K. Anthony Shanbour, M.D.
Obstetrics & Gynecology

Wesley Vaughan MD

Patient History Form

A

1. Marital Status: ☐ Single ☐ Married ☐ Long term Relationship ☐ Divorced ☐ Widowed
2. Reason for this visit: _____
3. Referring Physician: _____
4. Occupation: _____
5. Preferred phone number: _____ confidential voice mails OK: ☐ Yes ☐ No

B MENSTRUAL HISTORY(complete even if post-menopausal or no longer having periods)

7. Age at first period: _____ years.
8. If your menstrual periods are regular; periods start every: _____ days
9. If your menstrual periods are irregular; periods start every: ____ to ____ days (e.g.,12 to 60)
10. Duration of bleeding: _____ days
11. Does bleeding or spotting occur between periods? ☐ Yes ☐ No
12. Does bleeding or spotting occur after intercourse? ☐ Yes ☐ No
13. First day of last menstrual period _____ (month/day/year)
14. Is pain associated with periods? ☐ Yes ☐ No ☐Occasionally
15. If yes to 14, is it: ☐ before menses? ☐ during menses? ☐ both?

C PREGNANCY HISTORY (All pregnancies) **Have never been pregnant ☐**

16. OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES

					CHILD		
Year	Place of delivery or Abortion	Duration Preg.	Type of Delivery	Complications Mother and/or Infant	Sex	Birth Weight	Present Health

D BIRTH CONTROL HISTORY

17. What birth control method(s) do you currently use? _____

E SEXUAL HISTORY

18. Do you have a sexual partner? ☐ No ☐ Yes (Male ☐ Female ☐)
19. Are there concerns about your sexual activity which you want to discuss? ☐Yes ☐No

F PAST OBSTETRICAL/GYNECOLOGICAL SURGERIES

20. Check any that apply: or ☐ None

SURGERY	YEAR	SURGERY	YEAR
☐ D&C		☐ ovarian surgery	
☐ hysteroscopy		☐ L cyst(s) removed ovarian	
☐ infertility surgery		☐ R cyst(s) removed ovarian	
☐ tuboplasty		☐ L ovary removed	
☐ tubal ligation		☐ R ovary removed	
☐ laparoscopy		☐ vaginal or bladder repair for prolapse/incontinence	
☐ hysterectomy (vaginal)			
☐ hysterectomy (abdominal)		☐ cesarean section	
☐ myomectomy		☐ other (specify) _____	

G PAST SURGICAL HISTORY (Not OB/GYN)

21. List all surgeries and their year or ☐ None

Surgeries	Year
_____	_____
_____	_____
_____	_____
_____	_____

H PAP SMEAR/MAMMOGRAM HISTORY

22. ☐Date of last pap smear: _____

23. ☐Have you had abnormal pap smears? ☐ No ☐Yes

24. ☐Have you had treatment for abnormal smears? ☐ No ☐Yes

If yes, what type(s) of treatment have you had?

☐ cryotherapy ☐ laser ☐ cone biopsy ☐loop excision (LEEP)

25. Date of last mammogram: _____ _____

month **year**

26. Have you had an abnormal mammogram? ☐ No ☐Yes

OTHER PAST GYNECOLOGICAL HISTORY

27. Check any that apply: ☐None ☐ Venereal warts ☐Herpes-genital ☐Shpilis ☐Pelvic inflammatory disease ☐Endometriosis ☐Chlamydia ☐Gonorrhea ☐Vaginal infections ☐ Other _____

I PAST MEDICAL HISTORY Check any that apply: or None

☐ Arthritis
☐ Diabetes:
- ☐ Diet controlled
- ☐ Pill controlled
- ☐ Insulin controlled

☐ High blood pressure
☐ Heart disease
☐ Kidney Disease
☐ Kidney Disease
☐ Gallstones
☐ Liver Disease (including hepatitis)
☐ Epilepsy
☐ Blood Transfusions
☐ Thyroid disease
☐ Asthma
☐ Emphysema
☐ Bronchitis
☐ HIV+
☐ Eating Disorder
☐ Other:_____

J PAST MEDICAL HISTORY Check any that apply: or None

Medication	Dose	Frequency

K DO YOU CURRENTLY?:

28. Smoke No ☐ Yes☐ _____packs/day

29. Use alcohol ☐No ☐Yes __ wine (glass/day); __ beer (bottle/day); __ hard liquid(oz./day)
30. Use illicit drugs No ☐ Yes ☐ _____type _____amount
31. Exercise: Type:_____ How often_____

L DRUG ALLERGIES

32. No ☐ Yes ☐ List:

_____
_____
_____

M FAMILY HISTORY

☐Diabetes ☐Heart Disease ☐Breast Cancer ☐Other
☐Ovarian Cancer ☐Endometrial Cancer ☐Colon Cancer _____

If "yes" to any, please list affected relatives

_____ _____
_____ _____

☐ **None of the above.**

N OTHER SYMPTOMS

Have you had recent?

☐ weight loss	☐hair growth	☐none of the above
☐ weight gain	☐hair loss	☐other
☐change in energy	☐change in urinary function	_____
☐breast discharge	☐hot flushes/flashing	

_____ _____ _____

Patient Signature Date Time

_____

Patient Name Printed

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PATIENT DEMOGRAPHIC FORM

Please complete this form in order to ensure proper billing of your services.

Patient Information

Last Name: _____ First Name: _____ Today's Date: _____

Other Name: _____ Date of Birth: _____

Address (street): _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SS#: _____ Email: _____

PCP: _____ Ref. Physician (if different): _____

Address (street): _____ Address (street): _____

City, State, Zip: _____ City, State, Zip: _____

Telephone #: _____ Telephone #: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partner

Employment Information

Employer: _____

Employer Address (street): _____ City, State, Zip: _____

Emp. Status: ≤ Full Time ≤ Part Time ≤ Not Employed ≤ Self-Employed ≤ Active Military

Student Status: (circle) Full Time Student Part Time Student

Emergency Contact Information

Emergency Contact: _____ Relationship to You: _____

Home Phone: _____ Alt. Phone: _____

Insurance Information

PRIMARY CARRIER: _____ Telephone #: _____

Policy Holder: _____ Relationship to Patient: _____

DOB: _____ ID#: _____ Group #: _____

Address: _____ City, State, Zip: _____

SECONDARY CARRIER: _____ Telephone #: _____

Policy Holder: _____ Relationship to Patient: _____

DOB: _____ ID#:_____ Group #:_____

Address: _____City, State, Zip: _____

TERTIARY CARRIER: _____ Telephone #: _____

Policy Holder: _____ Relationship to Patient: _____

DOB: _____ ID#:_____ Group #:_____

Address: _____City, State, Zip: _____

Additional Information

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Island

☐ Asian ☐ White

☐ Black or African American ☐ Denied/ Refused to report

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Denied/ Refused to Report

Preferred Language: ☐ English ☐ Spanish ☐ Other:

How did you hear about our practice? ☐ Health Plan ☐ Internet ☐ Our Web Site

☐ Newspaper/Magazine ☐ Patient_____ ☐ Other_____

LMP (Date of last menstrual period)- _____

Pharmacy Information

Pharmacy Name: _____

Address (street): _____ City, State, Zip: _____

Phone: _____ Fax: _____

Pharmacy Name: _____

Address (street): _____ City, State, Zip: _____

Phone: _____ Fax: _____

_____ _____ _____

Signature of Patient or Representative Date Time

_____

Print Name of Patient or Representative

K. Anthony Shanbour, M.D.
Obstetrics & Gynecology

Wesley Vaughan MD

PROTECTED HEALTH INFORMATION AUTHORIZED PERSON(S)

Please print below information

I,_____, hereby authorize release of my Protected Health Information for **verbal discussion only** of my care and treatment to the person(s) specified below (45CFR, 164.502[F] & 164.502[G]): Authorized family member or person to receive information for the above named patient's care:

Name of Central Contact (other than patient)	Relationship to Patient	Phone

Others authorized to receive my verbal information (please list names and relationship):

Name of Central Contact (other than patient)	Relationship to Patient	Phone

NOTE: This form does not give the above referenced persons permission to make health care decisions for the patient or entitle them to paper copies or electronic access of your medical record. We will not release via the telephone or any other means of communication any information to any friends or family members not listed above unless the patient has an opportunity to object and does not (documented) or if it is reasonable to infer that the patient does not object such as when a patient brings a spouse into the room when treatment is being discussed. Exception: if the release is needed in emergency situations.

- **Leave message on answering machine or voice mail?**
(Example : We may leave message reminders , scheduling changes or notices that lab results are in on your answering machine. Would this process be acceptable, yes or no?) ☐ Yes ☐ No

- **Leave message for patient to return call?**
(Example: We may leave a message regarding appointment reminders , scheduling changes or notices that lab results are in with an individual who answers the phone. Would this process be acceptable , yes or no?) ☐ Yes ☐ No

NOTE: By signing and dating this Protected Health Information Authorized Person(s) form, I revoke all previously signed Protected Health Information Authorized Person(s) forms.

