

REGISTRATION
(PLEASE PRINT)



1330 North Beckley Avenue
Dallas, Texas 75203

Telephone: (214) 941-7200

Please Check Your Physician:

- Theresa M. Patton, MD
- Kecia L. Foxworth, MD
- Diane K. Huynh, DO
- Angelica Knickerbocker, MD
- Leslie Johnson, MD

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Middle Initial

Address _____ Email _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____ Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Primary Care Physician: _____ Pharmacy Preference: _____

Preferred Pharmacy Address: _____ Phone (____) _____

Emergency Contact: _____ Phone (____) _____ /Relationship _____

PRIMARY INSURANCE – MUST COMPLETE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Group # _____ ID # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (if different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Group # _____ ID # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ Name of Insurance Company(ies) _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient



Theresa M. Patton, MD
Kecia L. Foxworth, MD
Diane K. Huynh, DO
Angelica Knickerbocker, MD
Leslie Johnson, MD

FINANCIAL WAIVER

PATIENT NAME: _____ DATE OF BIRTH: _____

WE MAKE EVERY EFFORT TO VERIFY YOUR INSURANCE BENEFITS AND YOUR FINANCIAL RESPONSIBILITY AT TIME OF SERVICE PRIOR TO YOUR VISIT. **YOU ARE RESPONSIBLE FOR NOTIFYING US IF YOUR INSURANCE PLAN REQUIRES A REFERRAL OR PRECERTIFICATION.** WE OBTAIN REFERRALS AND PRECERTIFICATIONS WHEN WE HAVE BEEN ADVISED BY YOU THAT THEY ARE NECESSARY. OUR VERIFICATION CONFIRMATION IS AVAILABLE FOR YOUR REVIEW AT YOUR REQUEST.

MEDICAL SERVICES

INITIAL
HERE I AGREE TO PROVIDE ACCURATE, THOROUGH INFORMATION TO KESSLER WOMEN'S HEALTHCARE FOR THE PURPOSE OF BILLING MY INSURANCE COMPANY ON MY BEHALF FOR MY MEDICAL CARE.

INITIAL
HERE I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL MEDICAL SERVICES RECEIVED THAT ARE NOT A COVERED BENEFIT OF MY INSURANCE PLAN.

INITIAL
HERE I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR MEDICAL CLAIMS DENIED DUE TO LACK OF AUTHORIZATION OR REFERRAL IF I HAVE NOT PROVIDED THAT INFORMATION TO KESSLER WOMEN'S HEALTHCARE PRIOR TO RECEIVING MEDICAL CARE.

I HAVE READ, UNDERSTAND AND ACCEPT THESE TERMS FOR THE PROVISION OF MEDICAL SERVICES.

_____	_____
PATIENT	(SELF/GUARDIAN)
_____	_____
DATE	WITNESS

LABORATORY SERVICES

GENERALLY, MOST LABORATORY SPECIMENS ARE SENT TO CLINICAL PATHOLOGY LABORATORIES OR A SPECIALTY LABORATORY AT YOUR PHYSICIAN'S DISCRETION. A COPY OF YOUR INFORMATION AND INSURANCE CARD IS ALSO SENT. THEY WILL BILL YOUR INSURANCE (IF APPLICABLE) AND NOTIFY YOU OF YOUR RESPONSIBILITY.

YOU ARE RESPONSIBLE FOR NOTIFYING OUR STAFF AT THE TIME OF YOUR VISIT IF YOUR INSURANCE COMPANY OR EMPLOYER REQUIRES THAT YOUR LAB WORK BE PROCESSED AT A SPECIFIC LABORATORY.

REQUIRED LABORATORY: _____

IT IS MY DESIRE TO RECEIVE LABORATORY SERVICES AS NOTED ABOVE:

_____	_____
PATIENT	(SELF/GUARDIAN)
_____	_____
DATE	WITNESS



Designation for Release of Medical Information to a Family Member, Friend Or Legal Representative

It is the physicians' responsibility to ensure that the physician-patient relationship is confidential. This form is an aid to the physicians in making a determination on disclosing such information. Drs. LaRue, Patton, Foxworth, Huynh and Knickerbocker realize that there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medical needs. Your doctor wants you to be able, if you so desire, to name a person to whom you want the office staff to speak with about your medical condition. To enable that, we would ask that you complete the form listed below. Please note the following points:

- The designation is valid until you cancel it in writing.
- If you designate no one, Kessler Women's Healthcare may not be able to release information to any family member or friend.

