



Saima Jehangir, MD  
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[www.lotusobgyn.com](http://www.lotusobgyn.com)

Today's date:			Referred by:			
<b>PATIENT INFORMATION</b>						
Patient's Last name:		First	Middle	DOB:	Age:	Marital status (circle one)
				/ /		Single / Mar / Div / Sep / Widow
Street address:				SSN:		
P.O. Box:		City:	State:	ZIP Code:		
Home phone:		Cell#:	Email:			
( )		( )				
Occupation:		Employer:	Employer #:			
			( )			

<b>INSURANCE INFORMATION</b>					
(Please give your insurance card and Driver's License (or picture ID) to the receptionist.)					
Insurance Company:	Policy #:	Group #:	Phone #:		
			( )		
Subscriber's name:		Subscriber's SSN:	Subscriber's DOB:		
			/ /		
Employer:		Employer's phone #:			
		( )			
Employer's address:					
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other:
Name of secondary insurance (if applicable):		Subscriber's name:	Policy#:	Group #:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other:

<b>IN CASE OF EMERGENCY</b>				
Name:		Relationship to patient:	Home phone :	Work phone :
			( )	( )
Do you have an Advanced Directive?		If yes, would you like us to have a copy on file?		
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		

Preferred Pharmacy:	Location:	Phone #: (        )
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**MEDICAL HISTORY**

<input type="checkbox"/> NONE <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Blood Transfusion(s) <input type="checkbox"/> CHD (Coronary Heart Disease) <input type="checkbox"/> COPD <input type="checkbox"/> CHF (Congestive Heart Failure) <input type="checkbox"/> Cancer – Type: _____	<input type="checkbox"/> Depression/Anxiety <input type="checkbox"/> Diabetes – Type: _____ <input type="checkbox"/> Glaucoma <input type="checkbox"/> GI Problems – Type: _____ <input type="checkbox"/> HIV <input type="checkbox"/> Hypertension <input type="checkbox"/> Hepatitis – Type: _____ <input type="checkbox"/> Kidney infections <input type="checkbox"/> Kidney stones	<input type="checkbox"/> Kidney failure <input type="checkbox"/> Migraines <input type="checkbox"/> Pneumonia <input type="checkbox"/> Seizures/Convulsions <input type="checkbox"/> SLE <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid Disease – Type: _____ <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other: _____
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Last menstrual cycle:	Menopause? <input type="checkbox"/> Yes <input type="checkbox"/> No	Menses monthly? <input type="checkbox"/> Yes <input type="checkbox"/> No	Menstrual flow: <input type="checkbox"/> Heavy <input type="checkbox"/> Normal <input type="checkbox"/> Light Duration of flow: _____ days
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Total # of pregnancies:	Total # of deliveries:	# of vaginal deliveries:	# of Cesarean Sections:	# of ectopic pregnancies:
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Date of last mammogram:	Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Delivery or pregnancy complications? <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain:
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Date of last pap:	Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	If abnormal, explain treatment:
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Have you ever had abnormal pap smear? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what was the treatment
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**SURGICAL HISTORY**

NONE  
 Previous surgery on cervix?  No  Yes - Type: \_\_\_\_\_  
 Previous surgery on bladder?  No  Yes - Type: \_\_\_\_\_  
 Anesthesia complications?  No  Yes - Type: \_\_\_\_\_  
 Any abdominal surgery?  No  Yes - Type: \_\_\_\_\_  
 Previous hernia surgery?  No  Yes - Type: \_\_\_\_\_  
 Hysterectomy?  No  Yes - Type: \_\_\_\_\_  
 Ovaries removed?  No  Yes - both  Yes - right  Yes - left  
 Tonsils     Diagnostic Laparoscopy     Appendectomy     C-sections (how many? \_\_\_\_\_)  
 Gallbladder     D&C     Tubal Ligation     Back Surgery     Hip Surgery     Foot Surgery  
 OTHER SURGERIES: \_\_\_\_\_

**FAMILY HISTORY**      Significant problems:

Father	<input type="checkbox"/> NONE	
Mother	<input type="checkbox"/> NONE	
Brother	<input type="checkbox"/> NONE	
Sister	<input type="checkbox"/> NONE	

**HEALTH HABITS**

<b>Exercise</b>	<input type="checkbox"/> No exercise <input type="checkbox"/> Daily exercise <input type="checkbox"/> Couple of times per week <input type="checkbox"/> Once a week
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<b>Caffeine</b>	<input type="checkbox"/> NONE	<input type="checkbox"/> Coffee _____ cups/ day	<input type="checkbox"/> Tea _____ cups/day	<input type="checkbox"/> Cola _____ cans / day
<b>Alcohol</b>	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No		How many drinks per week?	
<b>Tobacco</b>	Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No		How many packs / day?	# of yrs. Year quit:

**PLEASE LIST ALL YOUR MEDICATIONS (INCLUDING OVER-THE-COUNTER DRUGS)**

MEDICATION	DOSAGE	FREQUENCY TAKEN

NONE   
 Penicillin   
 Sulfa   
 IV dye   
 Iodine/ Betadine  
 Other:

**CIRCLE IF YOU HAVE ANY SYMPTOMS IN THE FOLLOWING AREAS:**

General	<input type="checkbox"/> NONE	Chills    Fatigue    Fever    Insomnia    Loss of appetite    Night sweats Recent weight gain/loss
Eyes	<input type="checkbox"/> NONE	Glaucoma    Blurring    Cataracts    Tearing    Vision loss    Contacts    Eyeglasses
Ears, Nose, Throat	<input type="checkbox"/> NONE	Decreased hearing    Earache    Hearing aid    Nosebleeds    Bleeding gums
Cardiovascular	<input type="checkbox"/> NONE	Chest discomfort / pain    Fainting    Murmur    Palpitations    Varicose veins
Pulmonary	<input type="checkbox"/> NONE	Asthma    Bronchitis    Short of Breath    Pneumonia    Wheezing
Gastrointestinal	<input type="checkbox"/> NONE	Diarrhea    Fecal incontinence    Nausea/Vomiting    Bloody Stools
Genitourinary	<input type="checkbox"/> NONE	Pain with urination    Blood in urine    Frequent urinary infections Frequency    Kidney stones    Urgency
Breast	<input type="checkbox"/> NONE	Mass: R/L    Tenderness: R/L    Nipple Discharge: R/L
Female Genitalia	<input type="checkbox"/> NONE	Abnormal vaginal bleeding    Genital sores    Vaginal discharge    Vaginal itching
Menses	<input type="checkbox"/> NONE	Cramps: H M L    Heavy periods    Irregular periods Presence of menopausal symptoms    PMS
Sexual activity	<input type="checkbox"/> NONE	Abstinence    Exposure to STD    High interest    Low Interest
Musculoskeletal	<input type="checkbox"/> NONE	Neck pain    Back pain    Muscle Cramps    weakness    Arthritis
Integumentary	<input type="checkbox"/> NONE	Hair loss    Easy bruising    Non-healing sores    Skin Rash
Neurological	<input type="checkbox"/> NONE	Blackouts    Neuropathy    Seizures    Vertigo    Weakness
Psychiatric	<input type="checkbox"/> NONE	Anxiety    Depression    Insomnia    Mood swings    Memory loss
Endocrine	<input type="checkbox"/> NONE	Diabetes    Thyroid Condition    Excessive thirst/sweating    Hot flashes
Hematologic, Lymphatic	<input type="checkbox"/> NONE	Bruising easily    Bleeding    Anemia    History of transfusion
Immunologic	<input type="checkbox"/> NONE	Hay fever    Persistent infections    Seasonal allergies    HIV exposure

## **FINANCIAL POLICY AND HIPPA CONSENT FORM**

### ***Financial Responsibility***

I have requested medical services from Lotus Ob/Gyn and/or Saima Jehangir, MD on behalf of myself and understand by making this request, I become fully financial responsible for any and all charges incurred in the course of the treatment authorized.

I understand these fees are due and payable on the date that services are rendered and agree to pay all charges incurred in full, immediately upon presentation of the appropriate statement.

### ***Assignment of Benefits***

I hereby assign all medical and surgical benefits to Lotus Ob/Gyn and/or Saima Jehangir, MD. I authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payments directly to Lotus Ob/Gyn and/or Saima Jehangir, MD, for medical services rendered to myself. I understand that I am responsible for any amount not covered by insurance.

### ***Surgical Assistant***

If you are undergoing surgery, it may be necessary, at Dr. Jehangir's discretion, to use an assistant surgeon to safely complete your surgery. Any assistant surgeon fees will be billed by the assistant surgeon and not by our office. Assistant surgeon fees that are not covered by your insurance will be your responsibility.

### ***Missed Appointments***

Appointments not cancelled within 24 hours, will incur a \$35 charge if not kept. Please help us serve you better by keeping scheduled appointments.

### ***Co Payments***

Co-Payments are due at time of medical services. We accept Mastercard, Visa, AMEX, Checks, and Cash.

### ***Returned Check Fees***

We will charge any bank charges incurred by our practice as well as a \$30 fee, for returned checks.

### ***Medical Records***

Please be aware that there is a \$30.00 fee for release of medical records. Also, there is a \$20.00 fee for the completion of paperwork for your employer, school, attorney, disability paperwork, etc... We do not charge for return to work or school letters.

### ***Past Due Accounts***

Overdue accounts will be referred to a collection agency.

### ***CONSENT TO USE AND DISCLOSURE OF INFORMATION FOR TREATMENT, PAYMENT OR OPERATIONS***

I hereby consent to the use and disclosure of information in my medical records for treatment, payment and health care operations purposes. I understand that information in my medical records may be used and disclosed to persons other than Lotus Ob/Gyn and/or Saima Jehangir, MD to carry out their responsibilities in connection with my medical treatment, in payment for health care services rendered to me and in activities related to health care operations.

*I acknowledge that I have been provided the Lotus Ob/Gyn's Notice of Privacy Practices.*

If you have any questions regarding your account, please contact our office: **(512) 716-0971**.

**My signature below acknowledges that I have read this policy, understand and agree to my consent for treatment and financial responsibility.**

<b>Date:</b>	<b>DOB:</b>	<b>SSN:</b>
<b>Patient's Legal Name:</b>		
<b>Signature: (Patient's or Legally Authorized Representative)</b>		
<b>Relationship of Legally Authorized Representative to patient:</b>		