Leslie S. Welborne, M.D.
Alisa Ward, M.D.

CENTENNIAL OB/GYN, P.A.
5757 Warren Parkway, Suite 210
Frisco, TX 75034
PH: 972-731-6565 FX: 972-731-6570

Melissa Bailey, M.D.
Ruth Whiddon, W.H.N.P.

Name ______________ DOB ______ Marital Status _____ Date ______

Reason for Visit

____

____

Allergies to Medications

If yes, please name medicine and describe type of reaction

____

____

Medications and Supplements

Please give name and dosage

____

____

____

Pregnancy History

Total Pregnancies____ Full Term____ Pre-term____ Miscarriage____ Abortion____ Ectopic___

Date	Length of Pregnancy	Type of Delivery	Sex	Weight	Living	Complications

Menstrual History

At what age did you start having menstrual periods? ________

Number of days between first day of one and first day of next period? __________

Length of period? ____________ Regular or Irregular ____________________

Would you call your periods ( ) light ( ) medium ( ) heavy ( ) clots

When was the first day of your last menstrual period? _________ Do you have cramps?_____

Was it a normal period? ________ If not, when was the last normal one? ______________

Would you like information on a simple, safe procedure performed in our office that can significantly reduce or eliminate your monthly periods/cramps? __ Y __ N

Contraception

What is your current form of birth control?

Abstinence Birth Control pill Hysterectomy IUD Menopause Tubal ligation Vasectomy Nuvaring Patch Depoprovera Rhythm Condoms

How long have you been using your current form of birth control? (please check one)

__ 2 yrs or less __ 3-5 yrs __ 6-10 yrs __ over 10 yrs

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When are you planning to have another child? (please check one)
__ within 1-2 yrs __ within 5-10 yrs __ my family is complete
If menopausal, at what age did your periods stop? ________
Date of last pap smear? ________ Normal/Abnormal? Have you had an abnormal pap smear? ______
If yes, please give dates, type (ASCUS, HPV, CIN I, etc.) and treatments (Colposcopy, Cryo, Cone Biopsy, LEEP) ________________________________
Date of last mammogram? ______ Normal/Abnormal? Have you had an abnormal mammogram? _____
If yes, please give dates and explain: ________________________________
Date of last Bone densitometry? ________________________ Normal / Osteopenia / Osteoporosis

Past Medical History

Please check if you currently have or have had a history of any of the following:

YES	NO		YES	NO	
( )	( )	Reflux/Heartburn	( )	( )	Fibromyalgia
( )	( )	Spastic Colon/Irritable Bowel	( )	( )	Arthritis-Rheumatoid/Osteo
( )	( )	Hepatitis	( )	( )	Diabetes
( )	( )	Ulcers	( )	( )	Thyroid Problems
( )	( )	Hypertension	( )	( )	Osteoporosis
( )	( )	Heart Disease	( )	( )	Nervous Disorder/Depression
( )	( )	Angina	( )	( )	Rheumatic Fever
( )	( )	Heart Murmur	( )	( )	Migraines
( )	( )	Hypercholesterolemia	( )	( )	Dementia
( )	( )	Blood Clotting Problems/DVT	( )	( )	Stroke/TIA
( )	( )	Asthma	( )	( )	Epilepsy
( )	( )	Sleep apnea	( )	( )	Anemia
( )	( )	Tuberculosis	( )	( )	Sickle Cell Disease/Trait
( )	( )	Pneumonia	( )	( )	Allergies
( )	( )	Emphysema	( )	( )	Eczema
( )	( )	Kidney/Bladder Infections	( )	( )	Psoriasis
( )	( )	Kidney Stones	( )	( )	Cancer ____________
( )	( )	Hospitalizations - If yes, please explain:			

____
____

Past Surgical History

Dates: Procedure:

____
____
____
____
____

Immunizations (please list dates)

Tetanus: ______________ HPV: ______________ Flu: ______________

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Who is your Primary Care Physician?

____

Family History

YES	NO		YES	NO	
( )	( )	Breast Cancer	( )	( )	Diabetes
( )	( )	Ovarian Cancer	( )	( )	Thyroid Disorder
( )	( )	Uterine Cancer	( )	( )	Osteoporosis
( )	( )	Colon Cancer	( )	( )	Epilepsy/Seizures
( )	( )	Heart Disease	( )	( )	Stroke
( )	( )	Hypercholesterolemia	( )	( )	Depression/Bipolar/Schizophrenia
( )	( )	Hypertension	( )	( )	Birth Defects
( )	( )	DVT/Pulmonary Embolus	( )	( )	Other

If yes, please explain

____

Social History

Employer/Occupation ____________________ Marital Status ____________

Exercise Type/Frequency ____________________ Education Level ____________

Smoking ___cigs/day Alcohol ___drinks/wk Caffeine ___servings daily Illicit Drugs _____

Have you ever had a sexually transmitted disease? ________

Type/dates ____

____

Review of Symptoms: (Circle current symptoms)

GENERAL - Fatigue Fever Weight gain Weight loss
CARDIOVASCULAR - Palpitations Chest pain
PULMONARY - Cough Shortness of breath
GASTROINTESTINAL - Bloating Constipation Diarrhea Hemorrhoids Bloody stools Nausea
URINARY - Pain with urination Blood in urine Frequency UTI's Incontinence
GENITAL - Irregular periods Painful intercourse History of sexual abuse Vaginal discharge Vaginal itching
MUSCULOSKELETAL - Back pain Joint pain
BREAST - Perform self breast exams-Regularly/Irregularly/Never Masses Tenderness Nipple discharge
SKIN - Rash Warts
NEUROLOGIC - Dizziness Headaches
BLOOD/LYMPHATIC - Easy bruising Bleeding easily History of blood transfusion Enlarged lymph nodes
ENDOCRINE - Hair loss Temperature intolerance Excessive hair growth
ALLERGIES - Seasonal allergies
PSYCHIATRIC - Anxiety Depression PMS Insomnia

____

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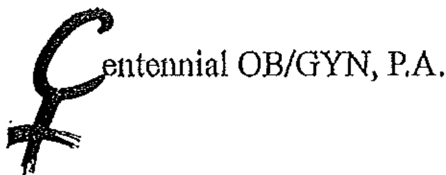

Dear Patient:

You are scheduled today for your annual routine Well Woman Exam. This exam includes a breast exam, pelvic exam, and could possibly include a PAP smear screening for cervical cancer prevention. A Well Woman Exam is preventative and does not address any current health problems or concerns.

We want to bring to your attention that if you are experiencing any problems, or if there is a problem identified during your exam, your insurance company may require us to collect an additional copay amount.

Please initial next to your preference for today's visit below:

________ I want ONLY my Well Woman Exam today.

________ I want ONLY to address my problems today. *
*Your office visit copay or co-insurance amount will be collected today.

________ I want both my annual Well Woman Exam AND problems addressed today. *
*Your insurance company may require us to collect additional copay or co-insurance amounts.

______________________________ ______________
Patient Printed Name Date of Birth

______________________________ ______________
Patient Signature Today's Date

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Patient Information

Please Print ALL Information

Name ______________________________ Marital Status ____________

Address ______________________ City __________ St _____ Zip ________

SSN ________________ Date of birth ________________ Age ________

Cell ______________ Work ______________ Other ______________

Email ______________________________ Referred By ______________

Emergency Contact ______________________ Relationship ______________

Cell ______________ Work ______________ Other ______________

Primary Insurance Information:

Is this a ☐ *Group (Through employer)* *OR* ☐ *Individual (self purchased)*

Primary Insurance ________________ Policy Holder ________________

Policy Holder's DOB ________________ Relationship to patient ______________

Claims Address ________________ Insurance Phone # ______________

Member ID# ________________ Group# ________________

Secondary Insurance Information:

Is this a ☐ *Group (Through employer)* *OR* ☐ *Individual (self purchased)*

Secondary Insurance ________________ Policy Holder ________________

Policy Holder's DOB ________________ Relationship to Patient ______________

Claims Address ________________ Insurance Phone # ______________

Member ID# ________________ Group# ________________

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, PPO plans, and all other health plans to CENTENNIAL OB/GYN, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize said assignee to release all information needed to secure the payment.

Signature ______________________________ Date ________________

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GENERAL CONSENT FOR TREATMENT

***The following is a general consent for treatment for any services rendered here in the office, e.g., pap smear, breast exam, pelvic exam. If your plan of treatment requires further procedures, you will be consented on those specific procedures.*

*The consent you are about to read was written by the Texas Medical Association and requires that all physicians have patient consent for general treatment.***

"I, knowing that I am suffering from a condition requiring diagnostic, medical, or surgical treatment, do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instructions of the Physicians of Centennial OB/GYN, P.A., their assistants, or their designee as is necessary in their judgment.

I also acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the result of treatments or examination by Centennial OB/GYN, P.A.
--Texas Medical Association.

****

Assignment of Insurance Benefits

I hereby authorize direct payment of surgical/medical benefits to Centennial OB/GYN, P.A. for services rendered by them in person or under their supervision. I understand that I am financially responsible for all of the fees or any balance not covered by my insurance.

Authorization to Release Information

I hereby authorize Centennial OB/GYN, P.A. to release any medical or incidental information that may be necessary for either medical care or in processing claims or applications for financial benefits.

Medicare

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf to Centennial OB/GYN, P.A., Dr. Leslie Welborne, Dr. Melissa Bailey, Dr. Alisa Ward and Ruth Whiddon, W.H.N.P.

A photocopy of these assignments shall be as valid as the original.

Print Patient Name: ______________________________ Date of Birth: __________

Print Parent or Guardian Name: ______________________________________

Signature: ______________________________ Date: ____________

Leslie S. Welborne, M.D.

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entennial OB/GYN, P.A.

OFFICE POLICIES

At Centennial OB/GYN, we are dedicated to providing you with the best medical care available. In order to do that, we will need your assistance in providing us with necessary information. This information will be kept confidential and is protected by law. We hope you understand that the information provided is used for purposes of providing services to you and is shared only with the insurance company for the purpose of reimbursement. If any type of lab work is done, this same information will be provided to them as well. We will not release your information to any other facility or person unless requested by you in writing.

We will file your insurance if we are a participating provider under the plan for which you are enrolled. Any out of pocket expenses, copays, deductibles or co-insurance is the responsibility of the patient and are due at the time of service. If we are not a participating provider on the plan you are enrolled, payment will be due at the time of service. We accept checks, cash, Master Card, Discover, Amex & Visa. If a check will be used as payment, your driver's license must be provided.

****** Please review and initial each line below ******

_____ Your insurance is a contract between you, your employer, and the insurance company. We do file your claims as a courtesy only. The lab companies will file your lab claims. Ultimately, medical and lab charges are the responsibility of the patient.

_____ Unfortunately, we are not always aware of the particular details of each insurance plan. Therefore, please be sure you are aware of any exclusions and/or provisions with your plan. Any service not covered by the insurance will be the responsibility of the patient.

_____ Please be aware that out of network providers may provide all or part of any services performed outside the office of CENTENNIAL OB/GYN, P.A. These may include: labs, anesthesiologists, pathologists, radiologists, other physicians, or facilities, etc...

_____ **A copay will apply for Well Woman visits which address problems or require additional medical decision making, as a problem office visit will be billed as well.**

If you have any questions or concerns with these policies, please feel free to contact our office. This form must be signed prior to services being rendered. It will become part of your permanent record with our office.

Print Patient Name: ______________________________ Date of Birth: ____________

Print Parent or Guardian Name: ______________________________

Signature: ______________________________ Date: ____________

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CANCELLATION AND NO SHOW POLICY

Thank you for trusting your health care to Centennial OB/GYN, P.A. When you have an appointment with our providers, we dedicate that time to focus on you and your medical care and concerns. Should you need to cancel or reschedule an appointment, we ask that you give us adequate notice to enable us to utilize that time for other patients in need of our care. We will pro-actively remind you of your appointment via text and/or phone call.

Cancellations / Rescheduled Appointments
We understand that there are a variety of reasons which can cause you to cancel or reschedule. We ask that you call us as soon as possible to do so. Out of courtesy to other patients' medical needs, please call us at least 48 hours (2 business days) prior to your appointment to cancel or reschedule.

No Show Appointments
A No-Show appointment is one which is missed without cancelling or rescheduling.

NO SHOW FEES

All fees are charged directly to the patient, not the insurance company, and must be paid before another visit will be scheduled. Fees will be assessed if you do not call to cancel or reschedule at least 1 business day in advance*.

Office Appointments – $25.

Diagnostic Appointments - (i.e. ultrasound, NST) - $50.

Procedure Appointments – (i.e. EMB, EndoSee, IUD, Nexplanon, etc) - $75.

Surgery Appointments – * $100 if not cancelled or rescheduled at least 72 hours (3 business days) prior to your appointed time. This applies to both in-office and hospital surgical procedures.

I HAVE READ AND UNDERSTAND THE CANCELLATION AND NO SHOW POLICY. I AGREE TO THE TERMS.

Signature (Patient / Legal Guardian) ______________________ Relationship to Patient ______________________

Printed Name ______________________ Date ______________________

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Disclosure of Health Information

I understand that as part of my healthcare, Leslie S. Welborne, M.D., Melissa Bailey, M.D., Alisa Ward, M.D. and/or Ruth Whiddon, W.H.N.P. ("PHYSICIAN") originates and maintains health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.
The PHYSICIAN's Notice of Privacy Practices provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the Notice f Privacy Practices and understand that I have the right to review the notice prior to signing this consent. I understand that the PHYSICIAN reserves the right to change the Notice of Privacy Practices. Prior to implementation of the revised Notice of Privacy Practices, the revised Notice will be mailed to me if I proved my address below. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment of healthcare operations and that the PHYSICIAN is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that the PHYSICIAN has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

☐ I restrict the use and/or disclosure of my personal health information from the following person(s).

____

☐ I authorize the use and/or disclosure of my personal health information to the following person(s):

____

☐ I authorize the use of my personal email for correspondence of my medical information:

Email: ____

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
I have been provided and have reviewed the PHYSICIAN's Notice of Privacy Practices dated_______________.

______________________________ ______________
Signature of Patient or Legal Representative Date

____
Print Name of Patient or Legal Representative

*I request that changes to the Notice of Privacy Practices be sent to me at this address:

____

____

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION BY RELEASE OF MEDICAL RECORDS

Disclosure of Personal Health Information (PHI), as required by applicable Federal and State Law, will be permitted only by following the HIPAA Privacy Practices that are set forth in the Centennial OB/GYN, P.A. Privacy Notice. A Patient's Privacy will be maintained in all instances where use of PHI is applicable. A copy of this Privacy Notice is available effective August 15, 2015.

REQUEST RECORDS FROM:	PLEASE SEND THE RECORDS TO:
Name: ______	Name: ______
Address: ______	Address: ______
City: ______ State: ______ Zip: ______	City: ______ State: ______ Zip: ______
Phone: ______ Fax: ______	Phone: ______ Fax: ______

PATIENT INFORMATION:

Patient Name: ______ Social Security number: ______

Address: ______

City: ______ State: ______ Zip: ______

Phone #: ______ Fax #: ______ Date of Birth: ______

I, ______, authorize the above listed person/s, physician/s, firm or entity (or its Agents, representatives, or employees) to release for inspection and copying, and all of the Personal Health Information (PHI) listed below that pertain to my treatment, hospitalization, or care from the date/s of : ______ to ______.

- O Entire Record – Inpatient
- O Radiology/X-Ray Reports
- O Operative Reports
- O Pathology Reports
- O Entire Record – Outpatient
- O Newborn/Neonatal Records
- O Laboratory Reports
- O ER Records
- O Labor & Delivery Records
- O Discharge Summary
- O Anesthesia Records
- O Other: ______

REASON FOR REQUESTING RELEASE: O Transfer care to: ______ O 2nd Opinion

O Continuity of care (PCP) O Relocating O Other:

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. O I DO NOT WANT HIV OR MENTAL HEALTH INFORMATION RELEASED.

I understand I have the right to refuse the release of records for self-pay services to health plans requesting medical information.
O I DO NOT WANT INFORMATION FOR SELF-PAY SERVICES RELEASED.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: ______
If I fail to specify an expiration date, event or condition, this authorization will expire 180 days from the date (below) it is initiated.

I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

The Patient's Authorization below confirms his/her agreement for this Disclosure of his/her PHI. Once a completed, signed Authorization is received in our office, please allow up to 10 business days for processing this request. A photocopy of this Authorization will have the same effect and force of an original.

Authorization of Patient or Personal Representative: ______ Date: ______

Patient's Printed Name: ______ Witness: ______