DAVID W. I. FONG, MD
OBSTETRICS•GYNECOLOGY•INFERTILITY

2840 Legacy Drive, Suite 300, Frisco, TX 75034
Phone: 972.890.9250 Fax: 214.872.4937

Patient Information Sheet

Patient Name _____ Patient Date of Birth _____ Patient Social Security # _____

Street Address _____ City, State & Zip code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ Pharmacy Address/Phone: _____

Patient Employer _____ Address _____

Spouse Information

Spouse Name _____ Spouse Date of Birth _____ Spouse Social Security # _____

Spouse Employer _____ Spouse Address (if different) _____

Spouse Cell Phone _____ Spouse Work Phone _____

Emergency Contact Information

IN CASE OF EMERGENCY, NOTIFY: _____
Emergency Name (other than spouse)

Emergency Contact Address _____ Emergency Contact Phone _____

Referral

Who may we thank for your referral? _____

Insurance Information

Insurance Information Payment is requested at the time of service, unless prior arrangements have been made

Insurance Company _____ Name of Primary Insured _____

Authorization to Release Information and Assignment of Benefits

☐By checking the box on the left, I certify that information I have reported about my insurance is correct.
☐By checking the box on the left, I authorize the release of any medical information necessary to process this claim.
☐By checking the box on the left, I authorize my doctor to apply for benefits on my behalf for covered services rendered by him or her, or by his or her order. I request that payment from my insurance company be made directly to my doctor or to the party who accepts assignment.
☐By checking the box on the left, I permit a copy of this authorization to be used in place of the original. This authorization may be revoked in writing by either me or my insurance company.
☐By checking the box on the left, I understand that I am financially responsible for the charges not covered by my insurance.

Signature _____ Date _____

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Patient Medical History & Physical

_____ _____
Patient Name Date of Last Examination

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Education (circle highest grade completed) ☐ 6th ☐ 7th ☐ 8th ☐ 9th ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ or More
High School College

_____ _____ _____
Occupation How Long? Previous Occupation

Doctors Notes _____

_____

Are you legally disabled? ☐ Yes ☐ No _____
Describe Disability

Do you use tobacco now? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

_____ _____
Type and daily amount of tobacco use? How long have/did you use tobacco?

Do you use alcohol now? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

_____ _____
Type and daily amount of alcohol use? How long have/did you use alcohol?

Do you use recreational drugs? ☐ Yes ☐ No
Do you use exercise regularly? ☐ Yes ☐ No _____
Please describe your exercise routine

Do you use follow a special diet (e.g. low cholesterol)? ☐ Yes ☐ No _____
Please describe your diet regime

Are your periods regular? ☐ Yes ☐ No _____ _____
Date of last period Any problems with your periods?

Family History

Relationship	Living?	Age or age at death	Describe any health problems or cause of death
Father	☐ Yes ☐ No		
Mother	☐ Yes ☐ No		
Spouse	☐ Yes ☐ No		

_____ _____
Ages of Brothers/Sisters List of Sibling Health Problems

_____ _____
Ages of Children(s) List of Children(s) Health Problems

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_____

Patient Name

Please check illnesses which have occurred in your blood relatives

☐Diabetes ☐Heart Attacks ☐Nervous Illness ☐Breast Cancer ☐Stroke ☐High Blood Pressure ☐Thyroid Problems ☐Asthma/Hay Fever

_____

Allergies (to medications)

_____

Medications (include vitamins, oral contraceptives, dosages and any you recently discontinued)

_____

Medications continued

_____

What percentage of time do you take medications exactly as prescribed?

Health Maintenance (Please indicate the year you last had any of the following):

_____	_____	_____	_____	_____
TB Skin Test	Pap Smear	Immunizations	Hepatitis B	Rubella
_____	_____	_____	_____	_____
Eye Exam	Mammogram	Tetanus	Stool for Blood	Cholesterol
_____	_____	_____	_____	
Proctoscopy	Urine Test	Influenza	Pneumovax	

_____

Surgeries, list type and year (include appendix, hysterectomy, biopsies, etc.)

_____

Surgeries continued

_____

Medical illnesses (e.g. diabetes, cancer, asthma, heart or kidney trouble, nervous disorder)

_____

Medical illnesses continued

_____

Main reason you are here

_____

Main symptom(s)

Doctor's Notes: _____

_____

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Adult Female DF

_____

Patient Name

Constitutional

☐ Yes ☐ No Chills
☐ Yes ☐ No Fatigue
☐ Yes ☐ No Fever
☐ Yes ☐ No Night Sweats
☐ Yes ☐ No Victim-Domestic Violence
☐ Yes ☐ No Weight Gain (unintentional)
☐ Yes ☐ No Weight Loss (unintentional)

Eyes

☐ Yes ☐ No Eye Pain
☐ Yes ☐ No Glasses/Contact

Ears/Nose/Throat

☐ Yes ☐ No Ear Pain
☐ Yes ☐ No Frequent Nose Bleeds
☐ Yes ☐ No Bleeding Gums
☐ Yes ☐ No Oral Gum Disease
☐ Yes ☐ No Dentures Present

Cardiovascular

☐ Yes ☐ No Chest Pain
☐ Yes ☐ No Dizziness
☐ Yes ☐ No Heart Palpitations
☐ Yes ☐ No Racing Heartbeat

Respiratory

☐ Yes ☐ No Cough (acute)
☐ Yes ☐ No Cough (chronic)
☐ Yes ☐ No Shortness of Breath

Gastrointestinal

☐ Yes ☐ No Abdominal Pain
☐ Yes ☐ No Bloating
☐ Yes ☐ No Constipation
☐ Yes ☐ No Diarrhea
☐ Yes ☐ No Heartburn
☐ Yes ☐ No Black Stool
☐ Yes ☐ No Nausea
☐ Yes ☐ No Vomiting
☐ Yes ☐ No Stool Caliber Change

Psychiatric

☐ Yes ☐ No Anxiety
☐ Yes ☐ No Crying Spells
☐ Yes ☐ No Depression
☐ Yes ☐ No Feeling Stressed
☐ Yes ☐ No Loss of Interest in Pleasurable Activities
☐ Yes ☐ No Mood Swings
☐ Yes ☐ No PMS
☐ Yes ☐ No Recreational Drug Use
☐ Yes ☐ No Sleep Disturbance
☐ Yes ☐ No Suicidal Thoughts

Musculoskeletal

☐ Yes ☐ No Back Pain
☐ Yes ☐ No Muscle Pains

Integumentary/Breast

☐ Yes ☐ No Rashes
☐ Yes ☐ No Breast Mass
☐ Yes ☐ No Breast Skin Changes
☐ Yes ☐ No Breast Tenderness
☐ Yes ☐ No Nipple Discharge
☐ Yes ☐ No Self Breast Exams?

Neurological

☐ Yes ☐ No Dizziness
☐ Yes ☐ No Fainting
☐ Yes ☐ No Headaches
☐ Yes ☐ No Weakness

Hematologic /Lymphatic

☐ Yes ☐ No Easy Bruising
☐ Yes ☐ No Excessive Bleeding
☐ Yes ☐ No Hx of Blood Transfusion

Endocrine

☐ Yes ☐ No Hair Loss
☐ Yes ☐ No Heat/Cold Intolerance
☐ Yes ☐ No Excessive Facial or Body Hair
☐ Yes ☐ No Hot Flashes
☐ Yes ☐ No Infertility

Allergic/Immunologic

☐ Yes ☐ No Seasonal Allergies/"Hayfever"
☐ Yes ☐ No Perennial Allergies

Genitourinary

☐ Yes ☐ No Painful Menstrual Cycle
☐ Yes ☐ No Pain With Intercourse
☐ Yes ☐ No Pain With Urination
☐ Yes ☐ No Genital Lesions
☐ Yes ☐ No Blood In Urine
☐ Yes ☐ No High Risk Sexual Behavior
☐ Yes ☐ No Irregular Menstrual Cycle
☐ Yes ☐ No Heavy Menstrual Cycles
☐ Yes ☐ No Frequent Awakening At Night to Urinate
☐ Yes ☐ No Post-Coital Vaginal Bleeding
☐ Yes ☐ No Post-Menopausal Bleeding
☐ Yes ☐ No Rape (history of)
☐ Yes ☐ No Sexual Abuse
☐ Yes ☐ No Urinary Incontinence
☐ Yes ☐ No Vaginal Discharge
☐ Yes ☐ No Vaginal Itch

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bioTE®

BHRT Checklist For Women

_____ _____
Patient Name Date

_____
Email Address

Symptom(s) (please check)

Depressive Mood	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Memory Loss	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Mental Confusion	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Decreased Sex Drive / Libido	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Sleep Problems	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Changes / Irritability	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Tension	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Migraine / Severe Headaches	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Difficult To Climax Sexually	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Bloating	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Weight Gain	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Vaginal Dryness	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Hot Flashes	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Sweats	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Dry and Wrinkled Skin	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Hair is Falling Out	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Cold All The Time	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Swelling All Over The Body	☐ Never	☐ Mild	☐ Moderate	☐ Severe
Joint Pain	☐ Never	☐ Mild	☐ Moderate	☐ Severe

Family History

Heart Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No
Breast Cancer	☐ Yes	☐ No

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Family Cancer History Questionnaire

Patient Name _____ Date of Birth _____ Age _____

Today's Date (MM/DD/YY) _____ Healthcare Provider _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: You, parents, brothers, sisters, daughters, grandparents, aunts, uncles, nephews, nieces, half-siblings, first-cousins, great-grandparents and great grandchildren.

You and Your Family's Cancer History (Please be as thorough and accurate as possible)

Y/N	CANCER	YOU Age at Diagnosis	Parents Siblings Children	Age at Diagnosis	Maternal Relatives	Age at Diagnosis	Paternal Relatives	Age at Diagnosis
Y	Example: Breast Cancer	45	------	-----	Aunt Cousin	45 61	Half-Sister	53
	Breast Cancer (Female or Male)							
	Ovarian Cancer							
	Uterine Cancer (Endometrial)							
	Colon/Rectal Cancer							
	10 or more Lifetime Colon Polyps (Specify #)							
	Other (Specify cancer type)							

☐ Yes ☐ No Are you of Ashkenazi Jewish descent?

☐ Yes ☐ No Are you concerned about personal and/or family history of cancer?

☐ Yes ☐ No Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? (Please explain/include a copy of result, if possible).

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Acknowledgement for Consent to Use and Disclosure of Protected Health Information (PHI)

Use and Disclose of your Protected Health Information (PHI)
Your Protected Health Information will be used by Dr. David Fong or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day heath care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information (PHI) may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your Protected Health Information. This office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practice
This office reserves the right to modify the privacy practices outlined in the Notice.

Signature
I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

Please list others we may release your PHI to: _____

Please indicate below whether you agree to allow us to leave a detailed telephone message regarding your test results at any of the phone numbers you have listed.

☐Agree ☐Deny

_____ _____
Patient Name Date

_____
Signature

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Preventative Well Woman Exam

Based on American College of Obstetrics and Gynecology and insurance standards, preventative office visits are routine well patient evaluations. Preventative well woman exams consist of health history, medication history, a physical exam with breast exam, pap smear, bimanual uterine/ovary exam (as indicated), urinalysis, and routine blood work (as indicated).

If an abnormality is encountered or a pre-existing problem is addressed in the process of performing this exam, you may be charged an additional fee/co-pay based on your insurance benefits. All visit information is sent electronically to your insurance company and you will be responsible for any additional fees as determined by your insurance benefits.

_____ _____

Patient Name Date

_____

Signature

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General Consent for Treatment

General consent to Treatment: By signing below, I, (or my authorized representative on my behalf) authorize Dr. David Fong and his staff to conduct any diagnostic examinations, tests, and procedures deemed necessary in my care. I authorize the provision of any medications, treatment or therapy necessary to effectively assess and maintain my health or diagnose and treat my illness or injury. I understand that it is the responsibility of Dr. Fong to explain the rationale for diagnostic tests or procedures, the available treatment options, common risks and benefits or procedures, and alternative treatment options.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended by Dr. Fong. I also understand that the practice of medicine is not an exact science and no guarantees have been made regarding the results of my evaluation and/or treatment.

_____ _____

Signature Date

I understand that I choose to send correspondence such as family photographs or birth announcements to the office of Dr. David Fong, the photos contained in these items may be displayed in public areas in the office. I understand that I have the right to request the photographs be kept private and will include a request of privacy with the correspondence if privacy is desired.

_____ _____

Signature Date

These consents remain active unless revoked in writing by patient or authorized representative.

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Cancellation Policy / No Show Policy
For Doctor Appointments and Surgery

1. *Cancellation / No Show Policy for Doctor Appointment*

   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise when another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.
   If an appointment is not cancelled at least 24 hours in advance, you will be charged a $50 fee; this will not be covered by your insurance company.

2. *Scheduled Appointments*

   We understand delays can happen; however, we must try to keep the other patients and Dr. Fong on time.
   If a patient is 15 minutes past their scheduled time, we have the right to reschedule the appointment.
   Similarly, we try our best to stay on schedule, although emergencies sometimes arise. If we are significantly delayed, or Dr. Fong needs to leave unexpectedly due to surgery or delivery, we will try to notify you beforehand.
   Please assist us by being on time for your appointment.

3. *Cancellation / No Show Policy for Surgery*

   Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expense for the office. If surgery is not cancelled at least 10 days in advance, you will be charged a $75 fee. This will not be covered by your insurance company.

4. *Account Balances*

   We will require that patients with self-pay balances to pay their account balances to zero prior to receiving further services by our practice.
   Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.
   Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____
Patient Name

_____ _____
Signature Date