Plano Wellness

Reason for Appointment (OFFICE USE ONLY)
☐ Dr. Marlene Diaz ☐ Lisa Price, FNP-C

☐ ANNUAL

☐ HORMONE CONSULT
(not available with Annual)

THE FOLLOWING ARE NOT INCLUDED IN PREVENTITIVE SERVICES. AN ADDITIONAL OFFICE VISIT CHARGE WILL BE ADDED.
☐ 2nd OPINION:
☐ OTHER/PROBLEM:

Name: _____ **DOB:** _____ **Age:** _____

E-mail: _____ **Phone:** _____

Complete Address: _____

Local Pharmacy: _____ **Pharmacy Address/Phone:** _____

LOCAL PHARMACY NAME & PHONE # MUST BE PROVIDED. DO NOT LEAVE BLANK

Mail Order Pharmacy: _____ Compounding Pharmacy: _____

EMERGENCY CONTACT: I give permission to Plano Wellness personnel to give any/all medical information pertaining to myself to the following: ☐ *I would not like my information shared with anyone.*

Name: _____ **Phone#:** _____ **Relationship:** _____

INSURANCE: Main Card Holder ☐ Self ☐ Spouse ☐ Parent ☐ No Insurance, I will be Self-Pay

If Spouse or Parent, Name: _____ DOB: _____

HEALTH SCREENING

HPV/Gardasil Vaccine completed? ☐ No ☐ Yes, Year: _____
Is your Tetanus vaccine current? ☐ No ☐ Yes, Year: _____
COVID vaccine? ☐ No ☐ Yes, Year: _____
Shingles vaccine? ☐ No ☐ Yes, Year: _____

Last Pap Smear? Date: _____
Last Mammogram? Date: _____
Last Colonoscopy? Date: _____
Last Bone Density? Date: _____

Tobacco:	☐ Never	☐ Sporadic	☐ Daily	☐ Quit, Year: _____
Alcohol:	☐ Never	☐ Sporadic	☐ Daily	☐ Quit, Year: _____
Exercise:	☐ Never	☐ Sporadic	☐ 3-4/wk	☐ Daily
Marital Status:	☐ Single	☐ Married	☐ Divorced	☐ Separated ☐ Widowed

PCP: _____ **(DR. DIAZ & LISA PRICE, FNP-C are not Primary Care)**

MEDICATIONS: ☐ I am NOT taking any medication/supplements.

Current Medication/Supplements:	Strength:	How Often?

ALLERGIES: ☐ I do not have any allergies.

Medication Allergy:	Reaction:	Medication Allergy:	Reaction:

OFFICE USE	Ht:	Wt:	BP:	P:	UA:	Temp:

*PLEASE ANSWER ALL QUESTIONS. DO NOT LEAVE ANY BLANKS. MARK BOXES WITH "NO"/ "DECLINE" IF SECTION DOES NOT PERTAIN TO YOU.

GYN History Menstrual Cycles

Next Section

Sexually Active? ☐ No ☐ Yes

Is your intimate life satisfactory? ☐ No ☐ Yes

Sexual Partner Preference: ☐ Male ☐ Female

Physical, Emotional, Sexual Abuse? ☐ No ☐ Yes

Attempting Pregnancy? ☐ No ☐ Yes
If yes, For how long? _____

Menstrual Cycles

Not having menstrual Cycles? **(Check any that apply)**

☐ Menopause ☐ Birth Control
☐ Hysterectomy ☐ Nursing
☐ Ablation

At what age was your first cycle? _____

Last cycle started on: _____/_____/_____

Menstrual Timing: ☐ Regular Cycle ☐ Irregular Cycle
How often? _____

Flow: ___Heavy Days ___Moderate Days ___Light Days

Cramps: ☐ No ☐ Yes **Clots:** ☐ No ☐ Yes

Method of birth control you are using? ☐ *I DO NOT USE ANY METHOD OF BIRTH CONTROL*

☐ Not sexually active yet
☐ None, would welcome pregnancy
☐ None, History of Infertility
☐ Abstinence
☐ Birth Control Pill
☐ Condoms
☐ Depo Provera
☐ Diaphragm
☐ Essure
☐ IUD Hormone Progestin
☐ IUD 10 yr Copper
☐ Natural Family Planning
☐ Hysterectomy
☐ Patch
☐ Vaginal Ring
☐ Progestin Implant (Nexplanon)
☐ Rhythm
☐ Salpingectomies, Bilateral
☐ Same sex partner
☐ Tubal Ligation, Bilateral
☐ Vaginal hormone inset
☐ Vaginal spermicide
☐ Vasectomy
☐ Withdrawal

Past GYN History - **Do you have or have you ever had:** ☐ *I DECLINE ALL GYNECOLOGICAL HISTORY BELOW*

☐ Abnormal Pap Smear
☐ Amenorrhea
☐ Anovulation
☐ Bartholin's gland cyst
☐ Cervical cancer
☐ Candidiasis (chronic yeast)
☐ Chlamydia
☐ Condyloma (genital warts)
☐ Cryotherapy
☐ Cystocele (dropped bladder)
☐ DES exposure in utero
☐ Dysplasia (pre-cancer)
☐ Dyspareunia (painful sex)
☐ Endometriosis
☐ Fibroid uterus
☐ Gonorrhea
☐ Heavy periods
☐ Herpes, genital
☐ HPV
☐ Hydrosalpinx
☐ Incontinence
☐ Infertility
☐ Irregular menses
☐ LEEP
☐ Ovarian cancer
☐ Ovarian problems
☐ Pelvic adhesions
☐ PID
☐ PMS
☐ Polycystic Ovaries (PCOS)
☐ Syphilis
☐ Trichomonas
☐ Uterine cancer
☐ Uterine Polyps
☐ Uterine Prolapse
☐ Vaginal or Vulvar Cancer

Past Obstetrical History ☐ *NO PREGNANCY HISTORY*

Total Pregnancies _____
Total Full Term _____
Total Pre-Term _____
Total Miscarriages _____
Total Terminations _____
Total Ectopic Pregnancy _____
Total Vaginal Births _____
Total Cesarean Births _____
Largest weight _____
Total Multiple Births _____
Total Stillbirths _____

Pregnancy Complications ☐ *NO PREGNANCY COMPLICATIONS*

☐ Breech
☐ Gestational Diabetes
☐ Hemorrhage
☐ Hypertension
☐ Incompetent Cervix
☐ Postpartum Depression
☐ Progesterone 1st Trimester
☐ Placenta Previa
☐ Pre-Term Labor
☐ Shoulder Dystocia
☐ Other:_____

*PLEASE ANSWER ALL QUESTIONS. DO NOT LEAVE ANY BLANKS. MARK BOXES WITH "NO"/ "DECLINE" IF SECTION DOES NOT PERTAIN TO YOU.

YOUR Medical History ☐ *I DECLINE ALL MEDICAL HISTORY BELOW*

- ☐ AIDS
- ☐ Alzheimer's disease
- ☐ Anemia
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood clotting disorder
- ☐ Breast cancer
- ☐ Cardiac arrhythmia
- ☐ Cholesterol(Hypercholesterolemia)
- ☐ Colon cancer
- ☐ Congestive heart disease
- ☐ COPD (Lung disease)
- ☐ Coronary heart disease
- ☐ Depression
- ☐ Diabetes
- ☐ DVT (venous embolism)
- ☐ Epilepsy
- ☐ Esophageal reflux
- ☐ Fibromyalgia
- ☐ Genetic disorder
- ☐ Hepatitis (**A**, **B**, or **C**)
- ☐ Hernia
- ☐ HIV
- ☐ Hypertension (HTN)
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Kidney stone
- ☐ Lung cancer
- ☐ Migraine headaches
- ☐ Mitral valve prolapse (MVP)
- ☐ Myocardial infarction
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Skin cancer
- ☐ Stroke (CVA)
- ☐ Suicide Attempt
- ☐ Thyroid (**Hypo** or **Hyper**)
- ☐ Transient Ischemic attack
- ☐ Triglycerides, Elevated
- ☐ Ulcer
- ☐ Other:_____
  _____
  _____
  _____

YOUR Past Surgical History ☐ *NO SURGICAL HISTORY*

- ☐ Abdominal, exploratory
- ☐ Appendectomy
- ☐ Back surgery
- ☐ Bariatric surgery
- ☐ Breast augmentation
- ☐ Breast Lumpectomy
- ☐ Bladder lift
- ☐ Cesarean section
- ☐ CABG (coronary bypass)
- ☐ Cervix procedure
- ☐ Cholecystectomy (gallbladder)
- ☐ Colon Resection
- ☐ D&C
- ☐ Endometrial Ablation
- ☐ Fallopian tube surgery
- ☐ Fibroid surgery
- ☐ Hemorrhoid
- ☐ Hernia
- ☐ Hip replacement
- ☐ Hysterectomy
- ☐ Knee surgery
- ☐ Laparoscopy
- ☐ Ovarian surgery
- ☐ Pacemaker implant
- ☐ Plastic surgery
- ☐ Splenectomy
- ☐ Thyroidectomy
- ☐ Other _____
  _____
  _____

Have you ever been hospitalized? *(excluding surgeries & childbirth)* ☐ **NO** ☐ **YES**

Family History Questionnaire for Common Hereditary Cancer syndromes

Has any *family member* ever had genetic testing for Hereditary Risk of Cancer? ☐ **NO** ☐ **YES**

If yes, please explain: _____

Family History ☐ *NO FAMILY HISTORY* ☐ *ADOPTED* **(M = Maternal, P = Paternal)**

(Provide Age of diagnosis)	**Mother**	**Father**	**Grand Parent**		**Sister**	**Brother**	**Aunt**	**Uncle**
			GM	**GF**				
Breast Cancer			☐ M ☐ P	☐ M ☐ P			☐ M ☐ P	☐ M ☐ P
Ovarian Cancer		X	☐ M ☐ P	X		X	☐ M ☐ P	X
Pancreatic Cancer			☐ M ☐ P	☐ M ☐ P			☐ M ☐ P	☐ M ☐ P
Uterine Cancer			☐ M ☐ P	☐ M ☐ P			☐ M ☐ P	☐ M ☐ P
Prostate Cancer	X		X	☐ M ☐ P	X		X	☐ M ☐ P
Colon Cancer (>10 polyps)			☐ M ☐ P	☐ M ☐ P			☐ M ☐ P	☐ M ☐ P
Melanoma			☐ M ☐ P	☐ M ☐ P			☐ M ☐ P	☐ M ☐ P
Other Cancer			☐ M ☐ P	☐ M ☐ P			☐ M ☐ P	☐ M ☐ P

*PLEASE ANSWER ALL QUESTIONS. DO NOT LEAVE ANY BLANKS. MARK BOXES WITH "NO"/ "DECLINE" IF SECTION DOES NOT PERTAIN TO YOU.

Check family members with the following conditions: ☐ *NO FAMILY HISTORY* ☐ *ADOPTED*

(Provide Age of diagnosis)		Mother	Father	Grand Parent		Sister	Brother	Aunt	Uncle
				GM	GF				
Alzheimer's Disease	Alz			☐ M ☐ P	☐ M ☐ P			☐ M ☐ P	☐ M ☐ P
Blood Clots	Clo			☐ M ☐ P	☐ M ☐ P			☐ M ☐ P	☐ M ☐ P
High Cholesterol/triglycerides	Dis			☐ M ☐ P	☐ M ☐ P			☐ M ☐ P	☐ M ☐ P
Coronary Heart Disease	CAD			☐ M ☐ P	☐ M ☐ P			☐ M ☐ P	☐ M ☐ P
Diabetes	DM			☐ M ☐ P	☐ M ☐ P			☐ M ☐ P	☐ M ☐ P
Genetic Disorder	Gen			☐ M ☐ P	☐ M ☐ P			☐ M ☐ P	☐ M ☐ P
Hepatitis (A, B, or C)	Hep			☐ M ☐ P	☐ M ☐ P			☐ M ☐ P	☐ M ☐ P
Hypertension	HTN			☐ M ☐ P	☐ M ☐ P			☐ M ☐ P	☐ M ☐ P
Myocardial Infarction	MI			☐ M ☐ P	☐ M ☐ P			☐ M ☐ P	☐ M ☐ P
Osteoporosis	Ost			☐ M ☐ P	☐ M ☐ P			☐ M ☐ P	☐ M ☐ P
Stroke	CVA			☐ M ☐ P	☐ M ☐ P			☐ M ☐ P	☐ M ☐ P
Thyroid Disorder	Thy			☐ M ☐ P	☐ M ☐ P			☐ M ☐ P	☐ M ☐ P

Review of Systems: *(Please **circle** any symptoms you **currently** have):* ☐ *NO SYMPTOMS*

OTHER SYMPTOMS:_____

General	Chills Fatigue Fever Night Sweats Weight gain Weight loss
Eyes	Blind spots Floaters in the visual field Eye pain
Ears, Nose, Throat, Neck	Bleeding gums Hoarseness Swollen neck Decreased hearing Difficulty swallowing Nosebleed
Endocrine	Cold intolerance Heat intolerance Excessive hair growth Hair Loss Excessive Thirst Breast discharge Hot Flashes
Respiratory	Hemoptysis (bloody cough) Shortness of breath Wheezing
Cardiac	Faint Chest pain Palpitations Shortness of breath at rest
GI	Abdominal pain Blood in stool Constipation Diarrhea Nausea Vomiting
Heme/Lymph	Anemia Easy bruising Prolonged bleeding Swollen glands
GU	Nocturia (urination at night) Pelvic pain Vaginal dryness Vaginal discharge Vaginal itching Vaginal burning Low sex drive Difficult to climax Painful intercourse Blood after intercourse Blood in urine Frequent urination Painful urination
Musculoskeletal	Back pain Painful joints Weakness Swollen joints Back Problems
Skin	Acne Dry skin New mole Rash
Neurologic	Dizziness Headache Poor memory Tingling/Numbness
Psychiatric	Anxiety Depressed mood Irritability Insomnia Suicidal thoughts Difficulty Sleeping

*PLEASE ANSWER ALL QUESTIONS. DO NOT LEAVE ANY BLANKS. MARK BOXES WITH "NO"/ "DECLINE" IF SECTION DOES NOT PERTAIN TO YOU.

Patient Financial Agreement

The following information is provided to all our patients, new and established, to inform patients of our office financial policies and of patient financial responsibility requirements. Please ask a team member if you have any questions regarding these policies.

- We are happy to bill your insurance as a courtesy; however, all charges, regardless of insurance coverage are your responsibility as our patient. We do expect payment for your portion at the time of service. (co-pays, co-insurance, deductibles). We ask that if your insurance has not paid within 45 days that you follow up with them.
- If you are seen for both an annual preventative exam and a separate problem/illness is identified and also addressed, proper coding will be used. This may result in a charge for both services. Additionally, some medically indicated lab tests may not be covered as a preventative screen by your policy. Your individual contract with your insurance carrier will determine how your insurance will pay. We make every effort to bill each visit with the proper diagnosis and procedure codes according to national coding guidelines. Please understand that we cannot make exceptions to our coding practices due to federal and state legal compliance concerns, and we are unable to bill for services other than those documented in your medical record.
- Injections and some medical supplies must be paid for in advance at the time of service. Specialized products or services must be preauthorized with insurance prior to service; otherwise, these services will need to be paid in full by the patient at the time of service.
- For surgical care, we will pre-certify your insurance and obtain the estimated patient responsibility for the procedure. This amount is due prior to the scheduled date of surgery. If the procedure results in additional charges, these fees will be billed to you. We would ask that you pay the balance within 30 days following your surgery.
- We routinely send our laboratory testing to third-party laboratory companies. The aforementioned providers may or may not participate with your health plan. You may request that we refer your testing to another location. This request will need to be done with each visit.
- It is necessary to strictly enforce the policy of financial obligation. All co-pays, patient self-payment, and estimated patient financial responsibility may be paid by cash, check, or VISA, MasterCard.
- There will be a charge for no show of $50 for missing a scheduled appointment without a cancellation notice. A charge of $25 will be applied to a cancellation notice of less than 24 hours (business hours) for office visits and $100 for surgical procedures. Payment of this fee is the responsibility of the patient and cannot be filed with insurance companies. These fees will not be waived.
- The charge for paperwork (for example Family Medical Leave Act (FMLA) & Short-Term Disability applications) is $25 for a long form and $10 for short forms. This is payable in full at the time the form is left for completion.

Assignment of Benefits: (ALLOWS US TO FILE YOUR CHARGES WITH YOUR INSURANCE):
We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by your insurance at the time of service. If this account is assigned to an attorney for collection and or suit, the prevailing party shall be entitled to reasonable attorney's fees for costs of collection.
I understand that I am responsible for providing all insurance information at the time of registration to allow for verification of benefits, and that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered.
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to **Plano Wellness Medical, PLLC or Plano Wellness, PLLC**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that in the event my health plan determines a service to be "non-covered", I will be responsible for all non-covered and allowable charges. I hereby authorize said assignee to release all information necessary to secure payment.

I have read and understand the above information and agree to comply with these financial policies.

Signature: _____ Date: _____

*PLEASE ANSWER ALL QUESTIONS. DO NOT LEAVE ANY BLANKS. MARK BOXES WITH "NO"/ "DECLINE" IF SECTION DOES NOT PERTAIN TO YOU.

Plano Wellness Medical, PLLC
Plano Wellness, PLLC
Plano Wellness Center, PLLC

Consent to Treat

General Patient Consent for Care

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary.

Telemedicine

I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care.

Billing and payment for a Televisit is the same process for billing and payment for an in-person, face-to-face visit.

A Televisit is available to you as an established patient through your secure patient portal. Your patient portal incorporates network and software security protocols to keep your identification and data confidential, preventing unauthorized parties from being able to access messages while they are in transmission. Video clips, audio clips, and/or photos may be taken of you during the visit for medical documentation and treatment purposes. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws.

Potential risks in utilizing this technology include but are not limited to distortions, interruptions or disconnections of the audio/video link which prompt discontinuation of a visit. If a Televisit do not adequately address my medical needs, an in-person medical evaluation may be necessary. If I experience an urgent matter, such as a bad reaction to any treatment after a Televisit, I will alert my treating physician and, in the case of emergency dial 911, or go to the nearest hospital emergency department.

I acknowledge that it is my responsibility to provide information about my medical history, condition and care that is complete and accurate to the best of my ability. Unlike traditional office visits, my provider does not have the use of senses such as touch or smell. **I may discontinue a Televisit at any time.**

Medication Records

I authorize Plano Wellness Medical, PLLC, Plano Wellness, PLLC and/or Plano Wellness Center, PLLC to download my medication history and Rx benefits into my account from a Rx clearinghouse.

Signed Consent

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Notice of Privacy Practices Acknowledgement

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. You have the right to review the Notice before signing this acknowledgment. A copy of the current Notice is available at the front check in counter. The Notice contains the effective date and as provided in our Notice, the terms of our Notice may change.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures on your prior consent.

_____	_____	_____
Patient Signature	Patient Date of Birth	Today's Date

*PLEASE ANSWER ALL QUESTIONS. DO NOT LEAVE ANY BLANKS. MARK BOXES WITH "NO"/ "DECLINE" IF SECTION DOES NOT PERTAIN TO YOU.