Patient Information Sheet

Patient Name _____ 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 _____

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 High School ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ or More 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 _____

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: _____

_____

_____

_____

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

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

Prenatal Questionnaire

Please complete and do not leave blanks

______________________________ Patient Name
______________________________ Social Security #

______________________________ Street Address
______________________________ City
__________ State
__________ Zip Code

______________________________ Home Phone
______________________________ Cell Phone
______________________________ Work Phone

______________________________ Name of Father of Baby

______________________________ First Day of Your Last Period
☐ Yes ☐ No Was this normal?
☐ Yes ☐ No Is This your first pregnancy?

Miscarriages

______________ Month/Year/Weeks Gestation
______________ Month/Year/Weeks Gestation
______________ Month/Year/Weeks Gestation
______________ Month/Year/Weeks Gestation

Abortions

______________ Month/Year/Weeks Gestation
______________ Month/Year/Weeks Gestation
______________ Month/Year/Weeks Gestation
______________ Month/Year/Weeks Gestation

Ectopics

______________ Month/Year
______________ Month/Year
______________ Month/Year
______________ Month/Year

Prior Pregnancies

_________ Month/Year ☐ Male ☐ Female ______ lb ______ oz ☐Vaginal ☐C-Section ______________ Anesthetic __________ Length of Labor

_________ Month/Year ☐ Male ☐ Female ______ lb ______ oz ☐Vaginal ☐C-Section ______________ Anesthetic __________ Length of Labor

_________ Month/Year ☐ Male ☐ Female ______ lb ______ oz ☐Vaginal ☐C-Section ______________ Anesthetic __________ Length of Labor

_________ Month/Year ☐ Male ☐ Female ______ lb ______ oz ☐Vaginal ☐C-Section ______________ Anesthetic __________ Length of Labor

_________ Month/Year ☐ Male ☐ Female ______ lb ______ oz ☐Vaginal ☐C-Section ______________ Anesthetic __________ Length of Labor

Are you currently taking prenatal vitamins? ☐ Yes ☐ No If yes, which type? ____________________________

Height _______ Pre-Pregnancy Weight ________

Are you allergic to any medications? ____

Patient Name _____ Patient # _____ Date _____

☐ Yes ☐ No 1. Will you be 35 year or older when the baby is due?

2. Have you, the baby's father or anyone in either of your families had any of the following disorders?

☐ Yes ☐ No
- Down Syndrome (mongolism)

☐ Yes ☐ No
- Other chromosomal abnormality

☐ Yes ☐ No
- Neural tube feed (i.e. spina bifida (meningomyelocete or open spine) anencephaly

☐ Yes ☐ No
- Hemophilia

☐ Yes ☐ No
- Muscular dystrophy

☐ Yes ☐ No
- Cystic fibrosis

☐ Yes ☐ No
- If yes, indicate the relationship of the affected person to you or the baby's father

_____

☐ Yes ☐ No 3. Do you or the baby's father have a birth defect?

☐ Yes ☐ No 4. In any previous marriages, have you or the baby's father had a child born dead or alive with one more birth defect(s) listed in questions 2 above?

☐ Yes ☐ No 5. Do you or the baby's father have any close relatives with mental retardation?
- If yes, indicate the relationship of the affected person to you or the baby's father.

_____

☐ Yes ☐ No 6. Do you, the baby's father, or a close relative of either of your families have a birth defect, any familial disorder or chromosomal abnormality not listed above?
- If yes, indicate the condition and the relationship of the affected person to you or the baby's father.

_____

☐ Yes ☐ No 7. In any previous marriages, have you or the baby's father had a stillborn child or three or more first-trimester spontaneous pregnancy losses?

☐ Yes ☐ No
- Have either of you had a chromosomal study?
- If yes, indicate who and the results:

_____

☐ Yes ☐ No

8. If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease?
    - If yes, indicate who and the results:

_____

☐ Yes ☐ No

9. If you or the baby's father of Philippine or Southeast Asian ancestry, have either of you been tested for A-thalassemia?
    - If yes, indicate who and the results:

_____

☐ Yes ☐ No

10. Excluding iron and vitamins, have you taken any medication or recreational drugs since being pregnant or since your last menstrual period? (Include nonprescription drugs)
    - If yes, give name of medication and time taken during pregnancy

_____

* Any patient replying "yes to questions should be offered appropriate counselling. If the patient declines, further counseling or testing, this is noted in the chart. Given that genetics is a field in a state of flux, alterations or updates to this form will be required periodically.