Designation Statement

I, _____, designate the following person to speak to a physician at Kessler Women's Healthcare, PA, a nurse or other staff member on my behalf should it be necessary. I hereby give permission to Kessler Women's Healthcare, through its physicians and staff, to release to my designee any information about my medical condition or medical needs and I release Kessler Women's Healthcare, PA, its physicians and staff, from any claim of confidentiality in connection with the release of this information.

Name of Designated Person: _____ Relationship: _____

Phone Number: _____ (home /work)

Patient's Name: _____ Patient's SSN #: _____

Patient's Signature: _____ Date: _____

Witness: _____

OR

I decline to designate another person to speak with my physician or clinical staff.

Patient's Signature: _____

Date: _____ Witness: _____



E-PRESCRIBING PBM CONSENT FORM

Whenever possible, Kessler Women's Healthcare sends your prescriptions to your pharmacy through a process known as ePrescribing. ePrescribing is defined as a physician's ability to electronically send an accurate, error-free and understandable prescription directly to a pharmacy. ePrescribe is an important element in improving the quality of patient care and is required by many insurance companies.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain lists of drugs covered by your particular drug benefit plan.

ePrescribe programs must include:

- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** – Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent you agree that Kessler Women's Healthcare can request and use your prescription medication history from third party pharmacy benefit management for prescribing and treatment purposes.

Patient Name (printed) _____ Date of Birth ____/____/____

Signature of patient (or the representative) _____

Date ____/____/____ Relationship if other than patient _____

I do not consent

Signature _____ Date ____/____/____



KESSLER WOMEN'S HEALTHCARE

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Kessler Women's Healthcare creates and maintains health records and other information describing, among other things, my health history, symptoms, examination and test results, diagnosis, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and Practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement, activities, underwriting, premium rating, conducting or arranging for medical review, legal services and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and healthcare operations. I have the right to revoke this consent in writing except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment, or healthcare operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or healthcare operations, be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

Patient's Name Printed

Date

Patient's Signature (or Guardian, if Minor)

Social Security # (Identification Purpose Only)

Witness (Optional)

Date



PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction of uses and disclosures of their protected health information (*PHI*). The individual 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 the individual's home.

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

- | | |
|--|---|
| <input type="checkbox"/> Home Telephone _____
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only

<input type="checkbox"/> Work Telephone _____
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication
<input type="checkbox"/> O.K. to mail to my home address
<input type="checkbox"/> O.K. to mail to my work / office address
<input type="checkbox"/> O.K. to fax to this number

<input type="checkbox"/> Cell Telephone
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only

<input type="checkbox"/> Other _____
_____ |
|--|---|

_____	_____
Patient Signature	Date
_____	_____
Print Name	Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to, the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

For Office Use Only

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure / Purpose of Disclosure	By Whom Disclosed	(2)	(3)

- (1) Check this box if the disclosure is authorized
 (2) Type key: T=Treatment Records; P=Payment Information; O=Healthcare Operations
 (3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

MEDICAL HISTORY
(PLEASE PRINT)



Please Check Your Physician:

- Theresa M. Patton, MD
- Kecia L. Foxworth, MD
- Diane K. Huynh, DO
- Angelica Knickerbocker, MD
- Leslie Johnson, MD

Name: _____ Date of Birth: _____

Reason for Visit:

Annual Exam Problem: _____

Primary Care Physician: _____

Other Physicians seen & why? _____

PAST MEDICAL HISTORY

	✓ Yes	If yes, list date diagnosed
Alcoholism		
Anemia		
Anxiety		
Arthritis / Joint Problems		
Asthma		
Back Problems		
Bladder Problems		
Blood Clots		
Blood Transfusions		
Bowel Problems		
Cancer (Type)		
Chronic Lung Disease		
Depression		
Diabetes (Diet or Insulin)		
Endometriosis		
Fibroids		
Fracture (Which part of body)		
Gastric Reflux or GERD		
Glaucoma		
Heart Murmur / Mitral Valve Prolapse		
Heart Trouble		
Hepatitis / Liver Disease		
High Blood Pressure		
High Cholesterol		
High Triglycerides		
Kidney Infections / Disease		
Migraines		
Motor Vehicle Accident		
Seizure Disorder		
Stroke		
Thyroid Disorder		
Any Other not listed		

SCREENING TESTS: (Please list MOST RECENT results & where performed)

Cholesterol: _____
 Thyroid: _____
 Blood Count / Hematocrit: _____
 Mammogram: _____
 Bone Density: _____
 Colonoscopy: _____
 Pap Smear: _____
 Flu vaccine: _____ Pneumonia vaccine: _____ Hep B vaccine: _____ Tetanus: _____

PAST SURGICAL HISTORY

Year	Illness or Operation	Complications

MEDICATIONS (Prescription & non-prescription medications, vitamins, birth control, herbs, etc.)

