Greenville OB-GYN Clinic

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Ph. (903)454-1722 Fax. (903)454-1750
Marie Hollis M.D
Teri Singleterry FNP-C, Heather Banker CNM
Daphney Ayinde DNP, FNP-C

Patient Intake Information

Date: _____

Name: _____
First MI Last

SS: _____ D.O.B. _____

Home PH: _____ Cell PH: _____ Work PH: _____

Address: _____ City: _____ State: _____ Zip code: _____

Marital Status: _____ Race: _____ Ethnicity: _____ Language: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ PH #: _____

Spouse: _____ Spouse D.O.B. _____

Spouse PH# _____ Spouse Work # _____

Insurance Information

Group # _____ Copay: _____

Name of Insured: _____ Insured D.O.B. _____

Relationship to Patient: _____ Employer: _____

Insurance Address: _____ Phone # _____

Insurance Company: _____ Policy #: _____

Secondary Insurance

Insurance Company: _____ Policy #: _____

Group # _____ Copay: _____

Name of Insured: _____ Insured D.O.B. _____

Relationship to Patient: _____ Employer: _____

Insurance Address: _____ Phone # _____

Dr. Marie Hollis M.D
Teri Singleterry FNP-C, Heather Banker CNM
Daphney Ayinde DNP, FNP-C

I authorize and direct **Marie Hollis** to examine me and perform those procedures necessary for prenatal and/or family planning care and/or women's healthcare and/or general medical care. Procedures that may be performed include, but are not limited to:

- Medical history and physical examination, including pelvic and breast examination
- Blood draws to screen for syphilis, anemia, rubella, diabetes, hepatitis, and AIDS or HIV, and other blood work determined to be necessary.
- Urinalysis, urine pregnancy test, urine culture, and drug screens.
- Gonorrhea/Chlamydia culture and pap smear
- Other appropriate lab work
- Ultrasound
- Necessary Immunizations

The nature of the procedures has been explained to me and no warranty to guarantee has been made to the result.

I understand that medical providers of the OB-GYN clinic who will be examining me include physicians, certified nurse midwives, advanced nurse practitioners and physician assistants.

- Advanced nurse practitioners are professional nurses educated to provide the full range of primary care services in the community and hospital settings. They are certified by the American Nurse Association or by nursing specialty organizations. They hold licenses from the state as Registered Professional Nurse Practitioners.
- Physician Assistants are skilled members of the health care team who are educated to work dependently with physicians and under their supervision provide diagnostic and therapeutic patient care.
- Certified Nurse Midwives are individuals educated in the two disciplines of the nursing and midwifery, which possess certification according to the requirements of the American College of Nurse Midwives. In addition, in the state of Texas, they hold license as Registered Nurses and Advances Nurse Practitioners.

I understand that I may request to be seen by a physician.

Additionally, the OB-GYN clinic employs or contracts with other professionals to provide some of the services offered as part of our treatment team. These individuals provide ancillary or allied health services such as sonography, phlebotomy, and psychotherapy. I understand that as part of my assessment or treatment at the OB-GYN, qualified professionals, may provide, at the request of my medical practitioner, ancillary or allied health service important to my care.

I authorized release of any medical information required for payment of my provider (including ancillary or allied health services) and/or hospital charges for services rendered by the OB-GYN clinic or by one of its providers or allied health practitioners. I further authorized release of information to any hospital or medical facility I present myself to medical care.

Patient Signature: _____ **Date:** _____
Print Name: _____
Guardian Signature: _____ **Date:** _____

Greenville OB-GYN Clinic
Marie Hollis M.D
Teri Singleterry FNP-C, Heather Banker CNM
Daphney Ayinde DNP, FNP-C

Missed Appointment/No show policy

Dear Patient:

Our goal is to provide quality medical care in a timely manner. In order to achieve this we implemented a missed appointment/no show policy. This allows us to better utilize available appointments for patients who need medical care.

Please be respectful and call our office if you need to cancel or reschedule an appointment at least 24 hour in advance. You may leave a message if you are unable to reach us. Be sure to leave your contact information and the best time to return your call if you wish to reschedule.

A "no show" is someone who misses an appointment without canceling or rescheduling in a timely manner. No show appointments are inconvenient to both patients who need medical care and our office.

If you do not give a 24 hour notice or you no show an appointment, you will be charged a 10.00 fee.

If you do not give a 24 hour notice or you no show an office procedure, you will be charged a 25.00 fee.

By signing below you are acknowledging that you have read and understand our missed appointment/no show policy.

Printed Name _____

Signature _____ Date _____

Witness Signature (Office Employee) _____

CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH OPERATIONS

Name: _____

D.O.B _____ Social Security:_____

I understand that as my part healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for the future care of treatment.

I understand that this information serves:

- A basis for planning my care and treatment
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill were actually provided.
- A too for routine healthcare operation such as assessing care quality and reviewing he competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out, treatment, payment, of healthcare operation and that the organization is not required to agree to the restrictions requested.

To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following names mentioned to the use of disclosure of my health information:

_____

_____

I further authorize my payment be made directly to Dr. Marie Hollis for medical or surgical benefits. I will be responsible for payment of any medical or surgical fees not covered by my insurance company.

_____ _____ _____

Signature of patient/Legal representative **Date** **Witness Signature**

Greenville OB-GYN Clinic
Marie Hollis M.D.

Patients Name: _____ **Date of Birth:** _____

Reason for Visit:

What brings you in today: _____

What other concerns would you like to address?

Past Medical History:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Autoimmune Disorder
- ☐ Back problems
- ☐ Blood Disorders
- ☐ Blood Transfusion
- ☐ Breast Cancer
- ☐ Clotting Disorder
- ☐ Colon Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Eating Disorders
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Heart Defects
- ☐ Hepatitis A,B, or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Liver Disorder
- ☐ Kidney Disorder
- ☐ Joint Disorder
- ☐ Lung Disorder
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Ovarian Cancer
- ☐ Psychiatric Illness
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Stomach Ulcer
- ☐ Substance Abuse
- ☐ Tuberculosis
- ☐ Uterine Cancer

Medications:

Past Surgical History:

Surgery	Date	Where Performed

Drug or Latex Alergies?: _____

Date of Birth: _____

Pregnancy History:

# of Pregnancies	#Term	#Preterm	#Miscarriages	#Abortions

Date:	#Weeks	Type of Delivery	M/F	Weight	Living	Complications

Are you currently pregnant: ☐ Yes ☐ No

Are you trying to get pregnant: ☐ Yes ☐ No

What is your current method of Birth Control: _____

Menstrual History:

Age at First Period? _____

Date of Last Period? _____

Frequency of periods? _____

Length of Period? _____

Are your periods regular? ☐ Yes ☐ No

Age at Menopause? _____

Health Maintenance:

Last Pap Smear: _____

Last Mammogram: _____

Last Colonoscopy: _____

Last Bone Density: _____

Last general health checkup: _____

Immunizations up to date? ☐ Yes ☐ No

OB-Gyn History:

☐ Abnormal Vaginal Bleeding
☐ Abnormal Pap Smear
☐ Bleeding Between Periods
☐ Breast Lump/Mass
☐ Cervical Cancer
☐ Cervical Displasia
☐ Chlamydia
☐ Fecal/Flatus Incontinence
☐ Fibriods
☐ Genital Warts
☐ Gonorrhea
☐ Herpes
☐ Hot Flashes
☐ HPV (Human Papilloma Virus)
☐ Infertility
☐ Irregular Periods
☐ Menstrual Pain
☐ Nipple Discharge
☐ Painful Intercourse
☐ Pelvic Inflammatory Disease
☐ Uterine Hyperplasia
☐ Urinary Incontinence
☐ UTI- Frequent

