MARY GRACE BRIDGES, MD

PATIENT REGISTRATION FORM

Name:____ Sex: M F
Last Name First Name MI

Date of Birth: ________________ Age: _____ Social Security# ________________

Address: ________________________City: __________ State: _____ Zip: _____

Home# _______________ Mobile# ________________ Work# ________________

Email: ____

Patient Portal Access? Yes No Register Family Member for Access? Yes No

Employer: ____________________________________ Work# ________________

Contact Preference: ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ Mail ☐ Portal

EMERGENCY CONTACT INFORMATION

Name: ____________________________________ Relationship ____________

Home# _________________ Cell# ________________ Email: ______________

DEMOGRAPHICS

Language ______________ Race ________________ Ethnicity ______________

Marital Status: ☐ **Minor** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Sexual orientation _________________ Gender Identity ____________________

PATIENT'S SPOUSE

Name:____ Sex: M F
Last Name First Name MI

Relationship: _________________________ Social Security# ________________

Date of Birth: ______________ Mobile# ________________ Alt# ______________

Name of Employer: ______________________________ Phone# ______________

NEXT OF KIN

Name: ____________________________________ Relationship ____________

Home# _________________ Cell# ________________ Email: ______________

EMPLOYMENT

Employer Name: ______________________________ Phone#: ______________________

Occupation: ____

GUARDIAN

Name: ____ Relationship ______________

RESPONSIBLE / INSURED PARTY

Guarantor Name: ___________________________ Relationship to Patient ________________

Guarantor Date of Birth: _______________________ Social Security #: __________________

Guarantor Address (if different from patient) ____

INSURANCE INFORMATION

Primary Insurance ____

Policy Holder Name __________________________________ Date of Birth: ______________

Policy ID# _________________ Group# __________________ Phone# __________________

Secondary Insurance ____

Policy Holder Name __________________________________ Date of Birth: ______________

Policy ID# _________________ Group# __________________ Phone# __________________

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for any balance and charges whether covered or not by insurance.

I request that payment of my insurance benefits be made on my behalf to the office of Women's Health Partners of the Permian Basin PLLC, for any services furnished to me by that group of physicians and providers.

____ Date: ____________________

Signature of Patient or Patient Representative (if under 18 years of age)

MARY GRACE BRIDGES, MD

NAME: ______________________ **DATE OF BIRTH:** __________ **DATE:** __________

PRIMARY CARE PHYSICIAN: ______________________

PHARMACY: ______________________

GYN HISTORY

Date of Last Pap Smear: __________ History of abnormal pap? ☐ Yes ☐ No HPV vaccine? ☐ Yes ☐ No

Have you gone through menopause? ☐ Yes ☐ No If Yes, age at menopause __________

Any postmenopausal bleeding? ☐ Yes ☐ No Any hormone therapy? ☐ Yes ☐ No

Sexually active? ☐ Yes ☐ No Current birth control __________ Desired birth control __________

Last Menstrual Period (LMP) __________ Age at Menarche __________ Menses monthly? ☐ Yes ☐ No

Frequency of cycle (Q days) _____ Duration of flow (days) _____ Flow: ☐ Light ☐ Moderate ☐ Heavy

Sexual problems? ☐ Yes ☐ No STIs/STDs? ☐ Yes ☐ No Date of last mammogram __________

Date of last colonoscopy __________

Hysterectomy? ☐ Yes ☐ No Removal of ovaries? ☐ Yes ☐ No Date of last bone density __________

OBSTETRICAL HISTORY

☐ **Check here if you have NEVER been pregnant** ☐ **Check here if you have adopted children (list names below)**

Pregnancies: Please list all pregnancies in order, including miscarriages, premature births, stillbirths, ectopic pregnancies (tubal), and abortions:

YEAR	LENGTH OF PREGNANCY	SEX	WEIGHT	TYPE OF DELIVERY (VAG/C-SEC)	LOCATION	PROBLEMS (eg preterm birth, diabetes, high blood pressure)	NAME/AGE

FAMILY HISTORY

Please list any close relatives with a history of the following

	RELATIVE/AGE AT DIAGNOSIS		RELATIVE/AGE AT DIAGNOSIS
☐ Breast Cancer		☐ Lung Cancer	
☐ Ovarian Cancer		☐ Diabetes	
☐ Uterine Cancer		☐ High blood pressure	
☐ Colon Cancer		☐ Heart Disease	

SOCIAL HISTORY

Tobacco smoking status ☐ Never ☐ Former ☐ Current every day smoker ☐ Current some day smoker
Smoking – how much _______ packs per ☐ day ☐ week Smoked since age ___________
E-cigarette use ☐ Yes ☐ No
Alcohol intake ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
Alcohol prepregnancy ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
Illicit drugs ☐ Yes ☐ No Type and frequency ____________________ Years of use ______
Illicit drugs prepregnancy ☐ Yes ☐ No Type and frequency ____________________ Years of use ______
Sexually active ☐ Yes ☐ No
Occupation ____________________________________ Education ____________________________
Relationship status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner
Number of children ___________ Exercise level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
Diet: ☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Cardiac ☐ Diabetic
Live with cats/exposure to cat litter ☐ Yes ☐ No Recent Travel? ☐ Yes ☐ No

SURGICAL HISTORY: **Please list all surgeries with dates**

_______________________________ _______________________________ _______________________________
_______________________________ _______________________________ _______________________________
_______________________________ _______________________________ _______________________________

MEDICAL HISTORY: **Please list all medical problems**

_______________________________ _______________________________ _______________________________
_______________________________ _______________________________ _______________________________
_______________________________ _______________________________ _______________________________

Have you ever had any of the following?

☐ Abuse/Domestic Violence	☐ Breast Problem	☐ Gestational Diabetes	☐ Mitral Valve Prolapse
☐ Acne	☐ Cancer	☐ Heart Disease	☐ Neurologic/Epilepsy
☐ Anemia	☐ Chicken Pox	☐ Heart Problems	☐ Osteoporosis
☐ Anesthesia Complications	☐ Depression/Anxiety	☐ Hematologic Disorders	☐ Ovarian Cancer
☐ Anxiety Disorder	☐ Postpartum Depression	☐ Hepatitis/Liver Disease	☐ Ovarian Cysts
☐ Art (IVFor FET)	☐ Dermatologic Disorders	☐ High Cholesterol	☐ Pain with intercourse
☐ Arthritis	☐ Diabetes	☐ History of STD/STI	☐ Pelvic infections
☐ Asthma	☐ Drug or Alcohol Problems	☐ History of abnormal pap	☐ Pelvic pain
☐ Autoimmune disease	☐ Drug/Latex Allergies	☐ Hypertension	☐ Pneumonia
☐ Bipolar Disorder	☐ Eating Disorder	☐ Infertility	☐ Polycystic ovary syndrome
☐ Birth Defects or Inherited	☐ Endometriosis	☐ Kidney Disease	☐ Pre-Eclampsia
☐ Bleeding Problems	☐ Epilepsy/Seizures	☐ Kidney or Bladder Problems	☐ Sickle Cell Disease
☐ Blood Clots in Lungs/Legs	☐ Fibromyalgia	☐ Liver Disease/Hepatitis	☐ Stroke
☐ Blood Transfusion	☐ Gall Bladder Disease	☐ Lung Disease	☐ Thrombophilias
☐ Breast Cancer	☐ Genetic Condition	☐ Migraines	☐ Thyroid Problems

Other:

____
____

PATIENT SIGNATURE ____ **DATE** ________________

CLINICIAN SIGNATURE ____ **DATE** ________________

WOMEN'S HEALTH PARTNERS
OF THE PERMIAN BASIN

601 N. Tom Green Ave, Suite B   Odessa, TX 79761
Phone: (432) 332 - 0090   Fax: (833) 908 - 2112

Name: ____ **DOB:** ________________

PHARMACY NAME: ____

Pharmacy Address: ____________________________________ **Phone#** ____________

ALLERGIES

(Please list ALL known allergies) **OR** ☐ **No Known Allergies**

ALLERGY	REACTION / SYMPTOMS

LIST OF CURRENT MEDICATIONS

MEDICATION	DOSE	FREQUENCY	PURPOSE	PRESCRIBED BY

AUTHORIZATION FOR ELECTRONIC COMMUNICATION

By signing this form, I authorize Women's Health Partners of the Permian Basin, PLLC to communicate with me electronically via telephone, text messaging, email, faxing, the clinic website, internet patient portal, designated insurance &/or EAP websites, appointment scheduling sites and claims filing sites. These communications will be used for scheduling, and for collecting or sending pertinent clinical, insurance information and claims, billing &/or collections information as is necessary to provide your treatment and or to correspond.

I understand that communications via the means as described above, are not always secure. Although it is unlikely, there is a possibility that information you send to us, or that we send to you, may be intercepted and read by other parties besides the person to whom it is addressed.

I understand that by federal law, Women's Health Partners of the Permian Basin, PLLC may not use/disclose my healthcare information without my authorization except the information designated in my Patient-Clinician Agreement.

My signature on this disclosure indicates that I am giving my permission to engage in the electronic and internet communication described above. I hereby release Women's Health Partners of the Permian Basin, PLLC from any and all liability that may arise from the release of electronic information.

I understand that I have the right to revoke this authorization at any time. If I want to revoke this authorization I must do so in writing and address it to Women's Health Partners of the Permian Basin, PLLC. I understand that if I revoke this authorization, it will not apply to any information previously released as a result of this authorization. I understand that I may refuse to sign this authorization. I also understand that Women's Health Partners of the Permian Basin, PLLC cannot deny or refuse to provide treatment or billing services if I refuse to sign this authorization. I understand that once the information is disclosed pursuant to this authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

______________________________ ______________

Printed Name Date

____

Signature of Patient/Guardian/Power of Attorney/Healthcare Surrogate

Mary Grace Bridges, MD
601 N Tom Green Ave, Suite B
Odessa, TX 79761
Phone: 432-332-0090
Fax: 833-908-1737

WOMEN'S HEALTH PARTNERS
OF THE PERMIAN BASIN

ASSIGNMENT OF BENEFITS AND AUTHORIZATION RELEASE

FINANCIAL RESPONSIBILITY

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our office. Necessary forms will be completed to file for insurance carrier payments.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment directly to Women's Health Partners of the Permian Basin, PLLC for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Women's Health Partners, PLLC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Women's Health Partners of the Permian Basin, PLLC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

PRINTED NAME ____ DATE OF BIRTH _____________

SIGNATURE ____ DATE _______________________

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name or Legal Guardian (print) _______________ Date _______________

Signature _______________

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below:

Patient Name: ______________________________ Date of Birth: ________________

The information you may release subject to this signed release form is as follows:

- ☐ Complete Records
- ☐ Care Plan
- ☐ Pathology Reports
- ☐ Hospital Reports
- ☐ History & Physical
- ☐ Lab Reports
- ☐ Treatment Record
- ☐ Medication Record
- ☐ Progress Notes
- ☐ Radiology Reports
- ☐ Operative Reports
- ☐ Other (Please specify below)

____

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Mary Grace Bridges, MD
601 N Tom Green Ave, Suite B
Odessa, TX 79761
Fax: (833) 908-2112

____ ________________
Printed Name Date

____
Signature of Patient/Guardian/Power of Attorney/Healthcare Surrogate

WOMEN'S HEALTH PARTNERS
OF THE PERMIAN BASIN

Patient's Request for Release of Information

Authorization for Verbal Release of Protected Health Information to Designated Persons

AT THE PATIENT'S REQUEST, THIS AUTHORIZATION GRANTS PERMISSION TO WOMEN'S HEALTH PARTNERS OF THE PERMIAN BASIN, PLLC TO COMMUNICATE IN PERSON OR BY TELEPHONE TO THE FOLLOWING PERSON(S), DESIGNATED BY THE PATIENT, TO ASSIST WITH THE PATIENT'S HEALTH SERVICES. THIS AUTHORIZATION IS APPLICABLE FOR VERBAL INFORMATION ONLY AND IS NOT VALID FOR THE RELEASE OF THE WRITTEN MEDICAL RECORD.

I AUTHORIZE Women's Health Partners of the Permian Basin PLLC to communicate my health information to the person(s) listed below ("Designated Person") for the following purposes: to orally confirm my appointments; to discuss results of my laboratory, radiology, or other test results; to pick up sample medications or written prescriptions for me; to discuss my healthcare, diagnosis, prognosis, and treatment plans; and to discuss billing and payment for my medical services provided by Women's Health Partners of the Permian Basin PLLC.

Name: ______________________________ Relationship to Patient: ____________________
Address: ____________________________ Telephone: ____________________________
____________________________________ Alt. Phone ____________________________

Name: ______________________________ Relationship to Patient: ____________________
Address: ____________________________ Telephone: ____________________________
____________________________________ Alt. Phone ____________________________

Name: ______________________________ Relationship to Patient: ____________________
Address: ____________________________ Telephone: ____________________________
____________________________________ Alt. Phone ____________________________

I UNDERSTAND that this authorization applies to all departments, healthcare providers, and/or employees at Women's Health Partners of the Permian Basin PLLC.

I UNDERSTAND that this authorization is voluntary.

I UNDERSTAND that once this information is disclosed to the Designated Person(s), it may be re-disclosed by them and may no longer be protected by state or federal privacy laws.

I UNDERSTAND that this authorization will be effective for my lifetime, unless revoked by me, and for one year following my death. I further understand that I may revoke this authorization at any time by sending a written statement of revocation to the office. If I revoke my authorization, it will not have any effect on any actions taken by Women's Health Partners of the Permian Basin PLLC prior to the processing of the revocation.

I UNDERSTAND that my refusal to sign this authorization will not negatively affect my health care services at Women's Health Partners of the Permian Basin PLLC.

____ Date: __________________
Signature of Patient or Patient Representative (if under 18 years of age)

WOMEN'S HEALTH PARTNERS
OF THE PERMIAN BASIN

OFFICE POLICIES

Our mission is to provide exceptional medical care in a compassionate, professional, and safe environment. If this is not being provided, please contact our business manager, Maria Cadena.

In order to provide the best care to all of our patients, we ask that you review and sign our Office Policies.

- Clinical visits are by appointment only. Please arrive 15 minutes prior to your scheduled appointment. Please give at least 24-hour notice prior to your appointment for cancellations. We may charge for the visit if notice is not provided. Patients arriving 20 minutes past their scheduled appointment may be rescheduled.
- Please provide accurate and updated contact phone number and address.
- Disruptive or disrespectful behavior by patients and/or patient family members is not tolerated and will result in dismissal from our practice. The following list are examples, not is not an exhaustive list:
    - **Use of profanity, threatening behavior, shouting, slander in person or on social media, theft, property damage, refusal to comply with recommendations, payment refusal**
- Please DO NOT BRING FOOD OR DRINKS into our lobby or office. Bottled water is allowed
- For your child's safety, please provide childcare arrangement. Infants strapped into a carrier and children over 12 years are the only children allowed in the lobby and office. **Please take full responsibility for your child.** Staff will be happy to reschedule your appointment if necessary.
- We prefer a maximum of only 1 additional guest in the patient room. Exceptions may be made with permission for obstetric ultrasounds.
- If you do NOT SHOW for your appointment without notice on more than one occasion, you will receive 30 days' notice to follow up or we will no longer consider you as our patient. Extenuating circumstances are taken into account.
- **Dr. Bridges and the staff respect your time, but hospital emergencies, obstetrical deliveries and unexpected additional time for surgical cases and clinic visits are at time unavoidable and take priority.**
- Phone calls: We currently have multiple phone lines with an answering service available during non-business hours. If all lines are being used a busy signal may occur. We ask that you as the patient make the phone call and not a family member unless extenuating circumstances arise.
- For non-emergent medical questions or medication refills please call between the following times:
    - 8:00 am - 8:30 am
    - 11:30 am - 12:00 pm
    - 4:30 pm – 5:00 pm
- For emergent questions or to reschedule an appointment, please call as soon as possible. Do not hesitate to contact the hospital or the emergency room if medically necessary. We want to answer your questions and provide exceptional care in a timely manner. First priority is with the patients we are currently seeing in the office.
- **If you transfer care to another provider in the area, you will no longer be considered our patient and records may be faxed in a timely manner upon new provider request. We reserve the right to refuse anyone as a patient upon initial consultation. We have the right to dismiss any patient from our practice at which time you will be provided 30 days' notice to seek another provider.**

I HAVE READ AND AGREE TO ADHERE TO THE OFFICE POLICIES STATED ABOVE

___

Signature Print Name Date

601 N. Tom Green Ave, Suite B
Odessa, TX 79761
Phone: (432) 332-0090 Fax: (833) 908-2112

Knowledge Consent for Procedure
I am aware if my private insurance does not reimburse Women's Health Partners of the Permian Basin PLLC, I will be responsible for full payment to the office.

Knowledge Consent for Procedure for all Self Pay, Private Insurance, and Medicaid
I am aware if my insurance does not reimburse Women's Health Partners of the Permian Basin PLLC, I will be responsible for full payment to the office.

Medicaid Knowledge Consent Office Policy
I am aware that Women's Health Partners of the Permian Basin PLLC does not back-file on any Private Insurance, Medicaid and Medicare. Any source of money given as payment will not be refunded.
I, the patient, by signing this waiver acknowledge that I understand this office policy.

____ Date: __________________
Signature of Patient or Patient Representative (if under 18 years of age)