Name	Dosage (mg)	Frequency	Date Started	Prescribing MD

ALLERGIES (Drugs, foods or latex)

REACTION

FAMILY HISTORY (Please fill in age of onset of each condition)

	Mother	Father	Sister	Brother	Mother's Mother	Mother's Father	Father's Mother	Father's Father	Aunt	Uncle
Blood Clots										
Bleeding disorder										
Breast cancer										
Colon cancer										
Dementia										
Diabetes										
Heart disease										
High blood pressure										
Osteoporosis										
Other cancers										
Ovarian cancer										
Stroke										
Thyroid Dz										

REPRODUCTIVE HISTORY

	Number		Number
Total Pregnancies		Miscarriages	
Full term births		Ectopic or tubal pregnancies	
Premature births (< 37 wks)		Multiple births (twins, etc.)	
Abortions / Terminations		Living children	

On the chart below, please fill in for each pregnancy – including miscarriages

	Date 00/00/00	Weeks pregnant	Length of labor	Birth wt.	Sex	Delivery type	Epidural (Y / N)	Preterm (Y / N)	Complications	Hospital or MD
1										
2										
3										
4										
5										

GYNECOLOGICAL HISTORY

Ever had **abnormal** Pap smear? Yes No When / what treatment: _____

Age periods began (menarche): _____ **Age periods ended** (menopause): _____

If still having periods: **Last menstrual cycle:** _____ / _____ / _____

Days between cycles: _____ Length of cycle: _____

Flow: Light Medium Heavy Clots: Yes No

of tampons/day: _____ # of pads/day: _____ Painful Cycles: Yes No

Recent change in cycles? No Yes How? _____

Sexually active? Yes No Do you have sex with? Men Women Both

Age you became sexually active: _____ # of partners in your lifetime: _____

DES exposure: Yes No

Please list birth control type: _____ Years used: _____

STD History: Chlamydia Gonorrhea Herpes Syphilis HIV PID HPV Trich

If menopausal, do you currently take hormone replacement? Yes No

Name: _____ Years used: _____

SOCIAL HISTORY

Occupation: _____

Marital Status: single married divorced domestic partner widowed

Religious Preference: Christian Jewish Muslim Hindu Catholic Other: _____

Tobacco use: Cigarettes: Never Socially

Current _____ packs/day x _____ yrs. Quit (date) _____

Alcohol use: No Socially Yes _____ drinks per week (beer wine liquor)

Is alcohol a concern for you or for others? No Yes

Drugs use: No Yes (type) _____

Have you ever used needles? No Yes

Safety: Do you use seatbelts consistently? No Yes

Is violence at home a concern for you? No Yes

Have you ever been abused? No Yes (when) _____

Exercise: Do you exercise regularly? No Yes

What kind? _____

How often? _____ How long? _____

Diet: Rate your current diet: Good Fair Poor **Take Calcium?** Yes No

REVIEW OF SYSTEMS: (please check all that apply to you today)

Constitutional	✓ Yes	Genitourinary	✓ Yes
Fever		Painful urination	
Chills		Leaking urine	
Weight gain		Urinary urgency	
Weight loss		Urinary frequency	
Fatigue		Blood in urine	
HENT		Urinating 2 or more times at night	
Sinus Pain		Vaginal discharge	
Congestion		Irregular bleeding	
Headaches		Painful periods	
Sore throat		Painful intercourse	
Breast		Genital sores / lumps	
Breast Lumps		Skin	
Nipple discharge		Dry skin	
Breast Pain		Acne	
Cardiovascular		New skin lesion	
Chest Pain		Musculoskeletal	
Heart palpitations		Back pain	
Respiratory		Joint pain	
Cough		Psychiatric	
Shortness of breath		Anxiety	
Wheezing		Depression	
Gastrointestinal		Difficulty sleeping	
Abdominal pain		Heme-Lymph	
Nausea		Easy bruising	
Vomiting		Easy bleeding	
Constipation		Unexplained lumps	
Diarrhea		Allergy	
Blood in stool		Hay fever	
Change in bowel habits		Seasonal	

Thank you for taking the time to fill out this health questionnaire.

Signature: _____

Date: _____