PATIENT INFORMATION

NAME: _____ D.O.B. ____/____/____ AGE _____
LAST FIRST MI

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

HOME #: _____ WORK # : _____ ALT #: _____

MARITAL STATUS: _____ SS #: _____ EMAIL: _____

LANGUAGE: _____ RACE: _____ ETHNICITY: _____

EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT: _____ EMERGENCY CONTRACT PHONE NUMBER:_____

REFERRED BY: _____

****

INSURANCE INFORMATION-
LIST ALL INSURANCES IN WHICH YOU ARE ENROLLED: _____

FAILURE TO PROVIDE ALL INSURANCES MAY RESULT IN CLAIM DENIAL THEREFORE MAKING THE PATIENT RESPONSIBLE FOR ALL DENIED CLAIMS. PLEASE PROVIDE FRONT OFFICE WITH COPY OF ALL INSURANCE CARDS AT TIME OF SERVICE.

X _____

****

WE REQUIRE THAT ALL DEDUCTIBLES, CO-INSURANCE, & COPAYS BE PAID AT TIME OF SERVICE
I, _____ HEREBY AUTHORIZE MY PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED IN THE COURSE OF MY TREATMENT TO MY INSURANCE COMPANY,EMPLOYER,PHYSICIANS, INSTITUTIONS OR THIRD PARTY PAYORS, AS REQUIRED FOR CERTAIN CLAIMS FILED.

X_____ _____
SIGNATURE OF PATIENT/PARENT GUARDIAN DATE

I AUTHORIZE DIRECT PAYMENT TO BE MADE TO DR TURNER FOR ANY AND ALL MEDICAL OR SURGICAL SERVICES RENDERED. I UNDERSTAND IF ANY SERVICES OR CHARGES ARE NOT COVERED BY MY INSURANCE CARRIER OR MY ELIGIBILITY CANNOT BE VERIFIED, I AM RESPONSIBLE FOR ALL CHARGES INCURRED. SHOULD YOU MISS A PAYMENT AND NO ARRANGEMENTS MADE PRIOR TO THAT BILLING CYCLE THERE WILL BE A $15 PAST DUE FEE PER MONTH. IF ANY REFUNDS ARE DUE BACK TO YOU PLEASE ALLOW 180 DAYS FOR PROCESSING.

X_____ _____
SIGNATURE OF PATIENT/ PARENT GUARDIAN DATE

I AUTHORIZE THE OFFICE OF ROD.J. TURNER M.D TO MAIL APPOINTMENT REMINDER CARDS TO MY HOME ADDRESS AND LEAVE MESSAGES ON MY ANSWERING MACHINE. ANY APPOINTMENTS THAT ARE NOT GIVEN A 24HR CANCELLATION NOTICE OR MISSED WILL INCUR A CHARGE OF $50 DUE IMMEDIATELY BEFORE SCHEDULING ANOTHER APPOINTMENT. SCHEDULED SURGERIES THAT NEED TO BE CANCELLED SHOULD BE GIVEN A 72HR NOTICE TO AVOID A $50 CANCELLATION FEE.

X_____ _____
SIGNATURE OF PATIENT/ PARENT GUARDIAN DATE

ROD J. TURNER, M.D., P.A. **NEW GYNECOLOGY EXAM FORM**

402 BLOSSOM STREET WEBSTER, TX 77598 PHONE 281-554-3107 FAX 281-557-0372

PRINT NAME: _____ DATE ___/___/20___

Date of birth: ____/____/_____ (MM/DD/YYYY) Age: _____ Race: _____

1. **Marital Status**: Single Married Separated Divorced Widow
2. Who is your **PRIMARY CARE PHYSICIAN (PCP)**? _____
3. When was you **LAST MENSTRUAL PERIOD**? (The start date): _____
4. When was your **LAST MAMMOGRAM**: _____ (Normal, Abnormal, or Not Applicable)
5. When was your **LAST PAP SMEAR**: _____ (Normal or Abnormal)
6. Have you had your **UTERUS** and/or **TUBES & OVARIES REMOVED**? YES or NO
7. **Smoker**? YES / NO _____ packs per day? **Alcohol**? YES / NO ____ per day. **Street Drug**? YES / NO
8. Any DRUG ALLERGIES? No Know Drug Allergies (NKDA) or YES (Please list them) _____

_____

9. **MEDICAL HISTORY:**

   A. Any **MEDICAL ILLNESS**? (I.E. High Blood Pressure, Diabetes, Asthma, Thyroid Disease, etc?) _____

   _____

   B. Any **SURGICAL PROCEDURES**? (I.E. Tonsils, Wisdom teeth, Appendix, Gallbladder, Eye, Head, Limb, Body surgeries, etc.?) _____

   _____

   C. And **SOCIAL HISTORY** problems? (I.E. Alcohol, Drugs, etc?) _____

   _____

10. What **MEDICATIONS** are you currently taking? (I.E. Including supplements, Vitamins, Herbs, or Over the counter (OTC) drugs): _____
11. What **BIRTH CONTROL METHOD** are you using? (**Please circle**) :

No Need, Oral Contraceptive Pills, Condoms, IUD, Diaphragm, Tubal Ligation, Vasectomy, Depo-Provera

Other: _____

12. **WHAT DID YOU SCHEDULE THIS APPOINTMENT WITH DR. TURNER FOR TODAY?**

    1. **Well Woman Exam** or
    2. _____

13. Will you need a **REFILL** on any **MEDICATION**? YES / NO (Please list): _____
14. Will you need an **ULTRASOUND** or **MAMMOGRAM**? YES / NO (Please list): _____
15. Will you need any **LABS** requested? YES / NO (Pease list): _____

_____

Signature Please

ROD J. TURNER, M.D., P.A.

NEW GYNECOLOGY EXAM FORM

402 BLOSSOM STREET WEBSTER, TX 77598 PHONE 281-554-3107 FAX 281-557-0372

16. **Have you ever been diagnosed with? (Please check & give dates):**

- ☐ Bacterial Infection _____
- ☐ Chlamydia _____
- ☐ Genital Warts _____
- ☐ Gonorrhea _____
- ☐ Herpes _____
- ☐ HIV/AIDS _____
- ☐ Human Papilloma Virus(HPV) _____
- ☐ Syphilis _____
- ☐ Trichomoniasis _____
- ☐ Yeast Infection _____
- ☐ Other _____

17. **Have you experienced any of the following vaginal symptoms recently?**

A. Discharge that is thick, white, and cottage cheese like?
B. Discharge that is thin, milky-white, or gray?
C. Discharge that is yellow-green, and frothy?
D. Increased vaginal discharge?
E. Itching or burning?
F. Unpleasant vaginal order (may be stronger after sex)
G. Other symptoms? (Please describe):
_____

Today	Past Two Months

18. **Have you ever used an over the counter yeast medication?** (I.E. Monistat, Mycelex): YES / NO

A. If yes, when was the list time? _____

B. Did it relieve your symptoms? _____

19. **Do you ever douche?** YES / NO

If yes, how often? _____ When did you last douche? _____

20. **Have you ever had vaginal intercourse (sex)?** YES / NO

A. **Are you sexually active now?** YES / NO

If yes, with a **MALE** or **FEMALE**? _____

B. **Have you recently had sex with a NEW PARTNER?** YES / NO

If yes, was your last partner a **MALE** or **FEMALE**? _____

21. **Do you do monthly self-breast exams?** YES / NO

If no, why? _____

22. **CONSENT FOR SEXUALLY TRANSMITTED DISEASE (S.T.D.) TESTING :**

I hereby and acknowledge that I have been informed that I will be tested today for **Chlamydia and Gonorrhea** during my annual exam. It is Dr. Rod J. Turner, M.D., P.A., routine (and A.C.O.G. RECOMMENDED) that all sexually active women be tested annually. Some health care plans **DO and DO NOT** cover the cost of this RECOMMENDED TEST. If you DO NOT AUTHORIZE Dr. Rod J. Turner, M.D., P.A. to perform the above STD cultures you might have an STD, which will not be detectable, causing further problems (especially sterilization) or the need for a hysterectomy and/or removal of one or both tubes and ovaries ; and other associated infectious complications from STD's. ***Please discuss further with Dr. Rod J. Turner M.D., P.A. if you DECLINE STD testing.***

☐ YES, I **ACCEPT** THE TESTING FOR STD'S.

☐ * NO, I **DECLINE** THE TESTING FOR STD'S *

Print name: _____

Signature please: _____

ROD J. TURNER, M.D., P.A. **NEW GYNECOLOGY EXAM FORM**

402 BLOSSOM STREET WEBSTER, TX 77598 PHONE 281-554-3107 FAX 281-557-0372

Patient information on Family History & Review of Systems

Print Name: _____

Do YOU or any of your FAMILY MEMBERS have ANY OF THE FOLLOWING?

	NONE	YOU	DAD	MOM	SIBLING(S)	GRANDPARENT(S)	OTHER
Alzheimer							
Asthma							
Bleeding Disorders							
Breast Cancer							
Cancer(s)							
Colon Cancer							
Diabetes							
Female Cancers							
Heart Attacks							
Heart Disease							
Hemophilia							
High Blood Pressure							
Leukemia							
Liver Cancer							
Lung Cancers							
Mental Illness							
Ovarian Cancer							
Strokes							
Thyroid Disease							
Other							

ROD J. TURNER, M.D., P.A. **NEW GYNECOLOGY EXAM FORM**

402 BLOSSOM STREET WEBSTER, TX 77598 PHONE 281-554-3107 FAX 281-557-0372

Print Name: _____

You're REVIEW OF SYSTEMS; CIRCLE all that you ARE experiencing; CHECK negative for ones you are NOT experiencing.

CONST: Weight gain / loss, Chills, Sweats, Fever, Appetite increase/decrease, Fatigue. NEG: ___

EYES: Eye pain, Blurred Vision, Eye Redness, Discharge. NEG: ___

ENT: Diminished hearing, Tinnitus, Ear pain, Epitasis, Hoarseness, Sinus pressure/pain, Mouth Sores, Nasal Drainage, Congestion, Throat pain/discomfort. NEG: ___

C/V: Chest pain, Pedal Edema, Palpitations, Doe, Claudication. NEG: ___

RESP: SOB, Wheezing, Cough NEG: ___

GI: Heartburn, Abdominal Pain, Bloating, Nausea, Vomiting, Diarrhea, Change in bowel habits, Constipation, Rectal Bleeding, Hemorrhoids, Bloody stools. NEG: ___

HEME/LYMP: Bleeding Problems, Bruising, Lymphadenopathy. NEG: ___

GU: Incontinence, Frequency, Urgency, Dysuria, Hematuria, Polyuria, Nocturia, Vaginal Discharge, Sexual Dysfunction, Post-Menopausal, Vaginal Bleeding, Vaginal pain/itching. NEG: ___

SKIN/BREAST: Change in moles (color, size, bleeding), Rash, Mass, Tenderness, Nipple Discharge. NEG: ___

ALLERGY/ IMMUNOLOGIC: Any Allergies? _____ NEG: ___

NUERO: Headaches, Dizziness, Memory Loss, Fainting, Confusion, Parethesias, Weakness NEG: ___

ENDOCRINE: Hair Loss, Hirsutism. NEG: ___

MUSCULOSKELETAL: Muscular pain, Joint pain, Joint stiffness, Swelling, Redness, Deformity. NEG: ___

PYSCH: Anxiety, Depression, Sleep disturbance, Mood swings, Suicidal or homicidal ideations, Hallucinations, Insomnia, Elevated Moods. NEG: ___

Patient Signature: _____

Physician to fill out BEWLOW:

Patient to follow up with PRIMARY CARE PHYSCIAN (PCP)? YES / NO

Physicians Signature: _____ M.D.

ROD J. TURNER, M.D., P.A.

♦♦♦

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

RELEASE RECORDS TO:

ROD J. TURNER, MD, PA

402 Blossom Street ♦

Webster, Texas 77598-4208 ♦ U.S.A.

Phone 281 / 554-3107 ♦ Fax 281 / 557-0372

REQUESTED RECORDS FROM:

Name:_____

Address:_____

City:_____State:____Zip:_____

Phone:_____ Fax:_____

PATIENT INFORMATION :

Patient Name: _____

Address:_____

City: _____ State: _____ Zip _____

Primary Phone# _____ Secondary Phone# _____

Date of Birth: _____ Social Security Number _____

I, AS ABOVE, authorize the above listed person/s, physician/s, firm or entity (or its agents, representatives, or employees) to release for inspection and copying, any and all of the Personal Health Information (PHI) listed below that pertains to my treatment, hospitalization, or care from date/s of:_____ to ***PRESENT***.

[ ] Entire Record - Inpatient [ ] Radiology/X-Ray Reports [ ] Operative Reports [ ] Pathology Reports

[ ] Entire Record - Outpatient [ ] Newborn/Neonatal Records [ ] Laboratory Reports [ ] ER Records

[ ] Labor & Delivery Records [ ] Discharge Summary [ ] Anesthesia Records [ ] Other: _____

_____

If requested by patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on LAST DAY OF THIS YEAR. The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. I do not have to sign this authorization in order to receive treatment from MY PROVIDER. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Office at the Office in which records are released.

REASON FOR REQUESTING RECORDS: *CONTINUITY OF CARE.*

Signature of Patient or Legal Representative: _____

Date: _____, 20 _____.

****CONFIDENTIALITY NOTICE****

The document(s) accompanying this facsimile transmission contain Confidential Information, belonging to the sender that is legally privileged. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this facsimile information is strictly prohibited. If you have received this facsimile in error. Please notify us by telephone 281-554-3107 immediately and return the original document(s) to us at the above address via the U.S. Postal Service. Thank You.

Rod J. Turner,M.D., P.A.

402 BLOSSOM ST.
WEBSTER, TX 77589-4208
281-554-3107 OFFICE
281-557-0372 FAX

PATIENT PRESCRIPTION REFILL AGREEMENT

This agreement is to protect your safety when utilizing prescriptions.

For medication refills please contact your pharmacy. Please do not call our office for medication refills. The pharmacy will send us the necessary information to refill your prescription. Allow yourself to have 1 (ONE) week of medication left when you call in a refill. Please allow our office two (2) business days to process the refill request. Some prescriptions may take longer to process due to insurance. All information regarding mail order prescriptions must be brought to our office. We are not responsible for mailing prescriptions. We will notify you when the prescription is ready for pick up. No prescription will be refilled on Weekends or Holidays

ALL CONTROLLED DRUGS WILL NEED A NEW PRESCRIPTION EACH TIME
PLEASE ALLOW ATLEAST 72 HOURS FOR US TO PROCESS THIS REQUEST.

I have read, and understand the office prescription policy.

X _____ Date: _____

Preferred Pharmacy

PHARMACY NAME:_____

PHARMACY NUMBER:_____

PHARMACY ADDRESS:_____ ZIP CODE_____

Rod J. Turner,M.D., P.A.

402 BLOSSOM ST.
WEBSTER, TX 77589-4208
281-554-3107 OFFICE
281-557-0372 FAX

PATIENT CONSENT FORM

Rod J. Turner, MD, PA requests that each patient sign this consent form which allows us to share protected health information with other physician's offices, your hospital and insurance company. By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing except where we have already made disclosures in reliance on your prior consent .Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing.

Name of Patient/Representative _____Signature _____

Authorization to Release Information

Under the requirements for H.I.P.A.A we are not allowed to give any information to anyone without the consent of the patient. If you wish to have any laboratory or radiology results released to any family members, please indicate their name and relationship to the patient below.

1. _____Relationship to Patient _____Date: _____
2. _____Relationship to Patient _____Date: _____

Patient Name: _____ Patient Signature: _____

Authorization to Leave Messages with Household Members/ Voice Mails

By signing this consent you give representatives of Dr. Rod J. Turner to leave messages with Household Members or Voicemails. The purpose of these messages is to remind patients that they have or to schedule an appointment, or to notify the patient that the staff would like to discuss an issue or concern. At no time will a representative of our office discuss your medical circumstances or condition with anyone not listed above. The purpose of this consent is to leave messages with members of your household or on your Voicemail.

Patient Name:_____

Patient Signature:_____

Date:_____

TO ALL PATIENTS:

Insurances do not reimburse for Preventative Medicine and Evaluation Management on one date of service. In other words, you cannot be seen for a well woman visit and problem visit at the same visit. If you are having a problem, please notify our office staff, and re-schedule your Preventative Visit.

Thank you ahead of time in your understanding of this Insurance Quandary.

X_____ Date: _____

I have been informed both in writing and orally that the doctors that take call with Dr. Rod J. Turner will no longer go to Methodist St. John Hospital effective July 01, 2006. Should I need any medical care that requires hospitalization, to receive medical care from Dr. Rod J. Turner I must go to Clear Lake Regional Medical Center.

X_____ Date:_____

Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed:_____Date:_____

Relationship (if not signed by patient): _____

ROD J. TURNER MD PC

Please Sign In

Please have your insurance card, photo ID, and credit card ready when you SIGN IN for Service.

Why is Dr. Rod J. Turner asking for a credit card?

At this time, we request your credit card information (this may be a health spending account card, credit card, or account debit card) and authorization to be placed on file for today's service.

*This preauthorization will allow the office to collect balances due after your insurance has processed today's charges (if applicable).

*No charges will be applied to your credit card unless your insurance plan indicates that you are responsible for charges under the guidelines of your coverage.

*We are aware that for some insurance plans there is no additional patient responsibility such as copayments, coinsurance, or deductibles for physician services covered by the insurance plan.

*Our office secures credit card data and protects it within our network. We follow the payment card industry standards.

*After your insurance processes your claim for today's services and notifies our office with an Explanation of Benefits (EOB) of your patient responsibility, we will apply the charges to your card up to the amount you authorize today.

*You can receive an acknowledgement receipt of your credit card authorization today at your request and a letter in the mail confirming the final amount charged.

*We will destroy your credit card information after the charge is processed.

X _____

Card #:
Exp Date:
CVC:

Patient LABEL