UROGYNECOLOGY
SAN ANTONIO

Name: **Date of Birth:**

Reason for your appointment:

Please list all medications along with dosage amounts:

Please list all medical problems:

Drug allergies:

GYN History:

Age of first menstrual cycle: _____

Age of menopause (if applicable): _____

Date of Last Menstrual Cycle: _____

Have you ever had an abnormal pap smear? _____

If Yes, When and what treatment was done: _____

Obstetrical History:

Please list all pregnancies, miscarriages or terminations, including type of delivery, complications, and year:

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Please list all surgeries along with the year performed:

_____ _____

_____ _____

Please list all hospitalizations along with year:

_____ _____

Family History:

Family Member	Diabetes	High Blood Pressure	Heart Attack	Stroke	Mental Illness	Cancer
Mom	☐	☐	☐	☐	☐	☐
Dad	☐	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐	☐
Maternal grandfather	☐	☐	☐	☐	☐	☐
Maternal grandmother	☐	☐	☐	☐	☐	☐
Paternal grandfather	☐	☐	☐	☐	☐	☐
Paternal grandmother	☐	☐	☐	☐	☐	☐

Has anyone in your family been diagnosed with Breast, Ovarian or Colon Cancer?

_____

Social History:

Do you smoke? _____

If yes, how much? _____

Do you exercise? _____

If yes, how many days a week? _____

Are you sexually active? _____

Do you drink alcohol? _____

If yes, how many drinks per month? _____

Do you use recreational drugs? _____

ASH DABBOUS, MD, FACOG
FEMALE PELVIC MEDICINE & RECONSTRUCTIVE SURGERY

335 E. Sonterra Blvd. Suite #170 | San Antonio, Texas 78258
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Urogynecology Of San Antonio

335 East Sonterra Blvd, Suite 170
San Antonio, Texas 78258
Phone (210) 614-7744 Fax (210)892-3886

OFFICE POLICIES

Office hours: Monday - Thursday 8: 30 am to 5:00 pm and Fridays 8:30am to 12:00 pm
Phone hours: Monday - Thursday 8:30 am to 11:30am and 1:00pm to 4:30 pm and Fridays 8:30 am to 12:00 pm.

- **Please arrive 15 minutes prior to your scheduled appointment.**
- **Please bring your insurance card(s) and photo ID.**
- **Payment is due at the time services are rendered.**
- **Your insurance may require authorization for non-covered medications. Please allow two weeks for authorization to be initiated. Please provide our office with your prescription card to avoid any delays. Note that, depending on your insurance, the entire process may take 4-6 weeks.**
- **We understand that emergencies may occur; however, if you miss more than three appointments (no show or same-day cancel), you may be dismissed from the practice.**
- **Cell phone use during your visit is prohibited.**
- **If you need a medication refill, an appointment will be required before a prescription is approved**
- **Inappropriate behavior toward staff, such as foul language, is prohibited and may result in dismissal from the practice.**

By signing below, I agree to adhere to the Urogynecology of San Antonio office policies outlined above.

Patient Signature	Patient Name	Date

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Patient Consent

Most office visits are subject to medical insurance filing. Any remaining charges are to be paid by the patient in the event a claim is not fully paid by insurance or is not subject to medical insurance filing. Patient's Out-of-Pocket Responsibility

As GUARANTOR of this account, I hereby assume all financial responsibility for the payment of the services rendered to the named patient. I confirm the insurance information I have given to Urogynecology of San Antonio is current and accurate. Urogynecology of San Antonio has been given all insurance information and coverage pertaining to my treatment.

I further understand that the information given to Urogynecology of San Antonio by my insurance company is not a guarantee of payment and is only an estimate of the amount that may be covered by insurance. I further understand that my Patient Responsibility, paid at the time of service, is only an estimate and the exact amount cannot be determined until final insurance payment has been received.

If I have questions about my insurance coverage or benefits, it is my responsibility to contact my insurance carrier directly.

I agree to make my estimated Patient Responsibility payment at the time of service.

I understand that any supplies or procedures not covered by my insurance are my financial responsibility.

I give Urogynecology of San Antonio consent to file all claims to my medical insurance.

I understand that a copy of this form will be provided to me upon request.

Patient Signature_____ **Date**_____

Patient Name_____

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PATIENT WEB PORTAL

To Our Patients-
We now have a patient portal available for your use. This will allow you to have access to some of your medical information. This is a HIPAA secure site. You will be given a user name and password. If you become locked out of the system you will need to call our office and we will reset your account. The turn-around time is 48 hours for a new password.

- ☐ **Yes, I would like to be web — enabled.**
- ☐ **No, I do not desire to be web — enabled.**
- ☐ **No, I am already web-enabled.**

Patient Name (Print)_____

Patient Signature_____

Date_____

Patient's E-Mail_____

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Notice of Privacy Practices—Acknowledgement of Receipt

Patient Name_____

Patient Signature_____

Date of Birth_____

I acknowledge that I have reviewed Urogynecology of San Antonio Notice of Privacy Practice document. If you would like a copy of the Notice, please ask one of our staff members.

HIPPA Release Form

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information to:

Name	Relationship	Contact Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do not release this information to anyone (Please initial) _____

Patient Name_____

Patient Signature_____

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Preventative Services Notice

Preventive care services (well woman) include a routine physical exam and pap smear, if necessary. These visits help prevent health problems prior to symptoms occurring. They do not include tests or services to monitor/manage a condition or disease once it has been diagnosed.

I understand that if symptoms of acute or chronic problems are discussed at my preventive care visit, it is considered diagnostic; therefore, my office visit copay/ deductible may apply for the non-preventive part of the visit.

Patient Name_____

Date of Birth_____

Patient Signature_____

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