Dear Patient:

In accordance with the guideline from the American College of Obstetrics and Gynecology, all pregnant patients are being screened for hepatitis B antigen. This is to protect your infant as well as your family and yourself from the problems of this potentially lethal disease. In addition to screening all pregnant women, those that are at high risk may need further evaluation and/or treatment. Please read over the following list of possible high-risk groups. If you are a member of any of these groups, please indicate by checking in front of the appropriate statement.

- ☐ Women of Asian, Pacific Island or Alaskan Eskimo descent, whether born in the Unites State or elsewhere
- ☐ Women born in Haiti or Sub-Saharan Africa
- ☐ Women with the histories of
- ☐ Work in a healthcare or public safety field
- ☐ Acute or chronic liver disease
- ☐ Work or reside in an institution for the mentally handicapped
- ☐ Work or treatment in a hemodialysis unit
- ☐ Rejection as a blood donor
- ☐ Blood transfusion on repeated occasions
- ☐ Frequent occupational exposure to blood in medical-dental settings
- ☐ Household contact with HBV carrier or hemodialysis patient
- ☐ Multiple episodes of sexually transmitted diseases
- ☐ Percutaneous use of illicit drugs
- ☐ None of the above

_____ _____

Patient Name Date

_____

Signature

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Sonogram Policy

Our physicians only schedule sonograms for our patients that they feel are medically necessary. one routine sonogram will be done at 24 weeks of pregnancy. Most, if not all insurance companies pay for medically necessary sonograms. However, the occasion may arise when a patient desires a sonogram to determine the sex of the baby or for other reasons that may not be medically necessary. In such a case, the physician will perform the sonogram for the patient but will ask that the patient pay for the procedure in advance. Thank you for your cooperation!!

_____ _____

Patient Name Date

_____

Signature

The HIV Antibody Blood Test

Disclosure Consent and Release of Liability

The purpose of this form is to document that I or my physician has requested that my blood be tested to detect whether or not I have antibodies in my blood to the HIV virus, which may be a causative agent of Acquired Immune Deficiency Syndrome (AIDS). I understand that the test is new and its accuracy and reliability are still

uncertain and that the test results may in some cases, indicate that a person has antibodies to the virus when the person does not (false positive) or the test may fail to detect that a person has the virus (false negative). I

also understand that a positive blood test does not mean that I have AIDS. I understand that no warranty and no guarantee has been made to me as to the results of this test. I voluntarily request and consent to the administration of the test. The confidentiality of my medical records will be maintained. However, my physician

or other health care providers, representatives of federal, state and local governmental agencies may ask to see the results for medical or scientific reasons or the results could be released by court order. Further, insurance companies and other third party payors may request these results if reimbursement is requested for the test from these third party sources. I agree that in the event of a positive test, this office reserves the right to notify the spouse of any individual subjects to potential exposure. I hereby release Dr. Fong, agents, and medical staff from responsibility and consequences resulting from the administration of the test.

_____ _____

Patient Name Date

_____

Signature

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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Disability & FMLA Fee Schedule

Dr. David Fong charges and administrative fee for the completion of certain work-related documents presented by patients. These documents include Disability Insurance Benefits Forms, Family and Medical Leave Act (FMLA) forms and return to work forms.

Typically, your employer or insurance company requires these forms when a medical condition prevents you from reporting to work. A licensed medical professional much sign these documents verifying that the information is correct. In the event that you need Dr. David Fong to complete one or more of these forms, we will be happy to assist you. The fee for this service is $30.00 per set of forms.

Please follow these steps to ensure the timely completion of your forms:

- Obtain a copy of the forms from your employer or insurance company.
- Complete and sign all parts of the form that are to be completed by the employee.
- Mail or drop off the form(s) at our office and pay the required fee either in person, by credit card over the phone or you may also mail a check.
- Please allow 10 business days for the completion. We will notify you as soon as your forms are available for pick up.

By signing below, I state that I have read and understand all office protocol for disability and FLMA forms.

_____ _____

Patient Name Date

_____

Signature

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 and 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 y patient or authorized representative.

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 do 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 ma 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