



PATIENT REGISTRATION

Please print clearly so that we can process your information quickly and efficiently. Thank you!

Name (First, M.I., Last) _____

Date of Birth _____ Age _____ Male / Female Marital Status: S M W D

Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email: _____ Social Security # _____

Employer _____ Full-Time / Part-Time

Employer Address _____

Referring Physician _____ Phone _____

If Student, School Name _____ Full-Time / Part-Time

Responsible Party

Name _____ Relationship to Patient _____

Address _____

Phone Number _____ Social Security # _____ Date of Birth _____

Employer _____ Phone Number _____

Emergency Contact _____ **Phone Number** _____

Insurance Information

Insurance Company _____ Phone Number _____

ID # _____ Group # _____

Insured's Name _____ Relationship to Patient: Self / Spouse / ~~Depend~~

Insured's Employer _____ Phone Number _____

Insured's Social Security # _____ Date of Birth _____ Male / Female

I hereby assign, transfer, and set over to PROGRESSIVE WOMEN'S CARE 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. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature _____ Date _____



Progressive
WOMEN'S CARE

CONSENT FOR CARE AND TREATMENT

Patient Name (Please Print) _____

I, the undersigned, do hereby agree and give my consent for Progressive Women's Care to furnish medical care and treatment to _____, considered necessary and proper in diagnosing or treating my/his/her physical and mental condition.

Patient/Guardian Signature

Date

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 45 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed to us, you recognize an obligation to promptly remit same payment to Progressive Women's Care. This does not apply for those patients that are on an HMO plan or considered Worker's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges rendered to you.

When you pay by check, you expressly authorize the physicians of Progressive Women's Care, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit (plus any applicable sales taxes). Please note: The above language authorizes an electronic debit to your account for the state-allowed recovery fee. In accordance with the rules of the National Automated Clearing House Association, you may call (888) 235-4635 to revoke the authorization for the electronic transaction. This does not mean, however, that Progressive Women's Care cannot collect a return check fee by other methods.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Signature: Patient/Guardian/Responsible Party

Date

Practice Representative

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

Patient Name (Please Print) _____

I, the undersigned, do hereby confirm that I have been given access to and have reviewed a copy of Progressive Women's Care Notice of Privacy Practices. I would like a copy of this statement.

Signature of Patient/Guardian

Date



Progressive
WOMEN'S CARE

Ann Bertles, M.D.
628 South Peek Road
Katy, TX 77450
Phone: 832-437-9690 Fax: 832-437-9694

AUTHORIZATION FOR RELEASE OF INFORMATION TO DESIGNATED PERSON(S)

Patient Name: _____ Date of Birth: _____

This form is part of the Federal Health Insurance Portability and Accessibility Act of 1966 (HIPAA) requirements for patient privacy. Signing this form and naming a person(s) who can receive your health information allows the staff of Progressive Women's Care to release all information regarding your healthcare.

Person(s) who can receive information for you:

Name: _____ Relationship: _____ Date of Birth: _____

Name: _____ Relationship: _____ Date of Birth: _____

Name: _____ Relationship: _____ Date of Birth: _____

I hereby authorize the staff of Progressive Women's Care to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary and that I may revoke this authorization at any time by notifying Progressive Women's Care in writing. I understand that once this information is disclosed, the released information may no longer be protected by federal privacy regulations.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing this authorization.

This authorization shall be in force until revoked by the patient or representatives signing the authorization.

Signature of the patient or patient's guardian/representative

Date

Practice Representative



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NEW PATIENT HISTORY

DATE _____

PERSONAL PROFILE

NAME		NAME YOU WOULD LIKE US TO USE:	
AGE		OCCUPATION	
BIRTH DATE		MARITAL STATUS	
RACE:	ETHNICITY:	LANGUAGE:	

GYNECOLOGICAL HISTORY

ARE YOU CURRENTLY PREGNANT?		CURRENT BIRTH CONTROL:	
LAST MENSTRUAL PERIOD (FIRST DAY):		LAST PAP SMEAR:	RESULT:
AGE PERIODS BEGAN:		ABNORMAL PAP IN PAST? <u> </u> NO <u> </u> YES DATE <u> </u>	
NUMBER OF DAYS BLEEDING:		LAST MAMMOGRAM	
NUMBER OF DAYS BETWEEN PERIODS:		ABNORMAL MAMMOGRAMS/BREAST BOIPSIES IN THE PAST?	
ANY RECENT CHANGES IN PERIODS?		<u> </u> NO <u> </u> YES DATE <u> </u>	
ARE YOU CURRENTLY SEXUALLY ACTIVE?		LAST COLONOSCOPY	RESULT:
SEXUAL ORIENTATION:		LAST BONE DENSITY EXAM	RESULT:

OBSTETRIC HISTORY

TOTAL PREGNANCIES:	FULL TERM	ABORTIONS	ECTOPIC	MISCARRIAGES	PREMATURE (<37 WKS)	LIVING CHILDREN
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PLEASE LIST EACH PREGNANCY BELOW:

DATE	WEIGHT OF BABY	SEX M OR F	WEEKS PREGNANT	COMPLICATIONS	VAGINAL OR C-SECTION DELIVERY
1.					
2.					
3.					
4.					
5.					

