

PATIENT NAME: _____ DOB: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CELL: _____ HOME: _____ WORK: _____ EMAIL: _____

SOCIAL SECURITY #: _____ PHARMACY: _____ PHARMACY ADDRESS: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT #1: _____ PHONE #: _____ RELATIONSHIP: _____

EMERGENCY CONTACT #2: _____ PHONE #: _____ RELATIONSHIP: _____

INSURANCE POLICYHOLDER NAME: _____

(If same as patient may leave the following blank)

DOB: _____ SSN #: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

PRIMARY INSURANCE CARRIER: _____

PLAN TYPE: ☐ HMO ☐ EPO ☐ PPO ☐ POS

BILLING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____

POLICY #: _____ GROUP #: _____

COPAY/COINSURANCE AMOUNT: _____

SECONDARY INSURANCE? ☐ Y ☐ N (IF YES, PLEASE PROVIDE A COPY OF ABOVE INFORMATION TO RECEPTIONIST)

Please complete entire form. If something does not apply, please mark N/A. Thank you!

PATIENT NAME: _____ DOB: _____

REASON FOR VISIT: ☐ Annual Well Woman Exam (No Problems) OR ☐ Problem Visit (please list): _____

PREFERRED PRONOUN: _____

What is your ethnicity: ☐ Northern European (e.g. British/German) ☐ Southern European (e.g. Italian/Greek) ☐ French Canadian/Cajun
☐ Ashkenazi Jewish ☐ Other/Mixed Caucasian ☐ East Asian (e.g. Chinese/Japanese) ☐ South Asian (e.g. Indian/Pakistani) ☐ African/African American
☐ Southeast Asian (e.g. Filipino/Vietnamese) ☐ Hispanic ☐ Middle Eastern ☐ Native American ☐ Pacific Islander ☐ Unknown

*MEDICATION ALLERGIES (PLEASE LIST REACTION): _____

*LIST ALL MEDICATIONS AND DOSAGES (INCLUDING OVER-THE-COUNTER MEDICATION):

MEDICATION NAME	DOSAGE	DIRECTIONS

*LIST ANY SUPPLEMENTS/VITAMINS: _____

MEDICAL HISTORY: (Please check if you have had any of the following)

☐ GERD/Heartburn	☐ Irritable Bowel Syndrome	☐ Gastric Ulcers
☐ Hepatitis	☐ Hypertension	☐ Heart Murmur
☐ Heart Disease	☐ Blood Clot Disorder/DVT/PE	☐ High cholesterol
☐ Asthma	☐ Sleep Apnea	☐ Tuberculosis
☐ Kidney Infection	☐ Kidney Stones	☐ Recurrent UTI's
☐ Fibromyalgia	☐ Arthritis-Rheumatoid or Osteo	☐ Osteopenia/Osteoporosis
☐ Diabetes	☐ Thyroid Disorder	☐ Rheumatic Fever
☐ Migraines	☐ Dementia	☐ Stroke/TIA
☐ Epilepsy/Seizure Disorder	☐ Anemia	☐ Sickle Cell Disease/Trait
☐ Thalassemia/Trait	☐ Allergies	☐ Eczema/Psoriasis
☐ Depression/Anxiety/Other Mental Health	☐ HIV	☐ Genital Herpes
☐ Oral Herpes/Cold Sores	☐ Gonorrhea	☐ Chlamydia
☐ Trichomonas	☐ Syphilis	☐ Condyloma/Genital Warts
☐ Infertility	☐ Endometriosis	☐ Cancer _____

Other: _____

PATIENT NAME: _____ DOB: _____

TOTAL PREGNANCIES: _____ TERM: _____ PRETERM: _____ MISCARRIAGE: _____ ABORTION: _____ ECTOPIC: _____

DATE	SEX	WEIGHT	VAGINAL/VACUUM/FORCEPS/C-SECTION	LIVING	EPIDURAL	HRS IN LABOR	COMPLICATIONS
	☐ M ☐ F			☐ Y ☐ N	☐ Y ☐ N		
	☐ M ☐ F			☐ Y ☐ N	☐ Y ☐ N		
	☐ M ☐ F			☐ Y ☐ N	☐ Y ☐ N		
	☐ M ☐ F			☐ Y ☐ N	☐ Y ☐ N		

ANY PROBLEMS W/MENSTRUAL CYCLE: ☐ Y ☐ N 1ST DAY OF LAST MENSTRUAL CYCLE: _____ DAYS BETWEEN 1ST DAY OF 1 CYCLE & 1ST DAY OF NEXT CYCLE: _____

ARE YOUR CYCLES REGULAR? ☐ Y ☐ N HOW MANY PADS/TAMPONS USED ON HEAVIEST DAY? _____ HOW MANY DAYS OF FLOW? _____

ARE YOU CURRENTLY SEXUALLY ACTIVE? ☐ Y ☐ N ☐ NEVER WITH: ☐ MALE ☐ FEMALE ☐ BOTH HISTORY OF SEXUAL ABUSE: ☐ Y ☐ N

AGE AT FIRST MENSTRUATION: _____ AGE AT MENOPAUSE IF APPLICABLE: _____ ANY BLEEDING AFTER MENOPAUSE? ☐ Y ☐ N

BIRTH CONTROL: ☐ PILL ☐ IUD ☐ TUBAL ☐ RING ☐ PATCH ☐ DEPO INJECTION ☐ NEXPLANON ☐ VASECTOMY ☐ CONDOMS ☐ OTHER

DATE OF LAST PAP SMEAR: _____ NORMAL? ☐ Y ☐ N HISTORY OF ABNORMAL PAP? ☐ Y ☐ N WHAT YEAR(S): _____

TREATMENT: ☐ ONLY REPEAT PAP SMEAR ☐ COLPO ☐ CRYO/FREEZE ☐ LEEP ☐ CONE

DATE OF LAST MAMMOGRAM: _____ NORMAL? ☐ Y ☐ N HISTORY OF ABNORMAL MAMMOGRAM? ☐ Y ☐ N DATE: _____ BIOPSY DONE? ☐ Y ☐ N

DO YOU PERFORM SELF-BREAST EXAMS? ☐ MONTHLY ☐ OCCASIONALLY ☐ NEVER WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

DATE OF LAST COLONOSCOPY: _____ NORMAL? ☐ Y ☐ N DATE OF LAST BONE DENSITY SCAN: _____ NORMAL? ☐ Y ☐ N

IMMUNIZATION DATES: TETANUS/TDAP: _____ HPV/GARDASIL: _____ FLU: _____ COVID: _____ SHINGLES: _____ HEPATITIS B: _____

OPERATIONS/HOSPITALIZATIONS	YEAR	OPERATIONS/HOSPITALIZATIONS	YEAR

FAMILY HISTORY: (Please list family members that are affected) ☐ Adopted

☐ Breast Cancer	☐ Colon Cancer	☐ Endometrial Cancer
☐ Leukemia/Lymphoma	☐ Melanoma	☐ Ovarian Cancer
☐ Pancreatic Cancer	☐ Prostate Cancer	☐ Heart Disease
☐ Blood Clot Disorder/DVT/PE	☐ High Cholesterol	☐ Hypertension
☐ Diabetes	☐ Thyroid Disorder	☐ Osteoporosis
☐ Seizure Disorder	☐ Stroke/TIA	☐ Mental Illness
☐ Spina Bifida/Heart Defect	☐ Chromosomal Disorder	☐ Down Syndrome/Trisomy
☐ Tay Sachs	☐ Fragile X Syndrome	☐ Hemophilia
☐ Cystic Fibrosis	☐ Muscular Dystrophy	☐ Other Birth Defect
☐ Canavan Disease	☐ Spinal Muscular Atrophy	☐ Familial Dysautonomia
☐ Huntington's Disease	☐ Sickle Cell/Thalassemia	☐ Developmental Delay

OTHER FAMILY ILLNESSES/CANCERS: _____

PATIENT NAME: _____ **DOB:** _____

SOCIAL HISTORY:

OCCUPATION: _____ MARITAL STATUS: ☐ SINGLE ☐ SIGNIFICANT OTHER ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

TOBACCO USE: ☐ Y ☐ N CIGARETTES/DAY: _____ HOW LONG? _____ VAPING: ☐ Y ☐ N HOW LONG? _____

ILLICIT DRUG USE: ☐ Y ☐ N ALCOHOL USE: ☐ Y ☐ N DRINKS/WEEK: _____ CAFFEINE USE: ☐ Y ☐ N SERVINGS/DAY: _____

EXERCISE REGULARLY? ☐ Y ☐ N TYPE: _____ DAYS/WEEK: _____

SPECIAL DIET: _____ EDUCATION LEVEL: ☐ GRADE SCHOOL ☐ HIGH SCHOOL/GED ☐ TRADE SCHOOL ☐ COLLEGE ☐ POST-GRADUATE

DO YOU FEEL SAFE IN YOUR CURRENT RELATIONSHIP? ☐ Y ☐ N

IS A BLOOD TRANSFUSION ACCEPTABLE IN CASE OF A LIFE-THREATENING EMERGENCY? ☐ Y ☐ N

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?

☐ Fatigue	☐ Fever	☐ Night sweats
☐ Weight gain	☐ Weight loss	☐ Palpitations
☐ Chest pain	☐ Shortness of breath	☐ Bloating
☐ Constipation	☐ Diarrhea	☐ Hemorrhoids
☐ Bloody stools	☐ Nausea	☐ Vomiting
☐ Pain with urination	☐ Blood in urine	☐ Frequency
☐ Incontinence	☐ Painful intercourse	☐ Painful periods
☐ Vaginal discharge	☐ Vaginal itching	☐ Vaginal dryness
☐ Back pain	☐ Joint pain	☐ Breast mass
☐ Breast tenderness	☐ Nipple discharge	☐ Acne
☐ Rash	☐ Warts	☐ Dizziness
☐ Headaches	☐ Easy bruising	☐ Easy bleeding
☐ Enlarged lymph node	☐ History of blood transfusion	☐ Hair loss
☐ Cold intolerance	☐ Heat intolerance	☐ Hot flashes
☐ Excessive hair growth	☐ Seasonal allergies	☐ Anxiety
☐ Depression	☐ PMS	☐ Insomnia

PATIENT NAME: _____

DOB: _____

Appointment Policy

We value our patients and the time we spend with each of you, and we would like to set aside appointments that work well for your schedule. If there is a conflict with your scheduled appointment time, we ask that you call the office at least 24 hours in advance to cancel or reschedule your appointment. **Appointments cancelled without a 24 hour advanced notice will be charged \$25. If you miss more than 3 appointments, you may be dismissed from the practice.**

HIPAA (Health Insurance Portability and Accountability Act)

You have been given a secure copy of our Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of your protected health information and your rights under HIPAA. You understand that we reserve the right to change the terms of this notice from time to time and that you may contact us at any time to obtain the most current copy of this notice.

Clarification of Medical Visits

In our office, we want to put the patient first by providing outstanding medical care. In order for us to do this, we want to make sure our patients understand our policy for billing your medical visits. If you are scheduled to come in for your annual well woman exam, the doctors will only discuss details or perform services regarding that visit. If there are other medical issues that you would like to discuss that are not considered part of an annual well woman exam, we ask that you schedule another appointment for those issues. If you have an emergent problem, we will address that problem and you will need to reschedule your annual well woman exam. If the problem visit and annual well woman exam are done on the same day, you will be billed for each service separately. Depending on your insurance benefits, you will be responsible for any out of pocket expenses associated with both services, as problems addressed are usually subject to a copay and/or deductible. If you have any questions or concerns regarding these policies, please ask our staff.

Policy on Insurance Coverage

We are enrolled in numerous insurance programs. While we are pleased to be able to provide this service to you, it is difficult for us to keep track of all the individual requirements of each plan. Each plan has different stipulations and restrictions. Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated. Your medical insurance is a benefit that your employer provides for you or you purchase for yourself. During the course of treatment, charges will be accumulated and routinely filed with your insurance company. Charges not covered by your insurance, such as copays, deductibles, and co-insurance will be your responsibility and are due at the time of service. Understanding your benefits can be confusing, and we will do our best to assist you in this area, but keep in mind we have limited access to your medical benefits. Your employer or you have chosen this plan and benefits, not your physician. **If you do not inform us of any special requirements in your contract, and we subsequently order services, such as labs, pathology, or hospitalization that are not covered, we or the selected medical facility will bill YOU directly for those charges.**

Your insurance company will never guarantee your benefits to you or to this office. Therefore, we can only estimate your portion. Regardless of what we calculate as your medical plan benefit, ultimately **YOU are responsible for the TOTAL cost of your medical treatment.** If you are unable to pay the estimated portion for your appointment today, we will be happy to reschedule it to a later date.

If your insurance company requires a "referral" from your primary care physician, **you will be responsible for contacting your primary care physician for the referral (this is NOT the responsibility of our office).** Treatment rendered by this office without the required referral will serve as your consent for treatment not covered by insurance and will be payable by you. If your insurance requires a referral and one was not obtained by you prior to your appointment, you may pay a cash fee for your visit or reschedule your appointment.

Please check the appropriate boxes:

- ☐ I certify that I have **no insurance** and will be solely responsible for payment in full.
(Payment is expected at the time of service)
- ☐ I certify that the insurance reported to this office is a complete and current listing. I understand the office will not submit a claim for any insurance not reported at the time of service.
- ☐ I **DO NOT** have any other insurance coverage other than that which has been provided upon submission of this authorization.

***** You are responsible for providing the correct information regarding which insurance is PRIMARY and SECONDARY. *****

I have read and understood the office policy stated above and agree to accept responsibility as described.

Signature of Patient/Guardian

Printed Name of Guardian if under 18

Date

PATIENT NAME: _____ DOB: _____

Authorization to Discuss Medical Information

Drs. Ward and Gulick are committed to quality patient care. We are advocates of maintaining patient confidentiality. Our policy is to speak only to patients and/or guardians in regards to their medical information. We will not leave any confidential medical information on a voicemail system without permission. By filling out this form and signing below, you are giving the physicians permission to communicate more detailed information on your voicemail and/or to individuals that you designate below. Examples include but are not limited to your lab and test results, information about your condition, prescription refills or changes, appointment scheduling, and/or insurance details.

Our office will keep this consent form in your chart. **THIS FORM WILL BE EFFECTIVE UNTIL OTHERWISE NOTIFIED BY YOU WITH A WRITTEN REQUEST.**

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

I _____ (initial) authorize the physicians and staff to leave a detailed voice message regarding my medical care at the following phone number(s).

Patient Phone #1 _____

Instructions: _____

Patient Phone #2 _____

Instructions: _____

I _____ (initial) authorize the physician and staff to speak with the following individual(s) about my medical care.

Name: _____ Relationship: _____ Date: _____

Instructions: _____

Name: _____ Relationship: _____ Date: _____

Instructions: _____

PATIENT NAME: _____

DOB: _____

Consent to Treat Patient

I, _____ (name of patient) have an appointment for an examination and treatment, and I give permission to be examined and treated by the following physicians. By signing this form, you are giving consent to be examined and treated by the physicians below. This consent is valid for one year from the date signed below.

☐ Alisa K. Ward, M.D.

☐ Jennifer R. Gulick, M.D.

PLEASE INITIAL EACH OF THE FOLLOWING SECTIONS TO ACKNOWLEDGE YOU HAVE READ THE INFORMATION AND SIGN BELOW:

_____ **Assignment of Benefits:**

By signing this form, you authorize payment of medical benefits, including private insurance benefits, directly to Alisa K. Ward, M.D., P.A. and Jennifer Gulick, M.D., P.L.L.C. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete your insurance claim. The duration of this consent is definite and continues until revoked in writing.

_____ **Acknowledgement of Receipt of Notice of Health Information Practices**

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. Alisa K. Ward, M.D., P.A. and Jennifer Gulick, M.D., P.L.L.C. are furnishing you with the attached notice, which provides information about how our office may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of this office's notice of Health Information Practices.

_____ **Acknowledgement of Receipt of Notice of Office Policies and Procedures**

Alisa K. Ward, M.D., P.A. and Jennifer Gulick, M.D., P.L.L.C. are furnishing you with the attached notice, which provides information regarding our office protocols and policies which we have developed in order to optimize our ability to deliver you care. By signing this form, you acknowledge that you have received a copy of our office policies.

_____ **Acknowledgement of Physician Ownership**

To further our commitment to the quality of care for our patients, both Dr. Ward and Dr. Gulick have chosen to participate in ownership at Baylor Medical Center at Frisco. Their ownership enhances their ability to direct the manner in which your care is delivered at this facility. This information is being provided to you to help you make an informed decision regarding your health care. You have the right to choose your healthcare provider and the option of obtaining care at a different facility. If you choose care at a facility outside of Baylor Medical Center Frisco, your physician will be unable to treat you. By signing this form, you acknowledge that you have read and understand this disclosure.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: _____ DATE: _____

Consent to Treat a Minor

_____ (name of minor) has an appointment for examination and treatment. I, _____ (parent/legal guardian) give permission for _____ (name of minor) to be examined & treated by the following physicians. By signing this form, you are giving consent for the above named minor to be examined and treated by the physicians below. This consent is valid for one year from the date signed below.

Signature of parent/legal guardian: _____ Date: _____

☐ Alisa K. Ward, M.D.

☐ Jennifer R. Gulick, M.D.



PathAdvantage

Patient Financial Responsibility Agreement for Laboratory Services

Your healthcare practitioner has chosen us, **PathAdvantage Associated**, a women's health specialty laboratory in Dallas, TX to perform your laboratory services (including but not limited to blood, urine, body fluid and tissue/biopsy testing.)

Our address and telephone number are as follows:

PathAdvantage Associated

5327 North Central Expressway, Suite 300, Dallas, TX 75205

Telephone number: 214 219 0888

Statement:

I accept FULL FINANCIAL responsibility for charges incurred from PathAdvantage Associated, should my insurance company deny payment for all or part of this laboratory bill. I understand that I am required to pay for these services IN FULL.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

OR

Authorized Representative/Guardian: _____ Date of Birth: _____

Signature of Representative/Guardian: _____ Date: _____