Well Balance Center

1110 East Austin St.
Paris, Texas 75460
Phone: (903) 785-6156
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Female Patient Information

Name: _____ _____ _____ _____
First Middle Last Name Used

Date of Birth: Social Security #:

Race: _____ Ethnicity: _____ Language: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

E-mail address: _____

Employed By: _____

Marital Status: ☐ Married ☐Divorced ☐Single ☐Widow ☐ Living With Sig.

Spouse's Name: _____ _____
First Last

Emergency Contact & Phone Number: _____

Do you have a Family Doctor? _____

Phone number(s): _____

Thank you for selecting Dr. Zimmerman for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience we accept Visa, MasterCard, cash and checks.

I AGREE THAT SHOULD THIS ACCOUNT BE REFERRED TO AN AGENCY OR AN ATTOURNEY FOR COLLECTION I WILL BE RESPONSIBLE FOR ALL COLLECTION COSTS, ATTOURNEY'S FEES AND COURT COSTS.

Signature: _____ Date: _____

OB HISTORY

1. How many times have you been pregnant? ______
2. How many live births have you had? ______
3. How many children do you have? ______

GYN HISTORY

1. Are you sexually active? ☐ YES ☐ NO
1a. Have you been sexually active? ☐ YES ☐ NO
2. Do you have pain with intercourse? ☐ YES ☐ NO
3. What type of contraception are you currently using? (Circle below)

Pills	Tubal Ligation	Condoms	Withdrawal	Depo Provera	IUD
Foam	Vasectomy	Diaphragm	Implants	Other ______	

4. What type of contraception have you used in the past? (circle below)

Pills	Tubal Ligation	Condoms	Withdrawal	Depo Provera	IUD
Foam	Vasectomy	Diaphragm	Implants	Other ______	

5. Are you having any problems with your method of Birth Control? ☐ YES ☐ NO
6. Have you ever had any vaginal, cervical and/or Tubal infection? ☐ YES ☐ NO
   If yes, please check below:

☐ Yeast	☐ Gardnerella	☐ Syphilis	☐ Condyloma	☐ PID	☐ Bacterial Vaginitis
☐ Herpes	☐ Trichomonas	☐ Chlamydia	☐ Gonorrhea	☐ Warts	☐ Other ______

7. Date of last pap smear? ______
8. Have you ever had an abnormal pap smear? ☐ YES ☐ NO
   If yes, how was it treated? Please check below:

☐ Repeated Pap Smear	☐ Colposcopy	☐ Laser Surgery	☐ Cone Biopsy
☐ Cryosurgery (freezing)	☐ Hysterectomy	☐ Loop Excision	

9. Do you have any breast lumps, tenderness or discharge? ☐ YES ☐ NO
10. Do you do breast self-exams? ☐ YES ☐ NO
11. Do you have PMS symptoms? ☐ YES ☐ NO
    If yes, any treatment? ______
12. Do you have any hot flashes or menopausal symptoms? ☐ YES ☐ NO
13. Do you have any uterine anomalies? ☐ YES ☐ NO
14. Do you have a history of infertility? ☐ YES ☐ NO
15. Do you have a history of DES exposure? ☐ YES ☐ NO

MENSTRUAL HISTORY

1. If you no longer have periods, please state why: ______
2. Are your periods regular? ☐ YES ☐ NO
3. Do you have any bleeding between periods? ☐ YES ☐ NO
4. Do you have any cramping with your periods? ☐ YES ☐ NO
   If yes, circle one: mild moderate Severe
5. Medicine taken for cramps?

SOCIAL HISTORY

1. Do you smoke cigarettes/smokeless tobacco/dip/chew? ☐ YES ☐ NO
   If yes, how many per day? ______ # of years? ______
2. Do you use street drugs? ☐ YES ☐ NO
   If yes, which ones? ______
3. Do you drink alcohol? ☐ YES ☐ NO

If yes, how much per day?

