Dr. Clayton Young

Patient Registration Information

Date Referring Provider

Last name First name Middle name

Date of birth Age Sex Marital Status

Social Security # Phone # Alternate #

Address

Email address Pharmacy name and phone #

Emergency Contact name and phone #

Employer name and phone #

Primary Insurance Information

Insurance plan name Phone #

Address for claims

ID # Group # Patient relationship to policy holder

Policy Holder Name Sex Date of birth Social Security #

Policy Holder Address Employer

Secondary Insurance Information

Insurance plan name Phone #

Address for claims

ID # Group # Patient relationship to policy holder

Policy Holder Name Sex Date of birth Social Security #

Policy Holder Address Employer

Patient Record of Disclosures

The HIPAA Privacy Act gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications, or that of a communication of their PHI is made by alternative means, such as sending correspondence to the individual's work place instead of their home. The private rule generally requires Health Care Providers to take reasonable steps to limit the use or disclosure of and request for health information to the minimum to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Health Care Entities must keep records of PHI Disclosures. Information provided below, if it is completed properly, will constitute an adequate record.

Note: Uses and Disclosures for treatment, payment and health care operations may be permitted without prior consent in an emergency.

Patient Name _____ Date of Birth _____

Mother's Maiden Name _____ (This will be used for identification when contacting our office for personal and/or treatment information)

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 call back number only

Work Telephone _____

- ◯ OK to leave message with detailed information
- ◯ Leave message with call back number only

Written Communications:

- ◯ OK to mail to my Work
- ◯ OK to mail to my Home
- ◯ OK to email information
- ◯ OK to fax to _____

Spouse/Significant other: Name _____

- ◯ OK to leave message with detailed information
- ◯ Leave message with call back number only

PCP or Referring Physician:

- ◯ **OK** to disclose Health Information to my PCP or Referring Physician
- ◯ **NOT OK** to disclose Health Information to my PCP or Referring Physician

Please list anyone else and their relationship to you that we may discuss information to: ***(please note that anyone requesting information on your behalf will need to know your mother's maiden name for identification).***

_____ _____

_____ _____

Patient Signature _____ Date of birth _____ Date _____

Authorization for release/request of protected health information

I, _____ authorize Conroe Physician Associates, Dr. Young's office to:

_____release to: ____ receive from:

Person or Organization Address

Phone Fax #

Information/Copies of the medical records on:

Patient Name date of birth social security #

Information to be released

This information is being released for the following purposes:

_____Continue Care _____Attorney/Litigation _____Insurance _____Disability Services _____Other

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this information in writing by contacting your office at the address that was notified to me, attention privacy officer.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be reported to HIPAA.
- Copies of all records including, but not limited to, progress notes, lab, x-ray, and ultrasound reports, records of hospitalizations, operative and procedure reports, as well as other data pertinent to my medical history.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific, written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose. (FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2).

Signature of patient or legally authorized representative relationship

Print name of legally authorized representative

Patient or legally authorized representative drivers license/ID/SS#

Witness-printed name/signature

Date signed Date Released

Consent for STD/HPV Testing

STD testing can be performed by either blood draw or cultures taken from vaginal secretions. The most common STD testing is for:

- ☐ Herpes
- ☐ Hepatitis Panel
- ☐ RPR (screening for Syphilis)
- ☐ Chlamydia and Gonorrhea
- ☐ HIV

[ ] I have read the above information and **I DO** consent to **[ ] ALL** or **[ ] JUST THE CIRCLED** screenings listed above.

[ ] I have read the above information and **I DO NOT** consent to the screenings listed above.

The American Society for Colposcopy and Cervical Pathology has now recommended routine screening for **high-risk Human Papilloma Virus (HPV)** to be performed along with your pap smear.

A few important things to know about HPV and cervical cancer screening:

- Most women will have HPV at some point during their lives but very few will develop cervical cancer.
- Cervical cancer develops if an HPV infection persists for many years.
- Knowing your HP status helps you and your provider determine how often you should be screened.
- Early detection of pre-cancerous cell changes is the key to preventing cervical cancer.
- Your HPV status is not a reliable indicator of our and your partner's sexual behavior. HPV can lie dormant in cervical cells for many years becoming an active infection.

[ ] I have read the above information and **AGREE** to have the HPV test performed with my pap smear. I also agree to pay for the HPV testing should my insurance carrier not cover the cost.

[ ] I have read the above information and **DO NOT** wish to have the HPV testing at this time.

Please note, these tests are considered screening tests and as such may not be covered by your insurance carrier. If you agree to have this testing performed, and any cost incurred due to insurance denial will become your responsibility.

Patient signature _____ Date _____

Witness signature _____

OBSTETRICAL INTAKE/MEDICAL HISTORY

Name Date of Birth Date of Visit

Birth date Age Race (White, African American, Asian, Hispanic, Other)

Marital Status (married, divorced, widowed, separated, single)

Address

Phone numbers (work and home)

Emergency Contact (Name and number)

Father of Child Name Age

Race of Father (White, African American, Asian, Hispanic, Other)

Menstrual History

First day of last period_____ Is your period: Regular_____ Irregular_____

Number of days your period lasts_____ Amount of flow: Light_____ Medium_____ Heavy_____

How many days between your period_____

Were your using some form of contraception (birth control) when you got pregnant)? Yes_____ No_____ Type_____

Was this pregnancy planned? Yes_____No____ Have you taken a home pregnancy test? Yes____ No____ Date_____

Pregnancy Information

How many times, including this pregnancy, have you been pregnant? _____

How many babies have you had that were: Full Term____ Premature____ Stillborn____ Miscarried____ Abortion____

How many children do you have that are living?_____ Have you ever had multiple births?_____(twin, triplet, etc)

Have you ever had an ectopic pregnancy (a pregnancy in your fallopian tubes or outside of your uterus) Yes___ No___

If yes, how was it treated?_____

Past Pregnancies

Date	Weeks gestation	Hours in labor	Weight	Sex	Type of delivery	Anesthesia	Place of delivery	Preterm labor Yes/no	Complications

Please indicate (X) if any of the following applies to you NOW or in the PAST:

	CURRENT	PAST	NOTES
Head • Migraine headaches • Headache	_____ _____	_____ _____	
Heart/Vascular • Hypertension • Heart disease	_____ _____	_____ _____	
Respiratory • Chronic asthma • Pneumonia • Tuberculosis	_____ _____ _____	_____ _____ _____	
Stomach Intestinal • Hepatitis/Liver disease • Stomach/Intestinal	_____ _____	_____ _____	
Respiratory • Chronic asthma • Pneumonia • Tuberculosis	_____ _____ _____	_____ _____ _____	
Gastrointestinal • Diarrhea • Bloody stools • Constipation/gas • Stomach ulcers • Hepatitis/Jaundice	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	
Genitourinary • Date of Last Pap_____ • History of abnormal pap • Endometriosis • Uterine abnormalities • Chlamydia/Gonorrhea • Herpes • Syphilis/HPV • Infertility • Kidney disease/kidney stones	Normal _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	Abnormal _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	
Musculoskeletal • Muscle pain/weakness • Arthritis/joint pain • Fractures	_____ _____ _____	_____ _____ _____	
Skin/Breast • Pain/masses in breast • Breast discharge • Rash/ulcers/skin problems	_____ _____ _____	_____ _____ _____	
Neurological • Dizziness/fainting • Seizures	_____ _____ _____	_____ _____ _____	

• Convulsions/epilepsy • Stroke • Numbness • Trouble walking			
Psychiatric • Depression/crying • Anxiety • Post-partum/depression			
Endocrine • Dry skin • Hot flashes • Abnormal thirst • Hypo/hyperthyroidism • diabetes			
Hematologic/Lymphatic • Unusual bruising/bleeding • Enlarged lymph nodes • Anemia • Blood transfusions			
Allergic/Immunologic • Drug/food allergies • Other allergies • HIV • Lupus/autoimmune disease			
Other • Cancer • Rubella • History of RH incompatibility			

Family History of Cancer

	You	Age	Siblings/ Children	Age	Maternal Side	Age	Paternal Side	Age
Breast								
Ovarian								
Bilateral Breast Cancer or Multiple Primaries								
Male Breast Cancer								
Are you Ashkenazi Jewish?								
Uterine (Endometrial) Cancer								
Colorectal Cancer								
Stomach, Kidney/Urinary tract, brain, or small bowel cancer								
10 or more colorectal polyps								
Other Cancers								

Operations/Hospitalizations

Reason	Date	Reason	Date

Injuries

Reason	Date	Reason	Date

Genetic Screening- Include any information of patient, baby's father, or anyone in either family.

For any YES answer, please indicate which family member

PROBLEM	YOUR FAMILY	FATHER'S FAMILY
Mental retardation/autism		
Hyperactivity/attention difficulties		
Epilepsy/seizures/convulsions		
Spina bifida		
Hydrocephaly (water on brain)		
Cleft lip (hare lip/palate)		
Down's syndrome		
Chromosomal abnormality		
Club foot		
Blindness		
Deafness		
Dwarf		
Congenital heart defect		
Hemophilia (bleeder)		
Sickle cell disease or trait		
Cystic fibrosis		
Muscular dystrophy		

Huntingtons chorea		
Thalassemia		
Tay-sacs		
Any other		

Social History

Tobacco Use: Yes_____ No_____	**Packs per day_____**	**Years Smoked_____**		**Quit?/When_____**
Alcohol Use: Yes_____ No_____	**Moderately_____**	**Daily Number of Drinks_____**		**Type Used_____**
Drug Use: Yes_____ No_____	**Type Used_____**	**Frequency_____**		**Quit?/When_____**
Domestic Violence: Yes_____ No_____			**Seat Belt Use: Yes_____ No_____**	
Currently on a diet: Yes_____ No_____	**Regular Exercise Yes_____ No_____**		**Type:_____**	

Patient Signature_____

Annual Review of History:

Date Reviewed_____ **Physician Signature_____**

Date Reviewed_____ **Physician Signature_____**

Date Reviewed_____ **Physician Signature_____**

Date Reviewed_____ **Physician Signature_____**

Consent for Screening Test-Obstetrical

As part of our ongoing dedication to patient care, there will be multiple screening tests performed during your pregnancy. The tests performed are to ascertain any pre-existing or developing health issues in order to provide the most informed care to mother and baby.

Routine Obstetrical Panel:

- Complete Blood Count
- Blood Typing and RH Factor
- Rubella Antibody Screen (testing for any antibody to measles)
- Thyroid Function Test
- Hepatitis Profile
- RPR (testing for venereal disease)
- One swab for Chlamydia, Gonorrhea and Group B Strep
- HIV

18-20 Weeks of Gestation:

- Quad or AFP (testing for increase risk of genetic malformations)

24-28 Weeks of Gestation:

- Complete Blood Count and Gestational Diabetes Screen

Other tests may b ordered during the pregnancy as requested by your physician.

In order for us to perform testing for sexually transmitted diseases, especially HIV, we must obtain informed consent from the patient. If you do not wish to have any of these tests performed, please inform your physician as such. Patient's rights dictate that you can refuse any invasive testing. Do keep in mind, however, that these tests are done in order to maximize patient care for possible diseases that may compromise mother or baby's health before and during labor.

I _____ have been informed of the need for obstetrical blood screening, especially screening for sexually transmitted diseases, including HIV testing and have been given adequate time to ask questions. At this time **I DO** { } **I DO NOT** { } consent to the screening tests listed above.

Patient signature _____ Date _____

Ultrasound Scanning in Pregnancy

Ultrasound scanning is a procedure that uses sound waves to create pictures of the uterus, placenta, and fetus. There is no exposure to radiation and no known risk. Early pregnancy scans are done after patient's first day of her last menstrual period, during the weeks 7 to 8, using a vaginal transducer covered with a clean disposable sheath. There is no discomfort, risk of infection or harm to the pregnancy by using this technique. Scanning in later pregnancy is done with a large transducer, which is placed on your abdominal area.

Ultrasound scanning may be used:

- To make sure the baby is developing in the uterus and not inside the fallopian tube (ectopic).
- To determine how far along you are in the pregnancy (due date).
- To check that the baby is growing normally.
- To estimate the weight of the baby.
- To check the position of the baby and the placenta.
- To check the amount of fluid around the baby.
- To see how many babies are in the uterus.
- To look for fetal movement and breathing.

Ultrasound scanning cannot detect all birth defects. Ultrasound examinations performed at Conroe Physician Associates are related to the above purposes only. A normal ultrasound in this office does not assure the absence of birth defects or abnormalities. If your are at high-risk for having a baby with a congenital anomaly, you should see a perinatologist for a level II ultrasound. A level II ultrasound is usually performed for women over 35 years old, with or without amniocentesis. Additional screening test such as Nuchal Thickness Screening, AFP triple marker screening and amniocentesis or ultrasound, can detect all birth defects.

Not all pregnancies require routine ultrasound exams and the American College of Obstetrics and Gynecology do not consider it necessary for all pregnancies. Some insurance carriers do not reimburse for elective ultrasound screening of a normal pregnancy. If any other reason for ultrasound screening arises, the ultrasound is more likely to be covered according to the details of your health insurance policy.

I understand the indication for my ultrasound today. I understand the limitations of ultrasound screening and wish to continue with the test. I have had all of my questions answered.

Patient signature _____ Date _____