

Women's Health Services  
Patient Information Form  
1001 N. Waldrop Suite 505  
Arlington, TX 76012 817-277-9415

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Your Doctor's Name: \_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_  
Last First MI Maiden

Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Driver's License: \_\_\_\_\_

Patient Employer: \_\_\_\_\_ Work Address: \_\_\_\_\_

**Spouse/Guardian Information**

Spouse/Guardian Name: \_\_\_\_\_ Cell/Work Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Driver's License: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Primary Insurance**

Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_

Self \_\_\_\_\_ Spouse \_\_\_\_\_ Parent \_\_\_\_\_ Other \_\_\_\_\_ Co-pay Amount: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Claim Address: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Insured SS#: \_\_\_\_\_

**Secondary Insurance**

Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_

Self \_\_\_\_\_ Spouse \_\_\_\_\_ Parent \_\_\_\_\_ Other \_\_\_\_\_ Copay Amount: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Claim Address: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Insured SS#: \_\_\_\_\_

Insurance Authorization and Assignment: I authorize WHS to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to WHS. I understand that I am ultimately responsible for all services whether covered by insurance or not. I also authorize my physician, based on her discretion to access my chart for utilization management review.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

## WHS Patient Health History Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Account #: \_\_\_\_\_ Who is your Primary Care Physician? \_\_\_\_\_

Date of last Pap smear: \_\_\_\_\_

Have you ever had an abnormal Pap smear? Yes No

At what age did you first start your period? \_\_\_\_\_

What was the first day of your last menstrual period?  
\_\_\_\_\_

Are your periods: Regular Irregular

Do you often skip periods? Yes No

Do you have heavy bleeding with your periods?  
Yes No

Do you have pain with your period? Yes No

Mild Moderate Severe

Do you have pain during or after intercourse?  
Yes No

Do you need birth control? Yes No

What form of birth control do you currently use?  
\_\_\_\_\_

How many children do you have? \_\_\_\_\_

How many miscarriages have you had? \_\_\_\_\_

Are you trying to become pregnant? Yes No

Do you have cyclic breast pain? Yes No

Do you have a history of breast lumps? Yes No

Do you have any nipple discharge? Yes No

Do you have a family history of breast cancer?  
Yes No

Have you ever had a mammogram? Yes No

When was your last mammogram? \_\_\_\_\_

Do you have any history of sexually transmitted  
disease? Yes No

If yes, please list: \_\_\_\_\_  
\_\_\_\_\_

Do you lose urine with heavy lifting, sneezing, or  
coughing? Yes No

Do you experience bladder symptoms of urgency,  
frequency, or pain? Yes No

Do you smoke? Yes No

If so, how many packs per day? \_\_\_\_\_

How much alcohol do you consume weekly/daily?  
\_\_\_\_\_

Family History: (If yes, please circle)

Cancer (type \_\_\_\_\_) Diabetes Heart Disease High Blood Pressure Stroke

List all of your ALLERGIES: \_\_\_\_\_  
\_\_\_\_\_

List your PREVIOUS SURGERIES: \_\_\_\_\_  
\_\_\_\_\_

List your CURRENT MEDICATIONS: \_\_\_\_\_  
\_\_\_\_\_

List your CURRENT MEDICAL PROBLEMS: \_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_

**WHS NEW PATIENT POLICY AND CONSENT FORM**

Patient SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Section I: Financial Agreement & Assignment of Benefits**

In consideration for the services to be rendered to me, I hereby assume full responsibility to pay for those services in accordance with the rates now in effect at Women's Health Services, to the extent that I am legally responsible for such payment. Payments that I am responsible for may include, but not limited to, balance after insurance, non-covered services, co pays, and deductibles.

I hereby assign to Women's Health Services any and all benefits for services rendered under insurance policies and reimbursement. I acknowledge any balance not covered or paid for by such policies is my legal responsibility. I understand that if my account is turned over to a collection agency, a 35% service charge will be added to the balance. I understand that I am required to inform Women's Health Services of any address, phone number, or insurance changes. THIS IS A LEGAL FINANCIAL AGREEMENT OF BENEFITS FORM. BE SURE ANY QUESTIONS YOU MAY HAVE ARE ANSWERED BEFORE YOU SIGN AT THE BOTTOM OF THE PAGE.

**Section II: Receipt Acknowledge for the Notice of Privacy Practices**

I, \_\_\_\_\_ have been made aware of the Notice of Privacy Practices for Women's Health Services. I understand that this notice states how Women's Health Services may use and disclose my Protected Health Information. I UNDERSTAND THAT A COPY OF THIS NOTICE IS AVAILABLE UPON REQUEST.

**Section III: Medical Records Release and Forms**

I understand that if I request a copy of my medical records to be sent to another doctor, I must allow 15 business days for processing from the time I submit a signed authorization. I understand if I request my medical records to be released to me, I must pay a prepayment of \$15 and allow 15 business days for processing from the time I submit the signed authorization.

I understand if I submit a disability for, Family Medical Leave Act form, or any other form that requires a doctors signature and/or specific information to be completed, I must pay a prepayment of \$25 for the 1<sup>st</sup> set of forms and \$5 for all additional and must allow 7 business days for processing.

I, \_\_\_\_\_ hereby authorize Women's Health Services to release my information, in the course of my treatment, necessary to process insurance claims and/or to any other requesting physician in reference to referrals or coordination of care.

**Section IV: Release of Records to a Designated Third-Party**

In addition to my treating physicians and medical facilities, I authorize Women's Health Services to release and discuss my medical/billing information and records to the following individuals. PLEASE PRINT

\_\_\_\_\_  
\_\_\_\_\_

**Patient Signature**

By signing below I am verifying that I have read each of the five sections on this page. I understand each section and consent to and agree with the information stated in each section.

\_\_\_\_\_  
Patient/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient/Guardian Name

E-mail: \_\_\_\_\_