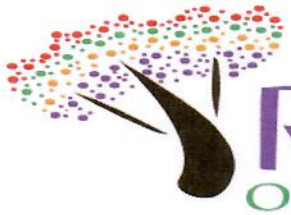

Ronni E Farris, MD
Obstetrics, Gynecology & Wellness

Today's Date: _____ Primary Care Physician: _____

Reason for today's visit: _____ Referring Physician: _____

Patient Information

- Last Name: _____ First Name: _____ Middle Initial: _____
- Other Name: _____ Date of Birth: _____ Age: _____
- Address: _____ City, State, Zip: _____
- Home phone: _____ Cell phone: _____
- Are confidential voicemails permitted? □ Yes □ No
- SSN: _____ Email: _____
- Occupation: _____
- Marital status: □ Single □ Married □ Widowed □ Separated □ Divorced □ Partner
- Spouse/Partner Occupation: _____

Emergency Contact Information

- Emergency Contact: _____ Relationship to You: _____
- Home Phone: _____ Cell phone: _____

Insurance Information

- Primary Carrier: _____ Phone #: _____
- Policy Holder: _____ Relationship to Patient: _____
- Date of Birth: _____ ID#: _____ Group#: _____
- Address: _____ City, State, Zip: _____

- Primary Carrier: _____ Phone #: _____
- Policy Holder: _____ Relationship to Patient: _____
- Date of Birth: _____ ID#: _____ Group#: _____
- Address: _____ City, State, Zip: _____

Additional Information

- Race: □ American Indian □ Asian □ African American □ Native Hawaiian or Other Pacific Island □ White □ None of the above □ Do not wish to specify
- Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Do not wish to specify
- Preferred Language: □ English □ Spanish □ Other: _____

  Would you like a translator for your visit? □ Yes □ No
- How did you hear about this clinic?

  □ Health Plan □ Internet □ Social Media □ Website □ Newspaper/Magazine

  □ Friend/Patient: _____

Pharmacy Information:

- Pharmacy Name: _____
- Address or Cross Streets: _____
- Phone number: _____

OBGYN history

Menstrual History

- First Day of last menstrual period? _____ (month/day/year)
- Age of first period: _____ years
- If your menstrual periods are regular: periods start every _____ days
- If you menstrual periods are irregular: periods start every _____ to _____ days (e.g. 12 to 60)
- Duration of bleeding: _____ days
- Does bleeding or spotting occur between periods? _____ yes _____ No
- Does bleeding or spotting occur after intercourse? _____ yes _____ No
- Is pain associated with periods? _____ yes _____ No _____ Occasionally
  - If yes, is it _____ before menses _____ during menses _____ both

Obstetrical history:

- Number of total pregnancies: _____ Total number of living children: _____
- Miscarriage: _____ Abortion: _____ Ectopic: _____
- Delivery history:

Year	Term or Preterm	Vaginal or C-section	Complications During pregnancy	Complications during delivery	Weight of baby

Other gynecological history

- Check all that apply:

□ Genital warts
□ Genital herpes
□ Syphilis
□ Gonorrhea
□ Chlamydia
□ Other vaginal infection
□ Endometriosis
□ PCOS
□ Pelvic inflammatory disease

- What birth control method do you currently use: _____
  - (e.g. pills, patch, ring, depo, Nexplanon, IUD, tubal, vasectomy)

Pap smear history

- Date of last pap smear: _____
- Have you ever had an abnormal pap smear? □ No □ Yes
  - If yes, have you had treatment for abnormal pap smears? □ No □ Yes
    - □ cryotherapy □ laser □ cone biopsy □ loop excision (LEEP)

Sexual history

- Are you sexually active? □ Yes □ No
- Do you have a sexual partner? □ Yes □ No
  - If yes, □ male □ female □ both
- Are there concerns about your sexual activity that you want to discuss? □ yes □ No
  - If yes, please explain: _____

Past Obstetrical / Gynecological Surgeries

(if yes, please write year next to the surgery)

- □ D&C
- □ hysteroscopy
- □ ablation
- □ Infertility surgery
- □ tubal reversal
- □ tubal ligation
- □ endometriosis surgery
- □ hysterectomy (vaginal)
- □ hysterectomy (abdominal)
- □ myomectomy
- □ ovarian surgery
- □ left ovarian cyst removed
- □ right ovarian cyst removed
- □ left ovary removed
- □ right ovary removed
- □ vaginal or bladder repair for prolapse/incontinence
- □ cesarean section

Medical History

Medical Problems (Check all that apply):

- □ None
- □ Arthritis
- □ Diabetes
  - □ Diet controlled
  - □ medication control
  - □ insulin controlled
- □ High blood pressure
- □ Heart disease
- □ Kidney disease
- □ Other: _____
- □ Gallbladder / Gallstones
- □ Liver disease (including hepatitis)
- □ Epilepsy
- □ History of blood transfusion
- □ thyroid disease
- □ Asthma
- □ COPD
- □ History of deep vein thrombosis (DVT)
- □ History of eating disorder

Medications:

Medication	Dose	Frequency

Allergies: □ None

- ❖ Do you have a latex allergy? □ yes □ no
- ❖ Do you have medication allergies? □ yes □ no
  - ○ If yes, please list allergy and reaction:

Medication	Reaction

Past Surgical History (Not OBGYN related): □ None

- ❖ List all surgeries and their year

Surgery	Year

Family History (if yes, please list affected relatives)

□ None
□ Diabetes _____
□ Ovarian cancer _____
□ Heart disease _____
□ Endometrial (Uterine) cancer _____
□ Breast cancer _____
□ Colon cancer _____
□ Other _____

Were any affected relatives diagnosed younger than age 50?

□ yes □ no

Preventative Screening:

- When was your last mammogram? □ Never _____
  - Have you ever had an abnormal mammogram? □ Yes □ No
  - If yes, please explain: _____
- When was your last colonoscopy? □ Never _____
  - Have you ever had an abnormal colonoscopy? □ Yes □ No
  - If yes, please explain: _____
- When was your last DEXA (bone density) scan? □ Never _____
  - Have you ever had an abnormal bone density scan? □ Yes □ No
  - If yes, please explain: _____

Do you currently?:

- Smoke: □ No □ Yes _____ packs/day □ previously (when did you quit) _____
- Use alcohol: □ No □ Yes _____wine (glass/day); _____beer (bottle/day); _____liquor (oz/day)
- Use illicit / recreational drugs □ No □ Yes _____ type _____ amount
  - Do you have a medical marijuana card? □ No □ Yes
- Do you exercise? □ No □ Yes _____ type _____ how often

Other symptoms?

Have you had recent?

□ weight loss

□ weight gain

□ change in energy

□ breast discharge

□ hair growth

□ hair loss

□ change in urinary function

□ hot flushes/flashing

□ None of the above

□ Other: _____

Other Questions, Concerns, or Comments today:

_____

_____

_____ _____ _____

Patient signature Printed Name Date

Ronni E Farris, MD
Obstetrics, Gynecology & Wellness

Protected Health Information Authorized Person(S)

Please print below information

I, _____, hereby authorize release of my Protected Health Information for verbal discussion only of my care and treatment to the person(s) specified below (45CFR, 164.502[F] & 164.502[G]): Authorized family member or person to receive information for the above named patient's care:

_____	_____	_____
Name of Central Contact (Other than patient)	Relationship to patient	Phone number

Others authorized to receive my verbal information

_____	_____	_____
Name of Central Contact (Other than patient)	Relationship to patient	Phone number

_____	_____	_____
Name of Central Contact (Other than patient)	Relationship to patient	Phone number

NOTE: This form does not give the above referenced persons permission to make health care decisions for the patient or entitle them to paper copies or electronic access of your medical record. We will not release via the telephone or any other means or communication any information to any friends or family members not listed above unless the patient has an opportunity to object and does not (documented) or if it is reasonable to infer that the patient does not object such as when a patient brings a spouse into the room when treatment is being discussed. Exception: if the release is needed in emergency situations

Leave message on answering machine or voice mail? ☐ Yes ☐ No
(Example: We may leave message reminders, scheduling changes or notices that labs results are in on your answering machine. Would this process be acceptable, yes or no?)

Leave message for patient to return call? ☐ Yes ☐ No
(Example: We may leave a message regarding appointment reminders, scheduling changes or notices that lab results are in with an individual who answers the phone. Would this process be acceptable, yes or no?)

NOTE: By signing and dating this Protected Health Information Authorized Person(s) form, I revoke all previously signed Protected Health Information Authorized Person(s) forms.

