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. If you leave out any information we can only assume it did not happen. 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 given to you on your next appointment unless they are abnormal and require immediate follow up. We will call you in these cases.

2) Unless you notify us in writing, we will call the numbers we have on file for you for your cell phone, your home phone, and your work phone in that order. By federal HIPPA regulation, we are not allowed to leave medical information on your answering machine. 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 clinic at prescheduled time. If you have insurance, there will be a co-pay charge just as if you were sent to another radiology facility for them. Unscheduled ultrasounds are usually never covered by your insurance company and can only be done if our schedule allows. You will be charged a small fee for these.

4) 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

5) 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.

6) 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.

7) Deliveries are at Methodist Sugar Land Hospital and at Memorial Hermann Southwest Hospital. Please let us know which hospitals you prefer. Pre-registration is usually done by 28 weeks gestation. Remember to register for your child birth classes early as these fills up very quickly.

8) Please be aware that if you are paying for your care in cash, the hospitals usually add a significant fee if you do not pre-register with them by 28 weeks.

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) Please make all your follow up appointment prior to leaving the clinic. Also, make sure you have our business card. On it is our 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 or when you go into labor. Please use that number only for emergency and not for problems which could be cared for during the day. During office hours, please call our office at 281.313.1193.

11) 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.

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

Pregnancy History	1st Pregnancy	2nd Pregnancy	3rd Pregnancy	4th Pregnancy	5th Pregnancy
Date					
Weeks Pregnant					
Labor Length					
Weight at Delivery					
Gender					
Mode of Delivery					
Anesthesia					
Place					
Baby's Name					
Complications					

Name:
DOB:
Date:

_____
Signature

OB Review of Systems

Please indicate and provide details of any condition in yours or your family's history. If none apply, draw a vertical line through the no column.

Yes	No	Condition	Details
		>35 year of age at delivery	
		Thalasemia (Italian, Greek, Asian, or Mediterranean descent) MCV<80	
		Neurotube Defect	
		Congenital Heart Defect	
		Down Syndrome	
		Tay-Sachs	
		Canavan Disease	
		Sickle Cell Disease or Trait	
		Hemophilia/Blood Disorder	
		Muscular Dystrophy	
		Cystic Fibrosis	
		Huntington's Chorea	
		Mental Retardation/Autism	
		Fragile X Syndrome	
		Other Genetic Disorder	
		TB Exposure	
		Genital Herpes	
		Condyloma	
		Other STD	
		High Risk Occupation	
		Teachers	
		Healthcare worker	
		Out door cats	
		Diabetes	
		Hypertension	
		Autoimmune disorder	
		Heart disease	
		Kidney disease/UTI	
		Neurologic/Epilepsy	
		Depression/Postpartum depression	
		Hepatitis/Liver disease	
		Varicosities/Phlebitis	
		Thyroid dysfunction	
		Trauma/Violence exposure	
		History of Blood Transfusion	
		D (Rh) sensitized	
		Latex Allergy	
		Breast Problem	
		Anesthesia Complications	
		Uterine Anomaly	

Name:
DOB:
Date:

_____
Signature

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: