

PATIENT INFORMATION
(please print)

DATE: _____

PATIENT'S LEGAL NAME: _____

SOCIAL SECURITY #: _____ BIRTHDAY _____ AGE _____

MAILING ADDRESS: _____

E-Mail ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

MARITAL STATUS _____ Race _____ Ethnicity _____

EMPLOYER: _____ WORK PHONE: _____

OCCUPATION: _____

NAME OF SPOUSE/GUARDIAN: _____

SOCIAL SECURITY # OF SPOUSE/GUARDIAN: _____ D.O.B. _____

EMPLOYER OF SPOUSE/GUARDIAN: _____ WORK#: _____

NAME OF CLOSEST LIVING RELATIVE: _____ PHONE: _____

IN CASE OF EMERGENCY, NOTIFY: _____ PHONE: _____

How did you hear about us? _____

*Lifetime Insurance Authorization: I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment to the Social Security Administration or its intermediaries or carriers involved in processing and collection of a claim. I understand that I am financially responsible for the charges not covered by this authorization.

X _____
Signed patient, or parent if minor _____ Date _____

IF PATIENT IS A MINOR, PLEASE COMPLETE:

I, _____, give permission to Dr. Mahan, Dr. Bonilla or the Nurse Practitioner to examine my daughter _____.

Parent or Guardian _____ Witness _____ Date _____

**Northeast Women's Healthcare
Obstetrics and Gynecology
Miles E. Mahan, MD, Board Certified
David Bonilla, MD, Board Certified
Penny Landers, RNC-WHNP**

**Consent for Patient Care Provided by a Nurse
Practitioner**

Northeast Women's Healthcare employs a highly qualified Nurse Practitioner. A Nurse Practitioner is a registered nurse with additional specialized training in diagnosing and treating illnesses and providing healthcare maintenance.

Penny Landers, RNC-WHCNP

Penny received her training at The University of Texas-Southwestern Medical School and specializes in Women's Health.

You can schedule your appointment with Dr. Mahan, Dr. Bonilla or Penny Landers and every effort will be made to ensure that you see the provider of your choice. However, occasionally the doctors are called from the office for or delivery or an emergency. In those instances, you will be offered to wait, reschedule, or have a Nurse Practitioner see you at that time.

By signing below, you consent for care and treatment provided by Penny Landers, RNC-WHNP.

Patient's Signature

Date

**Northeast Women's Healthcare
Obstetrics and Gynecology
Miles E. Mahan, MD, Board Certified
David Bonilla, MD, Board Certified
Penny Landers, RNC-WHNP**

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ~ **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- ~ **Obtain payment from third-party payers.**
- ~ **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have read and understand your Notice of Privacy Practices. I may request a copy of the Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices, but was unable to do so as documented below:

Date	Initials	Reason

Northeast Women's Health Care

In an effort to provide the best experience during your office visit today and help us keep current on your health, please take a few minutes to complete the following questions. Thank you!

Name _____ Date _____

CONTRACEPTION

1. What is your current form of birth control? _____
2. How long have you been using your current form of birth control? *(please check one)*
 Two years or less 3 to 5 years 6 to 10 years Over 10 years
3. When are you planning to have another child? *(please check one)*
 Within the next year Within the next 5 years
 Within the next 10 years My family is complete
4. Would you like information on a gentle, hormone-free permanent birth control procedure performed in the comfort of our office? Yes No

MENSTRUAL PERIODS

1. How long does your average monthly period last? _____ days
2. Do you ever feel as though your periods impact the quality of your life? Yes No
3. Do you ever experience irregular or inconsistent bleeding patterns? Yes No
4. Would you like information on a simple, safe procedure performed in our office that can significantly reduce or eliminate your monthly periods? Yes No

URINARY HEALTH

1. Do you ever leak urine when you cough, laugh or sneeze? Yes No
2. Do you ever feel as though you have to urinate urgently? Yes No
3. Do you feel like you have to urinate too frequently? Yes No
4. Do you ever experience painful urination? Yes No

AESTHETICS INTERESTS *(Please indicate any area of interest)*

- Laser Hair removal Vein Therapy Botox, Juvaderm, etc.
 Facials

Are there any concerns/issues that you would like to discuss today? _____

Northeast Women's Healthcare
Obstetrics, Gynecology & Infertility
Miles Mahan M.D. * David Bonilla M.D. * Penny Landers RNC-WHNP

NAME _____ DATE _____
DATE OF BIRTH _____ SOCIAL SECURITY # _____
HOME TELEPHONE # _____ WORK TELEPHONE # _____
EMAIL ADDRESS _____

1. Are you allergic to any medications? YES NO
Please list any medications you are allergic to: _____

2. Are you presently taking any medications? (this includes birth control pills) YES NO
Please list all medications you take: _____

3. Have you ever had surgery? YES NO
Please list the date & type of surgery performed: _____

4. Have you ever been hospitalized for some reason other than surgery? YES NO
Please list the dates & reasons for the hospitalization: _____

5. Do you have any chronic illnesses for which you receive frequent medical attention? YES NO
Please list: _____

6. Are you currently being treated for or have a history of chronic illness? (Diabetes, Depression, Asthmas, etc.) _____

7. Do you have any family history of the following? Please indicate the relationship of family member affected w/ disease.
Cancer _____
High Blood Pressure _____
Tuberculosis _____
Heart Disease _____
Diabetes _____
Epilepsy _____

8. How old were you when you started having periods? _____

9. Do you smoke? YES NO If yes, how many packs per day? _____

10. Do you drink alcoholic beverages? YES NO If so, how much? _____

11. Do you wear glasses? YES NO Contacts? YES NO Dentures? YES NO

12. What is the date of your last menstrual period? _____

13. When was your last pap smear? _____ Have you ever had an abnormal pap smear? _____

14. When was your last mammogram? _____ Have you ever had an abnormal mammogram? _____

15. Have you ever been pregnant? YES NO # of pregnancies _____ # of live births _____ # of miscarriages _____

16. Any history of sexually transmitted diseases? _____

Northeast Women's Healthcare
Obstetrics and Gynecology
Miles E. Mahan, MD, Board Certified
David Bonilla, MD, Board Certified
Penny Landers, RNC-WHNP

Release of Information to another party.

I _____ give permission for any medical information regarding myself including lab results to be released to the following individual/s.

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

I am aware that this note is valid until I terminate my authorization in writing.

Patient's Signature _____

Date _____

Welcome to Northeast Womens Healthcare

How did you hear about us?

Referred by a friend _____

Referred by another doctor-Dr.'s Name _____

Yellow Pages

Living Magazine

Internet

Insurance website

Hospital referral

Newspaper

Other _____