PHARMACY: _____

Life Style:

Are you sexually active? ☐ Yes ☐ No Would you like to be checked for STD's? ☐ Yes ☐ No

Is your partner a Male ___ or Female____

How many partners have you had this year? _____/ Life time partners _____

Do You smoke? ☐ Yes ☐ No Do you use recreational drugs? ☐ Yes ☐ No

How much alcohol do you drink per week? _____

How many times per week do you exercise? _____

Review of Systems:

- ☐ Ankle Swelling
- ☐ Any Cancer
- ☐ Arthritis
- ☐ Birth Defect
- ☐ Blood in Stool
- ☐ Broken Bone
- ☐ Chest Pain
- ☐ Constipation
- ☐ Coughing
- ☐ Diarrhea
- ☐ Dizziness
- ☐ Enlarged Heart
- ☐ Fainting
- ☐ Fatigue
- ☐ Gallbladder Disease
- ☐ Gout
- ☐ Head/Neck Injury
- ☐ Heart Attack
- ☐ Heart Burn
- ☐ Irregular Heartbeat
- ☐ Insomnia
- ☐ Lupus
- ☐ Memory Loss
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Murmurs
- ☐ Nausea
- ☐ Pancreatitis
- ☐ Pneumonia
- ☐ Scoliosis
- ☐ Shortness of breath
- ☐ Stomach Pain
- ☐ Tremors
- ☐ Vomiting
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

natera | Empower™ Hereditary cancer test

Name:

Date of Birth (MM/DD/YY):

Hereditary Cancer Risk Assessment Questionnaire - General Instructions

Please answer the following questions about your personal and family history to the best of your knowledge. This will help your provider understand if there could be patterns of hereditary cancer in your family. For personal history, enter the types of cancer you have had and your age at diagnosis. For family members who are bloo relatives, enter the types of cancer they had and their approximate age at diagnosis. Family members include parents, siblings, children, uncles, aunts, grandparents, great-grandparents, grandchildren, great-grandchildren, great-uncles, great-aunts, nieces, nephews, or half-sibling.

Family history of cancer

Type of Cancer	Personal / Family History	Personal - age at diagnosis	Parent/sibling/child - list sex and age at diagnosis	Family members on mother's side - list sex and age at diagnosis	Family members on father's side - list sex and age at diagnosis
Example: Breast Cancer	☑ Yes ☐ No	40	Mom, F, 47 Sister, F, 55	Aunt, F, 50	Niece, F, 36
Breast	☐ Yes ☐ No				
Ovarian	☐ Yes ☐ No				
Prostate	☐ Yes ☐ No				
Pancreatic	☐ Yes ☐ No				
Colorectal	☐ Yes ☐ No				
Uterine	☐ Yes ☐ No				
Gastric	☐ Yes ☐ No				
Melanoma	☐ Yes ☐ No				
Other (please fill in):	☐ Yes ☐ No				
Other (please fill in):	☐ Yes ☐ No				

Please complete the following with your provider, check all that apply:

- ☐ Personal or family history of cancer at age 50 or younger
- ☐ Personal or family history of ovarian or pancreatic cancer
- ☐ Personal or family history of one or more of the following conditions: Male Breast Cancer / Triple Negative Breast cancer / 10 or more colorectal polyps
- ☐ Two relatives with cancer on the same side of your family
- ☐ Ashkenazi Jewish descent
- ☐ You have had hereditary cancer genetic testing (if yes, please attach the report to the Empower Requisition Form)
- ☐ Family member that has had hereditary cancer genetic testing. If yes, list gene mutations found, if any:_____
- ☐ Concerned about personal and/or family history of cancer

Signatures

Patient Name _____ Patient Signature _____ Date _____

Provider's Name _____ Provider's Signature _____ Date _____

For office use only

Patient offered hereditary cancer genetic testing (check all that apply)

☐ Yes ☐ No ☐ Patient accepted ☐ Patient declined