



Saima Jehangir, MD
 301 Seton Parkway, Suite 407
 Round Rock, Texas 78665
 Phone: 512-716-0971 FAX: 866-765-3914
www.lotusobgyn.com

Today's date:	Referred by:
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PATIENT INFORMATION

Patient's Last name:	First	Middle	DOB: / /	Age:	Marital status (circle one) Single / Mar / Div / Sep / Widow
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Street address:	SSN:
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P.O. Box:	City:	State:	ZIP Code:
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Home phone: ()	Cell#: ()	Email:
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Occupation:	Employer:	Employer #: ()
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FATHER OF BABY INFORMATION

Last name:	First	Middle	DOB: / /	Age:	Marital status (circle one) Single / Mar / Div / Sep / Widow
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Street address:	SSN:
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P.O. Box:	City:	State:	ZIP Code:
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Home phone: ()	Cell#: ()	Email:
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Occupation:	Employer:	Employer #: ()
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INSURANCE INFORMATION

(Please give your insurance card and Driver's License (or picture ID) to the receptionist.)

Insurance Company:	Policy #:	Group #:	Phone #: ()
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Subscriber's name:	Subscriber's SSN:	Subscriber's DOB: / /
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Employer:	Employer's phone #: ()
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Employer's address:



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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:

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone : ()	Work phone : ()
Do you have an Advanced Directive? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, would you like us to have a copy on file? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Preferred Pharmacy:	Location:	Phone #: ()	

Menstrual History

Last menstrual cycle: / /	Normal amount?	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
Sure of Last Menstrual Period? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of positive pregnancy test:	Were you using Birth Control at the time? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Pregnancy History

Total # of Pregnancies:	# of Full term deliveries	# of preterm deliveries:				
# of miscarriages/abortions	# of Ectopic Pregnancies	# of Living children:				
Date	Weeks at Delivery	Length of Labor	Sex and Weight	Type of Delivery	Place of Delivery	Complications:



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MEDICAL HISTORY

<input type="checkbox"/> NONE <input type="checkbox"/> Diabetes Type: _____ <input type="checkbox"/> Hypertension <input type="checkbox"/> Heart Disease <input type="checkbox"/> Autoimmune Disorder <input type="checkbox"/> Kidney Disease/UTI <input type="checkbox"/> Neurologic/Epilepsy <input type="checkbox"/> Psychiatric <input type="checkbox"/> Cancer – Type: _____	<input type="checkbox"/> Depression/Anxiety <input type="checkbox"/> Hepatitis/Liver Disease– <input type="checkbox"/> Varicosities/Phlebitis <input type="checkbox"/> Thyroid Dysfunction: _____ <input type="checkbox"/> Trauma/Violence <input type="checkbox"/> History of Blood Transfusion <input type="checkbox"/> D (Rh) Sensitized <input type="checkbox"/> Pulmonary (TB, Asthma) <input type="checkbox"/> Seasonal Allergies	<input type="checkbox"/> Drug/Latex Allergies/Reactions <input type="checkbox"/> Breast <input type="checkbox"/> Gyn Surgery <input type="checkbox"/> Operations/Hospitalizations <input type="checkbox"/> Anesthesia Complications <input type="checkbox"/> History of Abnormal Pap <input type="checkbox"/> Uterine Anomaly/DES: _____ <input type="checkbox"/> Infertility <input type="checkbox"/> ART 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: _____

Tonsils Diagnostic Laparoscopy Appendectomy C-sections (how many? _____)
 Gallbladder D&C 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

Exercise	<input type="checkbox"/> No exercise <input type="checkbox"/> Daily exercise <input type="checkbox"/> Couple of times per week <input type="checkbox"/> Once a week			
Caffeine	<input type="checkbox"/> NONE	<input type="checkbox"/> Coffee _____ cups/ day	<input type="checkbox"/> Tea _____ cups/day	<input type="checkbox"/> Cola _____ cans / day
Alcohol	Amount per Day Prepregnancy:	Amount per day now:	# of Years of use:	
Tobacco	Amount per Day Prepregnancy:	Amount per day now:	# of Years of use:	Year quit:



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Illicit Drugs	Amount per Day Prepregnancy:	Amount per day now:	# of Years of use:	Year quit:
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PLEASE LIST ALL YOUR MEDICATIONS (INCLUDING OVER-THE-COUNTER DRUGS)

MEDICATION	DOSAGE	FREQUENCY TAKEN

ALLERGIES / REACTIONS TO MEDICATIONS:

NONE
 Penicillin
 Sulfa
 IV dye
 Iodine/ Betadine
 Other:

Genetic Screening: includes patient, baby's father or anyone in either family

Patient's age 35 years or older at date of delivery	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Thalassemia	<input type="checkbox"/> No	<input type="checkbox"/> Yes (Italian, Greek, Mediterranean or Asian background, MCV <80)
Neural Tube Defect	<input type="checkbox"/> No	<input type="checkbox"/> Yes (Meningomyelocele, Spina Bifida, or Anencephaly)
Congenital Heart Defect	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Down Syndrome	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Tay-Sachs Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Canavan Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Familial Dysautonomia	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Hemophilia or Blood disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Muscular Dystrophy	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Cystic Fibrosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Huntington's Chorea	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Mental Retardation/Autism	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Genetic or Inherited Disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Metabolic Disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Child with birth defects	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Recurrent Prenancy loss or stillbirth	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Medications or drugs since you got pregnant	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Other	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Infection History

Live with Someone with TB or exposed to TB	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Patient or partner has history of genital herpes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Rash or viral illness since last menstrual period	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Hepatitis B	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Hepatitis C	<input type="checkbox"/> No	<input type="checkbox"/> Yes
History of Gonorrhea	<input type="checkbox"/> No	<input type="checkbox"/> Yes
History of Chlamydia	<input type="checkbox"/> No	<input type="checkbox"/> Yes
History of HPV	<input type="checkbox"/> No	<input type="checkbox"/> Yes
History of HIV	<input type="checkbox"/> No	<input type="checkbox"/> Yes
History of Syphilis	<input type="checkbox"/> No	<input type="checkbox"/> Yes

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.



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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.

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