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

PATIENT INFORMATION
(please print)

DATE: ________________

PATIENT'S LEGAL NAME: ________________

SOCIAL SECURITY #: ________________ BIRTHDAY ________________ AGE ________

MAILING ADDRESS: ________________

E-Mail ADDRESS: ________________

HOME PHONE: ________________ CELL PHONE: ________________ MARITIAL STATUS ________

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: ________

*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. Biscette or the Nurse Practioner to examine my daughter ________________.

________________ ________________ ________________
Parent or Guardian Witness Date

20031 W. Lake Houston Parkway, Suite 200 • Kingwood, TX 77346 • 281-812-4447

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Consent for Patient Care Provided by a Nurse Practitioner

Northeast Women's Healthcare employs a highly qualified Nurse Practioner. A Nurse Practioner 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 Practioner see you at that time.

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

______________________________ ______________
Patient's Signature Date

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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 form 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

20031 W. Lake Houston Parkway, Suite 200 • Kingwood, TX 77346 • 281-812-4447

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?______________________________

____

____

NAME: ______________________________ **AGE:** ____________

CHIEF COMPLAINT ______________________________

OB HISTORY: No. of Pregnancies ______ No. of Miscarriages _______ No. of Abortions ________
List any complications of pregnancies or deliveries ______________________________
Method of birth control you are presenting using: _____ tubal _____ vasectomy _____ pills ___________ list other

GYN HISTORY: Last menstrual period ______ Age at onset of period _______ Cycle regular? __________
Cycle _______ days (start to finish). Flow: Light Moderate Heavy
Do you have a history of: Abnormal pap smears ______ Sexually transmitted diseases _______ IUD _______
DES _____ Cramps ______ Painful intercourse ______ Anemia _____ Do you practice self breast exams? ______
Date of last mammogram ______________________________

INFERTILITY: Temperature Charts _____ X-Ray of tubes _____ Semen Analysis _____ Cervical Mucous Test _____
Endometrial Biopsy ______ Hysteroscopy _______ Laparoscopy _______

MEDICAL HISTORY: ______________________________
____

Depression/Related Illness	Y N	Ovarian/Uterine Cancer	Y N	Diabetes	Y N
Excessive loss of Urine	Y N	Shortness of Breath	Y N	Migraines	Y N
High Blood Pressure	Y N	Blood Transfusion	Y N	Colitis	Y N
Frequent Bladder Infections	Y N	Kidney Infections	Y N	Asthma	Y N
Urinary Frequency	Y N	Thyroid Problems	Y N	Tuberculosis	Y N
Bloody/Tarry Stools	Y N	Hepatitis/Jaundice	Y N	Heart	Y N
Change of Bowel Habits	Y N	Bone/Joint Problems	Y N		

SURGICAL HISTORY: List dates of all surgeries and name of physician who performed surgery:________________
____
____

ALLERGIES TO MEDICATIONS:______________________________

MEDICATIONS TAKEN ON A REGULAR BASIS: ______________________________

FAMILY HISTORY: In your close family history (mother, brother, sister) is there a history of:

Heart attack under age 50	Y N	Diabetes	Y N	Birth Defects	Y N
High Blood Pressure	Y N	Breast Cancer	Y N		
Ovarian Cancer	Y N	Uterine Cancer	Y N		

SOCIAL HISTORY: Do you smoke? _____ Number per day ______ Do you use alcohol? ________ How many drinks per week? _______ Drug Abuse? ______
Are you presently being treated for any medical problems by your family physician? ____________________
Were you referred to this office by another physician? _______ Please list name of physician and address
____

SIGNATURE ______________________________ **DATE** ____________________

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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
______________________________	________________
______________________________	________________
______________________________	________________
______________________________	________________

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

Patient's Signature ________________________________

Date ___________________________

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