Patient Signature _____ Date_____

Personal Representative _____ Relationship to Patient _____

(PRINTED Name)

NOTE: Except to the extent that action has already been taken in reliance on this Protected Health Information Authorized Person(s), at any time I can revoke this Protected Health Information Authorized Person(s) by submitting a new Protected Health Information Authorized Person(s) form or by written notice to Mercy where my medical records are kept.

Patient Name: _____ Date of Birth: _____

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Obstetrics & Gynecology

Wesley Vaughan MD

Name: _____

Date of Birth: _____

Consent and Agreement Physician Services

1. **Annual Consent for Services:** I consent to the services that may be performed by Dr. K Anthony Shanbour or Wesley Vaughan or facility. I understand I can withdraw this consent at any time. This consent and agreement applies to any provider services I may obtain from Dr. K Anthony Shanbour or Wesley Vaughan or facility or from a hospital-based clinic location.
2. **Financial Agreement:** I guarantee and agree to pay for all goods and services provided to me or the patient named below at the rates listed by K Anthony Shanbour, M.D. Inc. or Wesley Vaughan MD, PLLC as of the date of treatment, unless I am entitled to pay a different amount under my (or the patient's) health insurance plan or my (or the patient's) status as a Medicare or Medicaid beneficiary. Should an account be referred to an attorney or collection agency for collection, I will pay attorney's fees and collection expenses. Dr. K Anthony Shanbour or Wesley Vaughan will provide a medical screening exam to anyone in need of emergency medical treatment, regardless of ability to pay.
3. **Assignment of Insurance Benefits:** I assign my (or the patient's) rights under all insurance and benefit plan documents and authorize direct payment to Dr. K Anthony Shanbour or Wesley Vaughan of all insurance and plan benefits payments for services provided by Dr. K Anthony Shanbour or Wesley Vaughan. By paying Dr. K Anthony Shanbour or Wesley Vaughan, my insurance company or employer is fulfilling its obligations to me (or the patient) under the health insurance policy, or the employer is fulfilling its obligations as required by law. I also agree that I (or the patient) am financially responsible for charges not paid according to this assignment.
4. **Medicare Assignment:** I certify that the information given by me in applying for payment from any third party payor, including payment under Title XVIII of the Social Security Act, is correct. I request that payment of authorized benefits be made in my (or the patient's) behalf, and I authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my (or the patient's) eligibility for coverage under Medicare Part A and Part B, including but not limited to the effective date of such coverage. I also authorize Mercy to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.
5. **Legal Relationship between Hospital and Provider:** I understand that when I am hospitalized, I am under the care and supervision of my attending provider, and it is the responsibility of the hospital and nursing staff to carry out his/her instructions. It is the responsibility of my provider or surgeon to obtain my informed consent, when required, for specific medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under instruction of the provider.
6. **Clinic and Rules:** I understand that my visitors and I must obey all Dr. K Anthony Shanbour or Wesley Vaughan or clinic rules. I understand that if I or my visitors do not follow the rules, Dr. K Anthony Shanbour or Wesley Vaughan or facility may pursue corrective action.

7. **Personal Valuables**: I understand that as a patient, I am encouraged to leave valuable personal items at home. While this office is a safe place, small personal items of unusual value, Dr. Shanbour or Wesley Vaughan and facility is not responsible for the loss or damage to these items.
8. **Demographic Information:** I have reviewed the demographic information listed for me and confirm that it is correct. I am aware that I need to inform Dr. Shanbour or Dr. Vaughan and facility of any changes as soon as possible.
9. **Independent Contractor/Providers:** I understand that separate bills may be sent for professional services from providers such as radiologists, pathologists, and anesthesiologists, in addition to Dr. Shanbour's or Dr. Vaughan's bill.

Consent and Agreement Physician Services Services Page 2

8. **Phone Calls:** I authorize Dr. Shanbour or Dr. Vaughan and its collection agencies to contact me, or a representative I appoint, about my account, including using any contact information or cell phone numbers that I have provided or will provide, or that is available to Dr. Shanbour or Dr. Vaughan from third parties. I authorize contact with me by telephone or voice messages and authorize the use of automated dialing technology and pre-recorded messages, even if I am charged for the call under my phone plan. I agree such contact will not be "unsolicited" for purposes of local, state or federal law. I agree that Dr. Shanbour or Dr. Vaughan, facility and its collection agencies may monitor and/or record any communication.

A copy of this form shall have the same force and effect as the original. The undersigned is the patient or is duly authorized to act on behalf of the patient to sign for the patient and accept the terms written above. A signed copy of this form is available upon request.

Signature: _____ Date:_____Time: _____

If signed by other than patient, indicate relationship:_____

Witness:_____Date:_____Time:_____