deAyala OB/GYN Associates of Houston

PATIENT INFORMATION Today's Date: ____________________________

First Name: ___________________________________ Last Name: _______________________________ Date of Birth: _______/_______/_______

Social Security #: _________ - _________ - __________ Mobile: _________ - _________ - __________ Home: _________ - _________ - _________

Address: ____ Apt: __________ City: _____________________ St.: _______ Zip: ______________

Marital Status: ☐ M ☐ S ☐ P ☐ D ☐ W E-mail Address: ____

(E-Mail Address/Mobile# will be used to set up a patient portal account through Healow to communicate with patients online)

Employer: _______________________________ Occupation: _____________________________ Work: _________ - _________ - ____________

Race:
☐ American Indian/Alaska Native
☐ Asian
☐ Native Hawaiian/Pacific Islander
☐ Black or African American
☐ White
☐ Hispanic
☐ Other
☐ Prefer not to answer

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Prefer not to answer

Pharmacy: _______________________________ Phone: _________ - _________ - __________ Address: __________________________________

(Our office only sends E-prescriptions; therefore, a pharmacy is required)

Referred by: ____ Phone (if another physician or midwife): _________ - _________ - _________

EMERGENCY CONTACT/RELEASE OF RECORDS: In addition to my treating physicians and medical facilities, I authorize deAyala OB/GYN Associates of Houston, PLLC. to release and discuss my medical history, treatment and records to the following individual.

Name: ____________________________________ Relationship: _______________________ Phone: ___________ - ___________ - ____________

INSURANCE INFORMATION

Primary Insurance: __________________________________ Member ID: ________________________________ Group#: ____________________

Subscriber: ___________________________________ DOB: _________/_________/_________ Social Security #: ________ - _______ - _________

Relationship to Patient: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER: ____

Secondary Insurance: ________________________________ Member ID: ________________________________ Group#: ____________________

Subscriber: ___________________________________ DOB: _________/_________/_________ Social Security #: ________ - _______ - _________

Relationship to Patient: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER: ____

Guarantor Name: ________________________________ DOB: ______/______/______ Social Security #: ______ - ______ - _______
(Financial Responsibility for Minors Only)
Address: ____ Apt: ________ City: ________________ St.: _______ Zip: ____________

ASSIGNMENT OF BENEFITS: I assign all medical and/or surgical benefits to which I am entitled, to deAyala OB/GYN Associates of Houston. I understand I am responsible for all charges whether they are paid by my insurance or not.
AUTHORIZATION FOR TREATMENT & PAYMENT OF MEDICAL BENEFITS: I authorize the release of any medical information, including diagnosis and treatment, necessary to process claims for services rendered and for payment from my insurance company to be made directly to deAyala OB/GYN Associates of Houston.
HIPAA NOTICE OF PRIVACY PRACTICES AND RECEIPT ACKNOWLEGEMENT:
We are required by law to maintain the privacy and security of your protected health information and must follow the duties and privacy practices described.
I, ____________________________________ have been made aware of the Notice of Privacy Practices for deAyala Obstetrics & Gynecology, PLLC., I understand that this notice states how deAyala OB/GYN Associates of Houston, PLLC. may use and disclose my Protected Health Information ("PHI"). I UNDERSTAND THAT A COPY OF THIS NOTICE IS AVAILABLE UPON REQUEST.

Patient Signature
By signing below, I am verifying that I have read all sections and consent to and agree with the information stated in each section.

Patient / Legal Guardian Signature ____ Date: _______/_______/_______

deAyala OB/GYN Associates of Houston

NEW PATIENT QUESTIONNAIRE Today's Date: __________________________

First Name: ______________________________ Last Name: __________________________ Date of Birth: _______/_______/_______

Reason for Visit: ____

Preventive Health: Please give approximate, most recent date or write never

	Date		Date		Date		Date
Pap Smear		Gardasil		Mammogram		Flu Vaccine	
Colposcopy		Colonoscopy		Bone Density		Rubella	

PAST MEDICAL HISTORY: Please check all that apply

- ☐ Arthritis
- ☐ Asthma
- ☐ Anemia
- ☐ Bowel Disorders
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney
- ☐ Seizures/Epilepsy
- ☐ Serious Injuries
- ☐ Headaches
- ☐ Skin Disease
- ☐ Stomach Problems
- ☐ Thyroid Disease
- ☐ Urinary Incontinence
- ☐ Sexually transmitted infection
- ☐ Other: ________________

PREVIOUS SURGERIES

Year	Description	Year	Description

CURRENT MEDICATIONS

Medication	Dosage	Medication	Dosage

Drug Allergies: ____

Family History: Have any of your close relatives had any of the following conditions?

Condition	Relation to you	Maternal/Paternal	Age Diagnosed
Blood Disorder			
Breast Cancer			
Cancer			
Diabetes			
Heart Attack			
High Blood Pressure			
Lung Disease			
Ovarian Cancer			
Stroke			

SOCIAL HISTORY

Smoking: ☐ NO ☐ YES, # per day ______ Alcohol: ☐ NO ☐ YES, drinks/week ______ Illicit Drugs: ☐ NO ☐ YES

Exercise: ☐ NONE ______times per week Activities: ____

Sexually Active: ☐ NO ☐ YES Sexual Orientation: ☐ Straight ☐ Lesbian ☐ Bisexual

deAyala OB/GYN Associates of Houston

MENSTRUAL HISTORY

Age at 1st period ___________ First day of last period ___________ ☐ Regular ☐ Irregular

Cramps: ☐ NO ☐ YES ☐ Mild ☐ Moderate ☐ Severe Medication for Cramps: ______________________________________

Contraceptive Method: ____________________ Menopausal: ☐ NO ☐ YES Symptoms: ___________________________________

OBSTETRICAL HISTORY

Total Pregnancies:	**Full Term Births:**	**Premature Births:**	**Miscarriages:**
Elective Abortions:	**Ectopic Pregnancies:**	**Multiple Births (twins):**	**Living Children:**

Month/Day/Year	Weeks at Delivery	Sex	Weight	Defects	Vaginal or Cesarean	Complications

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS THAT CURRENTLY APPLY TO YOU

CONSTITUTIONAL
- ☐ Significant Weight Loss
- ☐ Significant Weight Gain
- ☐ Hot flashes
- ☐ Fatigue

EYES
- ☐ Double Vision
- ☐ Spot before eyes
- ☐ Vision Changes

EARS, NOSE, THROAT
- ☐ Ringing in ears
- ☐ Sore throat
- ☐ Mouth sores

BREAST
- ☐ Pain in breast
- ☐ Discharge
- ☐ New Lumps
- ☐ Implants

CARDIOVASCULAR
- ☐ Painful/Difficult breathing
- ☐ Chest pain
- ☐ Swelling legs
- ☐ Palpations of heart

RESPIRATORY
- ☐ Wheezing
- ☐ Spitting up blood
- ☐ Shortness of breath
- ☐ Cough, chronic

GASTROINTESTINAL
- ☐ Frequent diarrhea
- ☐ Bloody stool
- ☐ Nausea/Vomiting
- ☐ Constipation

GENITOURINARY
- ☐ Blood in urine
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Abnormal periods
- ☐ Painful intercourse

SKIN
- ☐ Rash
- ☐ Ulcers

NEUROLOGIC
- ☐ Severe headaches
- ☐ Dizziness
- ☐ Seizures
- ☐ Memory loss
- ☐ Trouble walking

MUSCULOSKELETAL
- ☐ Muscle weakness

HORMONAL
- ☐ Dry skin
- ☐ Abnormal thirst
- ☐ Hot flashes

PSYCHIATRIC
- ☐ Depression
- ☐ Frequent crying

HEMATOLOGIC/LYMPHATIC
- ☐ Easy bruising
- ☐ Enlarged lymph
- ☐ Easy bleeding

deAyala OB/GYN Associates of Houston

IMPORTANT POLICY INFORMATION

Patient Name: ____ DOB: ______________________________________

NO CHILDREN Be aware that we DO NOT allow children under the age of 12 in our office, not even in the waiting area, except for your newborn. This is for their safety and the well-being of our patients. We will be happy to reschedule your appointment and we apologize in advance for any inconvenience this may cause.

INSURANCE I understand that it is my responsibility to ensure that all insurance information is up to date and accurate. It is also my responsibility to ensure that deAyala OB/Gyn Associates of Houston is in network with my insurance plan. They will bill my insurance for all services provided to me and I am responsible for payment of copays, deductibles, and/or coinsurance or any balances that I may have. All balances are due with-in 90 days of the initial statement date. If I am a self-pay patient on the day services are provided to me, I understand that the office will not go back and bill those services to any insurance. They will provide me with a detailed receipt that I may submit to my insurance to be reimbursed.

I understand that I MUST disclose all active insurance plans to my provider, including any commercial, Medicaid, or CHIP Perinatal plans that I may have. deAyala OB/Gyn Associates of Houston MUST bill my commercial insurance plan PRIOR to Medicaid or CHIP. If I do not disclose all insurances and there is a denial of services due to this reason, deAyala OB/Gyn Associates of Houston will automatically make the full balance my responsibility for the services that were provided to me. All balances are due with-in 90 days of the initial statement date.

MEDICAL RECORDS At any point during my care, I may request a copy of my medical records. There is a flat fee of $ 25.00. If I am transferring doctors, records may be transferred to my new doctor at no cost. A medical release request form must be completed for any release of records and may take 3-5 business days.

FMLA/DISABILITY FORMS All FMLA forms that need to be completed may take 3-5 business days and have a flat fee of $25.00. Please provide all forms within a timely manner so that they are completed by the date requested by your employer.

LABS I understand that deAyala OB/Gyn Associates of Houston performs labs tests and provides the laboratory with my personal information that may include but is not limited to my name, dob, address, social security number, insurance and diagnosis. I understand that my insurance company will process the claim and apply benefits accordingly. I understand that any difference in payments is entirely my responsibility to the laboratory provider.

SURGERIES If I am scheduling surgery with deAyala OB/Gyn Associates of Houston they will call my insurance and provide them with information about the surgery to determine benefits. An estimate of my financial responsibility will be provided to me. These fees are due BEFORE my surgery. I understand that benefits quoted are not a guarantee of payment from my insurance and that there is a possibility that I may have an additional balance due. All balances are due with-in 90 days of the initial statement date.

PREGNANCIES If I am pregnant and have a commercial insurance plan deAyala OB/Gyn Associates of Houston will prepare an OB Global Fee that will be due at approximately 36 weeks of pregnancy. This global fee is for routine prenatal care, delivery, and routine postpartum care. Labs and ultrasound are not included in the fee. If I have a problem visit, that will be considered a separate visit and may be subject to copay, deductible, and/or coinsurance and it is my responsibility.

ULTRASOUNDS I understand that the recommendation of my provider to have an ultrasound does not in any way guarantee or imply any level of insurance coverage. I understand that if my insurance carrier does not cover the ultrasound, then I will be financially responsible for the services provided.

CIRCUMCISIONS If I choose to have my baby circumcised at delivery by Dr. deAyala, the office will bill my insurance. I understand that I am responsible for payment of copays, deductibles, and/or coinsurance or any balances that I may have. All balances are due with-in 90 days of the initial statement date. If I have CHIP Perinatal, I understand that my plan does not cover circumcisions for my baby. If I choose to have my baby circumcised at delivery by Dr. deAyala there is a fee of $250 that must be paid in full before delivery.

BILATERAL TUBAL LIGATIONS If I have Medicaid, I may request to have a Bilateral Tubal Ligation. I understand that I must sign a consent form at least 30 days prior to the procedure and must be at least 21 years of age for my plan to cover these services. If I have CHIP Perinatal, I understand that my plan does not cover bilateral tubal ligation procedures. If I choose to have the procedure done, there is a $450 fee that must be paid in full before delivery. It does not include additional hospital fee. If I delivery vaginally the hospital fee is $900.00, if I delivery via C/Section the hospital fee is $300.00. If I have a commercial insurance plan, the office will bill my insurance. I understand that I am responsible for payment of copays, deductibles, and/or coinsurance or any balances that I may have. All balances are due with-in 90 days of the initial statement date.

I certify that the above information was reviewed with me and that I understand these policies for deAyala OB/GYN Associates of Houston. If I have any questions concerning these policies, I may contact the office at 713-827-4744.

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PATIENT COPY