PAST MEDICAL HISTORY

Please check all that apply:

☐ diabetes	☐ hypertension
☐ heart disease	☐ heart murmur
☐ kidney disease	☐ psychiatric problems
☐ rheumatic fever	☐ mitral valve prolapse
☐ urinary tract infection	☐ hepatitis/liver disease
☐ varicosities/phlebitis	☐ thyroid problems
☐ major accidents	☐ blood transfusions
☐ asthma/lung disease	☐ lupus/arthritis

1. Do you have any Drug Allergies?
   If yes, please list: _____
2. Please list any GYN surgeries: _____
3. Please list any other operations/hospitalizations (include year & reason): _____
4. Have you ever been anemic? ☐YES ☐ NO
5. Are you currently on any medications ☐ YES ☐ NO
   If yes, please list with dosage: _____
6. Have you had you cholesterol checked? ☐ YES ☐ NO
7. Do you have Lupus, Scleroderma, or similar diseases/arthritis? ☐YES ☐ NO

FAMILY HISTORY

1. Do you have a family history of breast cancer? ☐ YES ☐ NO
   If yes, whom? _____
2. Do you have a family history of colon cancer? ☐YES ☐NO
   If yes, whom? _____
3. Do you have a family history of ovarian cancer? ☐YES ☐NO
   If yes, whom? _____
4. Do you have a family history of osteoporosis? ☐YES ☐NO
   If yes, whom? _____
5. Do you have a family history of diabetes? ☐YES ☐NO
   If yes, whom? _____
6. Do you have a family history of hypertension? ☐YES ☐ NO
   If yes, whom? _____
7. Do you have a family history of heart disease? ☐YES ☐ NO
   If yes, whom? _____
8. Do you have a family history of kidney disease? ☐ YES ☐NO
   If yes, whom? _____

Patient Authorization to Disclose Protected Health Information to Family/Provider of Care

I, _____, understand that Robert O. Zimmerman, M.D. and the office staff are authorized to disclose my protected health information by telephone or in person to the people that I have listed below.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____

☐ OK to leave message with detailed information ☐ Leave message with callback number only

☐ Work Telephone _____

☐ OK to leave message with detailed information ☐ Leave message with callback number only

☐ Written Communication

☐ Ok to mail to my home ☐ Ok to mail my home/office

☐ Ok to fax to this number _____

☐ Other _____

_____

Name(s) of person(s) authorized by this form to disclose my protected health information:

Name(s) & Relationship(s)	Allowed Information
_____	☐ Appointment ☐ Testing ☐ Medical ☐ Billing
_____	☐ Appointment ☐ Testing ☐ Medical ☐ Billing
_____	☐ Appointment ☐ Testing ☐ Medical ☐ Billing

I understand that I have the right to revoke anyone listed on the authorization and fill out the form before the revocation can be completed. This request must be done in writing.

All revocations must be sent to Robert O. Zimmerman, M.D. to the attention of the Privacy Officer and are not effective until received by the Privacy Officer.

I fully understand and accept the terms of this authorization.

Patient Signature _____ *Date* _____

FOR OFFICE USE ONLY

Authorization added to the patient's record on _____

Authorization verified by _____ on _____

Robert O. Zimmerman

NO SHOW/MISSED APPOINTMENT POLICY

Effective September 1st, 2011

To ensure each patient is given the proper amount of time for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time.

If it is necessary to reschedule the appointment, please call us immediately. An appointment reminder call to you is made/attempted 2 days prior to your scheduled appointment.

A minimum of **24 hours cancellation notice** is required for appointments. If less than a 24 hour cancellation is given, the appointment becomes a "Missed" appointment. If you do not cancel in advance, and do not present to the office for your appointment, this will be considered a "No-Show" appointment.

After the "No-Show/Missed" appointment, The Well Balance Center will attempt to call and reschedule your appointment and a **$25.00 fee will be charged to your account.**

We understand that circumstance arise that do not allow you to keep your appointment, but please remember to be courteous to us and our other patients by calling at least **24 hours** prior to your appointment time to cancel if you cannot make it. You may also leave a voicemail or email to cancel your appointment.

Signature:_____ **Date:**_____