Patient signature: _____ Date: _____

Personal Representative: _____ Relationship to Patient: _____

(PRINTED Name)

NOTE: Except to the extent that action has already been taken in reliance on this Protected Health Information Authorized Person(s), at any time I can revoke this Protected Health Information Authorized Person(s) by submitting a new Protected Health Information Authorized Person(s) form or by written notice to Ronni E. Farris, MD, PLLC or Norman Regional where my records are kept.

Printed Name: _____ Date of Birth: _____

Ronni E Farris, MD
Obstetrics, Gynecology & Wellness

Name: _____

Date of Birth: _____

Consent and Agreement Physician Services

- **Annual Consent for Services**: I consent to the services that may be performed by Dr. Ronni E. Farris or staff at Ronni E. Farris, MD, PLLC. I understand I can withdraw this consent at any time. This consent and agreement applies to any provider services I may obtain for Dr. Ronni E. Farris or facility.
- **Financial Agreement**: I guarantee and agree to pay for all goods and services provided to me or the patient named below at the rates listed by Ronni E. Farris, MD, PLLC as of the date of treatment, unless I am entitled to pay a different amount under my (or the patient's) health insurance plan or my (or the patient's) status as a Medicare or Medicaid beneficiary. Should an account be referred to an attorney or collection agency for collection, I will pay attorney's fees and collection expenses. Dr. Ronni E. Farris will provide a medical screening exam to anyone in need of emergency medical treatment, regardless of ability to pay.
- **Assignment of Insurance Benefits**: I assign my (or the patient's) rights under all insurance and benefit plan documents and authorize direct payment to Dr. Ronni E. Farris of all insurance and plan benefits payments for services provided by Dr. Ronni E. Farris. By paying Dr. Ronni E. Farris, my insurance company or employer is fulfilling its obligations to me (or the patient) under the health insurance policy, or the employer is fulfilling its obligations as required by law. I also agree that I (or the patient) am financially responsible for charges not paid according to this assignment.
- **Medicare Assignment:** I certify that the information given by me in applying for payment from any third party payor, including payment under Title XVIII of the Social Security Act, is correct. I request that payment of authorized benefits by made in my (or the patient's) behalf, and I authorize that Social Security Administration Office of the Department of Health and Human Services to release information regarding my (or the patient's) eligibility for coverage under Medicare Part A and Part B, including but not limited to the effective date of such coverage. I also authorize Ronni E. Farris, MD, PLLC or Norman Regional to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.
- **Legal Relationship between Hospital and Provider**: I understand that when I am hospitalized, I am under the care and supervision of my attending provider, and it is the responsibility of the hospital and nursing staff to carry out his/her instructions. It is the responsibility of my provider or surgeon to obtain my informed consent, when required, for specific medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under instruction of the provider.
- **Clinic and Rules:** I understand that my visitors and I must obey all Dr. Ronni E. Farris or clinic rules. I understand that if I or my visitors do not follow the rules, Dr. Ronni E. Farris or facility may pursue corrective action.

- **Personal Valuables**: I understand that as a patient, I am encouraged to leave valuable personal items at home. While this office is a safe place, small personal items or unusual value, Dr. Ronni E. Farris and facility is not responsible for the loss or damage to this items.
- **Demographic Information:** I have reviewed the demographic information listed for me and confirm that it is correct. I am aware that I need to inform Dr. Ronni E. Farris and facility or any changes as soon as it is possible.
- **Independent Contractor / Providers**: I understand that separate bills may be sent for professional services such as lab services, and from providers such as radiologists, pathologists, and anesthesiologists, in addition to bills from Ronni E. Farris, MD, PLLC.
- **Phone Calls:** I authorize Ronni E. Farris, MD, PLLC, and its collection agencies to contact me, or a representative I appoint, about my account, including using any contact information or cell phone numbers that I have provided or will provide, or this is available to Ronni E. Farris, MD, PLLC from third parties. I authorize contact with me by telephone or voice messages and authorize the use of automated dialing technology and pre-recorded messages, even if I am charged for the call under my phone plan. I agree such contact will not be "unsolicited" for purposes of local, state or federal law. I agree that Dr. Ronni E. Farris, facility, and its collection agencies may monitor and/or record any communications.

- A copy of this form shall have the same force and effect as the original. The undersigned is the patient or is duly authorized to act on behalf of the patient to sign for the patient and accept the terms written above. A signed copy of this form is available upon request.

Signature: _____ Date: _____ Time: _____

Printed Name: _____

If signed by other than patient, indicate relationship: _____

Witness: _____ Date: _____ Time: _____