Release of Patient Health Information

In general, HIPAA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. This information will remain in effect until revoked in writing, except to the extent that action has already been taken.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home or Cell Phone: _____
  - ☐ OK to leave a message with detailed information
  - ☐ Leave name and doctor with call back number only
- ☐ Work Telephone: _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave name & doctor with call back number only
- ☐ When unable to contact me by phone, a written communication may be sent to my home address.
- ☐ Other: _____

I consent and authorize the release of NORMAL test results to the following:

- ☐ Only Myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize the release of ABNORMAL test results to the following:

- ☐ Only myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize your office or a facility on my behalf, to conduct benefit verification services.

☐ Yes ☐ No

I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

☐ Yes ☐ No

Do you have an advanced directive (Living Will)?

☐ Yes ☐ No

I consent and authorize your office or facility to make calls and/or send text messages containing important information about my account including marketing information and past-due notifications through an automated telephone dialing system.

☐ Yes ☐ No

_____

Patient Signature (Must be an adult 18 yrs or older) Date

_____

Print Name Birthdate