MEDICATIONS (INCLUDE OVER THE COUNTER)

MEDICATION ALLERGIES

DRUG NAME/DOSE		DRUG NAME/DOSE		1	
1		4		2	
2		5		3	
3		6		4	

SOCIAL HISTORY

CIGARETTES: NEVER CURRENT PAST PACKS PER DAY YEARS

ALCOHOL: NONE # DRINKS PER DAY #DRINKS PER WEEK

RECREATIONAL DRUGS (DESCRIBE) CURRENT PAST NEVER

HAVE YOU BEEN SEXUALLY ABUSED, THREATENED OR HURT BY ANYONE? NO YES

PERSONAL AND FAMILY MEDICAL HISTORY

HAVE YOU OR A FAMILY MEMBER HAD ANY OF THE FOLLOWING CONDITIONS (PAST OR CURRENT)

	SELF	FAMILY MEMBER	DETAILS (DATE/DESCRIPTION)
ABNORMAL HAIR GROWTH/HAIR LOSS			
ABNORMAL VAGINAL DISCHARGE			
ABNORMALLY PAINFUL/HEAVY PERIODS			
ARTHRITIS/JOINT PROBLEMS			
ASTHMA OR LUNG DISEASE			
BIRTH DEFECTS			
BLOOD CLOTS IN LEGS OR LUNGS			
BLOOD TRANSFUSION			
BOWEL PROBLEMS			
CANCER			
CYSTIC FIBROSIS			
DEPRESSION/ANXIETY			
DIABETES			
DOWNS SYNDROME			
ENDOMETRIOSIS			
HEART PROBLEMS			
HERPES			
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
INFERTILITY			
INVOLUNTARY LOSS OF STOOL			
INVOLUNTARY LOSS OF URINE			
IRREGULAR OR ABSENT PERIODS			
KIDNEY INFECTIONS/STONES			
LUMPS OR BREAST PAIN			
LUPUS/RHEUMATOID DISEASE			
MENOPAUSE SYMPTOMS			
MIGRAINES/HEADACHES			
REFLUX/STOMACH ULCER			
SEIZURES			
SEXUALLY TRANSMITTED DISEASES			
SICKLE CELL DISEASE			
STROKE			
SUBSTANCE ABUSE			
THYROID DISEASE			
UNEXPLAINED WEIGHT LOSS OR GAIN			
UTERINE FIBROIDS			
OTHER FAMILY HISTORY			

FAMILY HISTORY

MOTHER: _____ LIVING _____ DECEASED – AGE/CAUSE OF DEATH

FATHER: _____ LIVING _____ DECEASED – AGE/CAUSE OF DEATH

SIBLINGS: #LIVING _____ #DECEASED _____ AGES/CAUSES OF DEATH

OPERATIONS/HOSPITALIZATIONS

PROCEDURE/REASON HOSPITALIZED	DATE	HOSPITAL	COMPLICATIONS
1			
2			
3			
4			
5			
6			

REVIEW OF SYSTEMS

ARE YOU CURRENTLY EXPERIENCING ANY PROBLEMS WITH THE FOLLOWING BODY SYSTEMS? (MARK ALL THAT APPLY)

GENERAL fatigue fever weight gain weight loss

HEAD/EARS/NOSE/THROAT headaches sore throat decreased hearing congestion

BREASTS breast lumps breast tenderness nipple discharge

CARDIOVASCULAR chest pain irregular heart beat

RESPIRATORY shortness of breath cough wheezing

GASTROINTESTINAL nausea vomiting diarrhea constipation abdominal pain

SKIN rashes skin lesions

NEUROLOGICAL seizures tingling numbness

MUSCULOSKELETAL joint pain joint swelling

ENDOCRINE hair loss temperature intolerance abnormal hair growth

GENERAL INFORMATION

PRIMARY CARE PHYSICIAN: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE: _____

ARE YOU HERE TODAY FOR A _____ ROUTINE ANNUAL EXAM OR A _____ PROBLEM?

IF YOUR VISIT IS FOR A PROBLEM, PLEASE DESCRIBE: _____

HAVE YOU RECEIVED A FLU SHOT? YES NO

PHARMACY NAME & PHONE NUMBER: _____

THANK YOU!!

NAME: _____

DATE OF BIRTH: _____

ARE YOU EXPERIENCING PAIN?



0

No hurt



1

Hurts little bit



2

Hurts little more



3

Hurts even more



4

Hurts whole lot



5

Hurts worst

Over the last 2 weeks, how often have you been bothered by the following problems? Circle the number in the appropriate column.	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
<p>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? Check the appropriate answer on the right please.</p> <p>Not difficult at all _____</p> <p>Somewhat difficult _____</p> <p>Very difficult _____</p> <p>Extremely difficult _____</p>				