New Patient History & Physical

Name | Date of Birth | Social Security #

Street | Apt# | Phone

City | State | Zip | Email

Race | Language

Emergency Contact | Phone

Primary Care Physician | Phone

Preferred Pharmacy | Phone

Dates of:	Other:
First day of Last Period	Birth Control Method
Last PAP	History of STD/ Type
Last Mammogram	History of Abnormal PAP
Last Bone Density	

Medications:	Conditions/ Reason:

Allergies:	Surgery History:	Surgery Dates:

Are Antibiotics Required Before Surgery? ☐ YES ☐ NO

Pregnancy History:

Childs Name:	Birth Date:	Week's Gestation:	Type of Birth:	Birth Weight:	Pregnancy Complications:	Delivery Complications:

Dates of: Miscarriage | Still Birth | Ectopic | Abortion

Lifestyle:

Do you Exercise? | How Often?

Use Tobacco? | Cigarettes/day? | How many years?

Drink Alcohol? | How often and what kind?

Street drugs? | Last Used?

Additional Notes:

NAME:

DATE OF BIRTH:

Everyday, we're learning how much a person's background can affect their own health, particularly if there's a history of cancer in the family. Family history is important because we know people can inherit an abnormal gene that can affect their risk for developing cancer.

Your answers to the questions below can help us determine if you may have a chance of having an inherited risk of certain cancers

Please consider your immediate family as well as grandparents, aunts, uncles and cousins

Have you or any of your family members been diagnosed with breast cancer before 50?	
Have you or any of your family members been diagnosed with triple negative (estrogen receptor, progesterone receptor, and HER2 negative) breast cancer?	
Have you or any of your family members been diagnosed with male breast cancer?	
Have you or any of your family members been diagnosed with ovarian, fallopian tube or primary peritoneal cancer?	
Have you or any of your family members been diagnosed with two separate breast cancers (including bilateral breast cancer)?	
When considering the following cancers, are there two or more on the same side of your family? Cancer types to consider breast, ovarian, pancreatic and /or prostate cancer.	
Are you of Ashkenazi Jewish heritage? *	
Have you or any of your family members been diagnosed with colon cancer before age 50?	
When considering the following cancers, are there two or more on the same side of your family? Cancer types to consider: colon, endometrial (uterine), ureter, kidney, biliary tract, small bowel, pancreatic cancer and/or brain cancer.	
Have you or any of your family members had 10 or more colon polyps (growths found during a colonoscopy)?	
Is there a known inherited cancer gene mutation in your family (for example BRCA or Lynch syndrome)?	

If you have a checkmark for any of the above responses, please turn this page over and write out the information about your family cancer history on the back. You can Share this with your doctor and talk about your cancer risk

National* guidelines recommend that individuals with Ashkenazi Jewish (AJ) heritage and a family history of breast, ovarian or pancreatic cancer consider genetic testing. However, some studies suggest that testing individuals of AJ heritage regardless of their personal family history may be beneficial.

Note* This form is for information purposes only. Ultimately, you and your doctor will determine the best course of action based on the information you have provided. by answering "No" to all of the above questions does not eliminate risk for hereditary or other cancers.

New Patient History & Physical

Please Complete this form (Please check all that apply) Past Medical History for Patient and Family, Please list if Grandparent, Aunt, Uncle is Maternal or Paternal.

Disease Condition	Self	Mother	Father	Grandmother	Grandfather	Sister	Brother	Aunt	Uncle
Anemia	☐	☐	☐			☐	☐		
Asthma	☐	☐	☐			☐	☐		
Breast Cancer	☐	☐	☐			☐	☐		
Cervical Cancer	☐	☐	☐			☐	☐		
Bleeding Disorder	☐	☐	☐			☐	☐		
Colon Cancer	☐	☐	☐			☐	☐		
Heart Disease	☐	☐	☐			☐	☐		
Diabetes	☐	☐	☐			☐	☐		
Genetic Disorder	☐	☐	☐			☐	☐		
Hepatitis	☐	☐	☐			☐	☐		
High Cholesterol	☐	☐	☐			☐	☐		
High Blood Pressure	☐	☐	☐			☐	☐		
Infertility	☐	☐	☐			☐	☐		
Lung Cancer	☐	☐	☐			☐	☐		
Ovarian Cancer	☐	☐	☐			☐	☐		
Ovarian Cyst	☐	☐	☐			☐	☐		
Polycystic Ovary Syndrome	☐	☐	☐			☐	☐		
Prolapsed Uterus	☐	☐	☐			☐	☐		
Psychiatric Disease	☐	☐	☐			☐	☐		
Pulmonary Embolism	☐	☐	☐			☐	☐		
Seizure Disorder	☐	☐	☐			☐	☐		
Thyroid Disease	☐	☐	☐			☐	☐		
Tuberculosis	☐	☐	☐			☐	☐		
Uterine Cancer	☐	☐	☐			☐	☐		
Other	☐	☐	☐			☐	☐		

Patient Responsibility Notice

Thank you for choosing Wildflower Women's Center for your obstetrical and /or gynecological care. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patients guardian, if a minor) is ultimately responsible for the payment of treatment and care.
- We'll bill your insurance for you. However, the patient is required to provide us with the most current and correct insurance and billing information
- **Co-payments are due at the time of service.**
  We are a specialist. However, since most insurance companies consider us primary care, we collect the primary care physician co-payments as a specialist co-payment, we will bill you for the difference.
- coinsurance, deductibles and non-covered services should be paid in full within 60 days of the services that were provided.
- **There is a charge for missed or same day cancellation, without 24-hr notice.**
  - Missed appointment fee for an office visit is $25.00
  - Missed appointment fee for and ultrasound visit is $50.00
- We accept most insurance plans. **We highly recommend contacting your insurance company to see if the physician providing care is in your insurance network. Failure to do so could result in being billed for todays visit.**
- if your Insurance company requires you to use a specific laboratory, please tell the rooming assistant
- Most insurance companies will only cover one preventive exam per calendar year. If it has not been a complete year or you have seen a different provider for preventive services within the past year, you could be responsible for payment of preventive services.

Print Name:_____Date:_____

Patient Signature:_____

Tina Gingrich, MD
3122 Milrany Ln. Melissa, TX 75454
(214) 295-8675
Wildflowerwomenscenter.com

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ hereby acknowledge receipt of Wildflower Women's Center Notice of Privacy Practices.

The Notice OF PRIVACY PRACTICES provides detailed information about how Wildflower Women's Center may use and disclose my confidential information. I have been offered a paper copy of NOTICE OF PRIVACY PRACTICES. I understand that WILDFLOWER WOMEN'S CENTER has reserved a right to change the privacy practice that are described in the Notice. I also understand that a copy of any revised Notice will be provided to me or made available. Copies of the most current NOTICE OF PRIVACY PRACTICES are posted at the front desk. I understand that I may request a paper copy at any time.

Print Name _____ Date of Birth _____

Signature _____ Date _____

If you are not the patient, please specify your relationship to the patient below:

_____

CONSENT TO TEXT & EMAIL PATIENT

At Wildflower Women's Center we want to get results to you quickly. Our secure portal is the most efficient way to do this. We request that you make every effort to sign up and use our portal as we can provide information, articles and links regarding your care as well as get you results as quickly as possible. It also allows you to correspond with us privately at your convenience rather than playing phone tag.

If you do not read our message to you in a week it will automatically return to us as unread. If the message is returned or if we believe we need to contact you with the results, we prefer to text you. Our initial text will ask you if you prefer to be called or texted to receive your results.

I consent to receiving a text that my results are available:

Email address:_____

Phone#_____

Print Name _____

Signature _____ Date _____

Tina Gingrich, MD
3122 Milrany Ln. Melissa, TX 75454
(214) 295-8675
Wildflowerwomenscenter.com

Tina Gingrich, MD

Wildflowerwomenscenter.com

OFFICE: 214-295-8675

FAX: 866-207-2534

3122 Milrany LN. Melissa, TX 75454

AUTHORIZATION TO RELEASE RECORDS TO FAMILY MEMBERS

Understand the requirements of HIPPA, We are not allowed to give medical or billing information to anyone without patient consent. However, many patients allow family members such as spouses, parents or others to call and request this information. If you wish to have your medical or billing information released to family members, you must sign this form.

Information will be given only to individuals indicated below.

I, _____, born on _____ hereby authorize Wildflower Women's Center to release my medical and/ or billing information to the following individuals.

Name	Relationship to Patient	Phone #
Name	Relationship to Patient	Phone #
Name	Relationship to Patient	Phone #

I understand that I have the right to revoke this authorization at anytime and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that the information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclose by the above recipient.

I understand that I have the right to revoke this consent in writing.

Print Name:_____Date:_____

Patient Signature:_____