New Patient

JOSE E. SAN MARTIN, M.D.
OBSTETRICS / GYNECOLOGY

286 Ed English Dr Unit C Shenandoah Tx, 77385
P: 281-651-2090 F: 281-607-5700

Information patient:

Date:	Patient Name:	
DOB:	Social Security #:	
Address:	City/State/Zip:	
Home Phone:	Work phone:	Cell Phone:
Emergency Contact Name:		
Emergency Contact Phone:	Employer:	
Email Address:	Spouse Name:	
Spouse DOB:	Spouse Social Security #:	
Spouse Work Phone:	Spouse Cell:	
How did you hear about us?		
Primary Care Physician:		

RESPONSIBLE PARTY:

Insured/Responsible Party Name:		
Insured/Responsible Party DOB:	Insured/Responsible Party Social Security #:	
Address:	City/State/Zip:	
Home Phone:	Work Phone:	Cell Phone:
Employer:	Email address:	
Relationship to Patient:		

Please provide proof of insurance and photo identification upon submission of these forms

Medications (include over the counter medications, herbal remedies and vitamins)

Name	Dose	Times per day	Reason

Preferred Pharmacy

Preferred Pharmacy Name:	Preferred Pharmacy Address:
City/State/Zip:	
Pharmacy Phone Number:	Pharmacy Fax Number:
Signature of Patient/Legal Guardian:	Date:

SAN MARTIN OB/GYN & WOMEN'S HEALTHCARE

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for San Martin OB/GYN and Women's Healthcare to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent. San Martin OB/GYN and Women's Healthcare reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy may be obtained by forwarding a written request to 25329 Interstate 45 STE 129; The Woodlands, TX 77380.

With this consent, San Martin OB/GYN and Women's Healthcare may call, mail, email, leave a message on voicemail or in person, to my home or other alternative location in reference to any items that assist the practice in carrying out TPO. Such items include: appointment reminder calls and cards, patient statements, insurance items and any calls pertaining to my clinical care, including laboratory test results.

I have the right to request that San Martin OB/GYN and Women's Healthcare restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I authorize my insurance carrier to release information regarding my coverage to San Martin OB/GYN and Women's Healthcare. I also authorize agents of any hospital, treatment center or previous physicians to furnish San Martin OB/GYN and Women's Healthcare copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within this office.

By signing this form, I am consenting to allow San Martin OB/GYN and Women's Healthcare to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, San Martin OB/GYN and Women's Healthcare may decline to provide treatment to me.

Signature of Patient or Legal Guardian	Relationship to Patient
Print Patient's Name	
Print Name of Legal Guardian (if applicable)	Date

SAN MARTIN OB/GYN & WOMEN'S HEALTHCARE

Release of Medical Information

OPTIONAL: ONLY SIGN IF YOU WANT US TO BE ABLE TO RELEASE YOUR MEDICAL INFORMATION TO SOMEONE ELSE.

By signing the following form I, _____ , allow the following person, _____ (name of relative or spouse who you would like information released to) to have access to my medical information associated with San Martin OB/GYN & Women's Healthcare. This includes any personal information that should be documented in the chart, results of any lab work and phone calls.

If you want to release information to more than one person, please list the names and relationships below...

Patient Signature/Legal Guardian	Date

PATIENT CONSENT FORM

For Medical and/or Surgical Treatment

I authorize the physician at San Martin OB/GYN to provide medical care, including without limitations, routine diagnostic procedures and medical treatment, which includes any procedures deemed necessary by the attending physician or other such physicians or assistants as may be designated by the physician for medical care.

I understand no warranty, guarantee or assurance has been made by San Martin OB/GYN as to the results of any treatment, examinations, or other medical care.

Patient Signature	Date
Parent or Legal Guardian's Signature	Date

Financial Policy and Procedures

San Martin OB/GYN & Women's Healthcare believes all patients deserve the best medical care that can be provided. In order to provide the highest quality medical care and current technology, we must ensure we are able to meet the expenses necessary to operate this facility. To ensure these expenses are met, we provide you with this agreement to acquaint you with our financial policy.

Payment At Time of Service

As a courtesy, we will bill your insurance for all office visits, procedures, surgeries and obstetrical care and delivery. We ask that you pay any portion not covered by your insurance due to deductibles or copayments on the day of service.

Appointment Policy

Due to the nature of our busy practice, if you are more than 15 minutes late you will be asked to reschedule. Should you need to cancel your appointment, please give 24-hour prior notice in consideration to other patients. Failure of 24 hour notification will result in a $25.00 fee.

Insurance Claims

We will submit your insurance claims to your insurance company. However, it is important to remember your insurance is a contract between you and your insurer. Although we file insurance claims as a courtesy to you, you are still responsible for payment of services regardless of the amount your insurance pays.

Balances Due After Insurance Pays

Any remaining balance after your insurance carrier pays is due in 30 days. We attempt to collect these balances prior to any services, but this is an estimate. You will receive a statement from our office regarding any balance due.

Outstanding Balances

We encourage you to keep your account current. Outstanding balances will need to be cleared before appointments can be made. Account balances past due will be sent to an outside agency for collections. At this point the account is out of our hands. To make appointments after accounts have been sent to an outside agency, you will need to clear your account with the collection agency. You will be responsible for the full amount of your account balance and any charges incurred with the agency. It is your responsibility to contact our business office if there are special circumstances regarding your account before your account is turned over to an outside agency.

Payment Options

Our office accepts VISA, MasterCard, Discover, cash or check. A $35.00 fee is charged for returned checks.
I have read the above statements and accept the terms.

Patients Signature	Date

Responsible Party's Signature	Date
Relationship to patient	

Gynecologic History:

What was the first day of your last period?		
At what age did your periods start?		
How often do you have a period?		
How many days does your period last?	Every_____Days	
Any pain with your periods?	☐ Yes	☐ No
Any changes in your periods?	☐ Yes	☐ No
When was your last pap test?		
Have you ever had an abnormal pap?	☐ Yes	☐ No
If yes, when?		
If yes, explain...		
Are you currently sexually active?	☐ Yes	☐ No
If no, have you ever had sex?	☐ Yes	☐ No
Any abnormal vaginal discharge?	☐ Yes	☐ No
Have you ever been treated for a pelvic infection?	☐ Yes	☐ No
Any pain with sex?	☐ Yes	☐ No
Have you ever been treated for infertility?	☐ Yes	☐ No
Have you ever had herpes?	☐ Yes	☐ No
Your present method of birth control is:		
Are you trying to get pregnant?	☐ Yes	☐ No

Obstetrical History

	Number		Number		Number
Total Pregnancies		Abortions		Miscarriages	
Premature		Term Births		Living Children	

N°	BIRTH DATE	WEIGHT	BABY SEX	GESTATIONAL AGE@ DELIVERY	VAGINAL OR C-SECTION	COMPLICATIONS
1						
2						
3						
4						
5						
6						

Any history of diabetes, high blood pressure or pre-clampsia with your pregnancy?

Any history of depression?

History of chicken pox or chicken pox vaccination?

History of rheumatic fever or heart disease?

Medical History

Are you allergic to any medications?	☐ Yes	☐ No

If so, please provide name and list reaction…

Any history of…

Asthma	☐ Yes	☐ No	Heart Failure	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No
Eating Disorder	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Bowel Problems	☐ Yes	☐ No	Abnormal Heart Rhythm	☐ Yes	☐ No
Ulcer or Gastritis	☐ Yes	☐ No	Blood Clots	☐ Yes	☐ No
Liver Problems	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Blood Problems	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No	If so, where?		

Family History

Any history of these in a parent, sibling, child, grandparent or other relative?

Stroke	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Bleeding Tendencies	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No	Sickle Cell or Thalassemia	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Hereditary Defects	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Cystic Fibrosis	☐ Yes	☐ No
Abnormal Heart Rhythm	☐ Yes	☐ No	Arthritis or Gout	☐ Yes	☐ No
Blood Clots in legs or lung	☐ Yes	☐ No	Mental Illness	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	If so, where?	☐ Yes	☐ No

Serious Illness? If yes, explain…

Serious Illness? If yes, explain…

Blood Transfusion? If yes, explain…

Surgeries? If yes, list along with date…

Recent Immunizations: Hepatitis B? Tetanus?

Social History

Marital Status:	☐ Single	☐ Married	☐ Partner	☐ Widowed	☐ Divorced
Tobacco:	☐ Never smoked		☐ Quit	☐ Smoker	☐ years smoked,
	☐ packs per day				
Alcohol:	☐ Never	☐ <1 week	☐ 1-5 per week	☐ Other	
Drug Use:			☐ Yes	☐ No	
Seat belt use:			☐ Yes	☐ No	
Regular exercise:			☐ Yes	☐ No	
Do you take calcium or dairy products:			☐ Yes	☐ No	
Have you been hurt by anyone:			☐ Yes	☐ No	
Do you have an advance directive (living will):			☐ Yes	☐ No	

REASON/CONCERNS FOR TODAY'S VISIT: