SUGARLAND WOMEN'S HEALTH CENTER
14090 SW Freeway, Suite 101
Sugar Land, TX 77478

Welcome to the Sugarland Women's Health Center. Thank you for choosing us for your women's healthcare needs. Please find enclosed our patient information packet. Fill it out as completely as possible. You do not have to complete sections with which you are not comfortable. Be aware, however, that your care here is dependent on the information we have about you. Be sure you sign each page.

A few notes on our clinic procedures:

1) For your convenience, we will draw most of your labs at this facility. Results will be called to you in two weeks unless they are abnormal and require immediate follow up. We will call you in these cases. If you have not received your results in two weeks, please call our office. Do not assume they are normal.

2) Unless you notify us in writing, we will call the numbers we have on file for you for your cell phone, your home, and your work phone in that order. Per federal HIPPA regulations, we are not allowed to leave medical information on your answering machine or answering services. We can only leave a message for you to call us back. Please do not be alarm if you get a phone call or message from us, we call everyone back whether their lab results are normal or abnormal. In cases of medical emergency or during deliveries where we are not available for your scheduled appointment, we will attempt to call you at least 30 minutes in advance. So, please always leave us a current number where you can be reached during the day.

3) Ultrasounds are performed in our facility at prescheduled time. Results will be given to you as the ultrasound is performed. If you have insurance, there will be a co-pay charge just as if you were sent to another radiology facility for them.

4) We do not perform mammogram at our facility, but we will refer you to a radiology facility of your choice. The results will return to us which will be forwarded to you within two weeks. Again, please do not assume your tests are normal if you do not hear from us.

5) It is your responsibility to follow up on all referrals. We have no way of tracking if you showed up for your referrals or not. If you would like a mailed reminder of your next visit here please fill out our reminder card before leaving.

Name:
DOB:
Date:

_____
Patient Signature

6) On discharge from the clinic, please pick up our business card. On it is Dr. Cuong Nguyen's cell phone number. We want to be available for you in an emergency, so do feel free to use that number after hour for emergency. Please use that number only for emergency, and please do not distribute that number. During office hour, please call our office 281.313.1193.

7) If you need your medication refill, please call us at least three days in advance. And, please do not call on weekend. We want to have access to your chart before prescribing any medicine. This is for your safety.

8) The co-pay, if required, is due at the time of service. We do accept cash, VISA, Mastercard, Discover card, and checks. Deductibles for procedures will be collected in advance. Additional fees not covered by your insurance company will be billed to you.

9) If you are going to be more than 30 minutes late or if you need to reschedule an appointment, please let us know as soon as you know.

10) There are extensive patient education materials on our web page at www.slwhc.com. There is also drug information there for all drugs we prescribe. Please make full use of these materials. If you need additional information, please email us at dr.nguyen@slwhc.com. Be aware that you may not get a reply to your email for 1-2 days. If you need more immediate attention, please call our office or in an emergency our cell phones.

Again, thank you for your trust in us. We hope you will like it here. Please let us know if we could do anything else to improve your experience here.

Best regards,

Cuong M. Nguyen, M.D.

Name:
DOB:
Date:

_____
Patient Signature

Patient Demographics

Personal Information	
Last Name	
First Name	
MI	
Address	
City	
State	
Zip Code	
Home Phone	
Work Phone	
Work Extension	
Cell Phone	
Primary Care Physician	
Date of Birth	
Marital Status	
Social Security No.	
Patient's Employer	
Occupation	
Employ. Status	
Student Status	
Referring Physician/Patient	

Emergency Contact	
Last Name	
First Name	
Relation to Patient	
Address	
City	
State	
Zip Code	
Home Phone	
Work Phone	
Work Extension	

Pharmacy	
Name	
Telephone	

Responsible Party	
Last Name	
First Name	
MI	
DOB	
Social Security No.	
Telephone	
Gender	
Address	
City	
State	
Zip Code	
Primary Insurance	
Subscriber	
Relation to patient	
Insurance Name	
Address	
City	
State	
Zip	
Telephone	
Subscriber No	
Group No	
Specialty Co-pay	
Coverage Start	
Secondary Insurance	
Subscriber	
Relation to patient	
Insurance Name	
Address	
City	
State	
Zip	
Telephone	
Subscriber No	
Group No	
Specialty Co-pay	
Coverage Start	

Name:
DOB:
Date:

_____
Patient Signature

Medical History

Reason you are being seen today:

Please describe your condition:

Current Medication:	
Medication	Dose

Allergies:	
Medication	Reaction

Medical History	
Condition	Status

Past Surgeries:	
Date	Procedure

Hospitalization:	
Date	Reason

Family History:	
Relative	Condition
Mother	
Father	
Sister	
Brother	
Daughter	
Son	
Maternal Grandmother	
Paternal Grandmother	
Maternal Aunt	
Cousins	
Other	

Social History:	
Occupation	
Alcohol	
Tobacco	
Illicit drugs	
Physical abuse	
Sexual abuse	

Name:
DOB:
Date:

_____
Signature

OB/GYN History

Gyneclogic History	
Last Menstrual Period	
Menarche (age of first menses)	
Menstrual regularity	
Menopause (age of last menses)	
Contraception	
Abnormal PAP	
Abnormal Mammogram	
Last PAP	
Last Mammogram	
Sexually Transmitted Disease	
Pelvic Inflammatory Disease	
Urinary Incontinence	

Obstetrical History	
Total pregnancy	
Living Children	
Miscarriage	
Abortion	
Ectopic Pregnancy	
Vaginal Delivery	
Cesarean Section	

Partner's Name

Name:
DOB:
Date:

_____
Signature

GYN Review of Systems

Please indicate and provide details of any condition in your current history. If none apply, draw a vertical line through the entire no column.

Yes	No	Condition	Details
		heavy periods	
		dyspareunia – pain during sex	
		sexually active	
		premenstrual syndrome	
		dysmenorrhea – pain during period	
		infertility	
		Inter-menstrual bleeding	
		post coital bleeding – after sex	
		pelvic pain	
		irregular periods	
		abnormal vaginal discharge	
		weight gain	
		weight loss	
		rash	
		lumps	
		breast changes	
		chest pain	
		palpitations	
		dizziness	
		shortness of breath	
		nausea	
		vomiting	
		diarrhea	
		Abdominal pain	
		constipation	
		urinary urgency	
		frequent urination	
		urinary incontinence	
		fatigue	
		excessive thirst	
		excessive urination	
		cold intolerance	
		heat intolerance	
		headache	
		high stress level	
		depression	
		sleep disturbances	
		mental or physical abuse	
		sexual abuse	

Name:
DOB:
Date:

_____
Signature

SUGARLAND WOMEN'S HEALTH CENTER

HEALTH INSURANCE PORTABILITY AND ACCESSIBILITY ACT
PRIVACY NOTICE (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information, please review it carefully.

Uses and Disclosures of Health Information

With your consent,, we may use health information about you for treatment (such as sending your medical record information to other physicians as part of a referral), to obtain payment for treatment (such as sending billing information to health insurance plan), for administrative purposes, and to evaluate the quality of care that you receive (such as comparing patient data to improve health treatment methods).

We may use or disclose identifiable health information about you without your authorization for several reasons: Subject to certain requirements, we may give out your health information for public health purposes, abuse or neglect reporting, auditing purposes, research studies, funeral arrangements, organ donation, worker's compensation purposes, and emergencies. We provide information when requested by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at anytime. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and on our web site. You can also request a copy of our notice at anytime. For more information about our privacy practices, contact Dr. Nguyen.

Individual Rights

In most cases, you have the right to look at or get a copy of the heath information that is about you, that we use to make decisions about you. If you request copies, we will charge you 10 cents each page. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You have the right to request that your health information be communicated to you in a confidential manner such as sending mail to an address other than your home. If this notice is sent electronically, you may obtain a paper copy of the notice.

You may request, in writing, that we not use or disclose your information for treatment, payment, or administrative purposes or to persons involved in your care except when specifically authorized by you, when required by law, or in emergent circumstances. We may consider your request but are not legally required to accept it.

Name:
DOB:
Date:

_____
Signature

SUGARLAND WOMEN'S HEALTH CENTER

Authorization to release information, assign benefits, and accept financial responsibility

I authorize the Sugarland Women's Health Center who has treated me or my dependent(s) to furnish any medical information requested. In consideration of services rendered, I transfer and assign any benefits of insurance to the Sugarland Women's Health Center. I understand that I am responsible for any co-pay or deductible amounts. I understand I am fully responsible for payment of my account balance if my health plan does not reimburse (or only partially reimburses) my medical services.

Name:
DOB:
Date:

_____
Signature

SUGARLAND WOMEN'S HEALTH CENTER

14090 Southwest Freeway, Suite 101
Sugar Land, TX 77478
Office 281.313.1193
Fax 281.313.1194

REQUEST FOR MEDICAL RECORD

To:

Medical Facility:_____

Address: _____

City, State, Zip:_____

Phone: _____

Fax: _____

I hereby authorize the release of all my medical records and test results including HIV test results, in your possession regarding my medical condition. Please send of fax record to:

Dr. Cuong M. Nguyen
Sugarland Women's Health Center
14090 Southwest Freeway, Suite 101
Sugar Land, TX 77478
Fax: 281.313.1194

I release you from liability for following this request.

Patient Name:

Date of Birth:

Signature: _____

Date: