LOTUS
Gynecology, Health & Wellness

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Today's date:	Referred by:

PATIENT INFORMATION

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: Race	Employer: Primary Language:		Work Phone:

INSURANCE INFORMATION

(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 address:		Employer's phone #: ( )	
Patient's relationship to subscriber:	❑ Self	❑ Spouse ❑ Child	❑ Other:
Name of secondary insurance (if applicable):	Subscriber's name:	Policy#:	Group #:
Patient's relationship to subscriber:	❑ Self	❑ Spouse ❑ Child	❑ Other:

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone : ( )	Work phone : ( )
Do you have an Advanced Directive? ❑YES ❑NO	If yes, would you like us to have a copy on file? ❑YES ❑NO		
Preferred Pharmacy:	Location:	Phone #: ( )	

MEDICAL HISTORY

☐ **NONE** ☐ Arrhythmia ☐ Arthritis ☐ Asthma ☐ Blood Transfusion(s) ☐ CHD (Coronary Heart Disease) ☐ COPD ☐ CHF (Congestive Heart Failure ☐ Cancer – Type:_____	☐ Depression/Anxiety ☐ Diabetes – Type:_____ ☐ Glaucoma ☐ GI Problems – Type:_____ ☐ HIV ☐ Hypertension ☐ Hepatitis – Type:_____ ☐ Kidney infections ☐ Kidney stones	☐ Kidney failure ☐ Migraines ☐ Pneumonia ☐ Seizures/Convulsions ☐ SLE ☐ Stroke ☐ Thyroid Disease – Type:_____ ☐ Tuberculosis ☐ Other:_____

Last menstrual cycle:	Menopause? ☐ Yes ☐ No	Menses monthly? ☐ Yes ☐ No	Menstrual flow: ☐ Heavy ☐ Normal ☐ Light Duration of flow:_____ days	
Total # of pregnancies:	Total # of deliveries:	# of vaginal deliveries:	# of Cesarean Sections:	# of ectopic pregnancies:

Date of last mammogram:	Results: ☐ Normal ☐Abnormal	Delivery or pregnancy complications? ☐ Yes ☐ No Please explain:
Date of last pap:	Results: ☐ Normal ☐Abnormal	If abnormal, explain treatment:
Have you ever had abnormal pap smear? ☐ Yes ☐ No	If yes, what was the treatment	

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	☐ NONE	
Mother	☐ NONE	
Brother	☐ NONE	
Sister	☐ NONE	

HEALTH HABITS

Exercise	☐ No exercise ☐ Daily exercise ☐ Couple of times per week ☐ Once a week			
Caffeine	☐ NONE	☐ Coffee _____cups/ day	☐ Tea _____cups/day	☐ Cola _____cans / day
Alcohol	Do you drink alcohol? ☐Yes ☐No	How many drinks per week?		
Tobacco	Do you smoke? ☐ Yes ☐ No	How many packs / day?	# of yrs.	Year quit:

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

MEDICATION	DOSAGE	FREQUENCY TAKEN

ALLERGIES:

☐NONE ☐ Penicillin ☐ Sulfa ☐ IV dye ☐ Iodine/ Betadine

☐ Other:

CIRCLE IF YOU HAVE ANY SYMPTOMS IN THE FOLLOWING AREAS:

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

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