NEW PATIENT INFORMATION

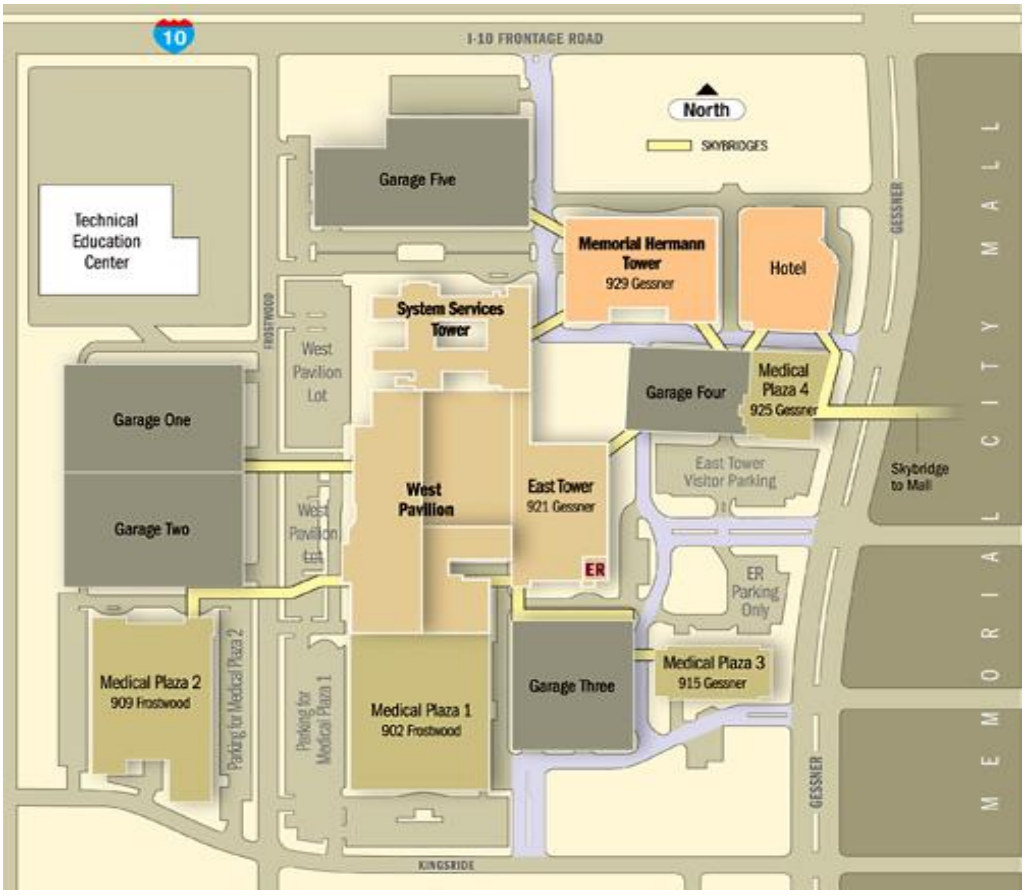
Please complete all attached forms leaving no blanks. If something does not apply then mark with N/A. Please do not print double sided.

Please **fax** your completed forms **within 2 days of making your appointment** so we can load your medical information into our computer system before your visit. Our fax number is 713-464-3116. If you are unable to fax then you can **email** the form back to our office using the secure email we sent to you.

Please bring your **insurance card, and picture ID** with you to your appointment.

****

SHERRI S. LEVIN, M.D. & ASSOCIATES
Sherri S. Levin, MD, Anne V. Gonzalez, MD, Amelie Lam Chu, MD,
Sooyoung C. Hwang, MD, Lauren J. Tharp, MD
929 GESSNER SUITE 2100
HOUSTON, TX 77024



We are located in the Memorial Hermann Tower (MHT) that faces I-10
(with the glass tower on top)
Park in parking garage #5 on the Frostwood side of the complex
On level B take the crosswalk to the Memorial Hermann Tower (MHT)
Take the crosswalk to the escalator and take the escalator down to the lobby
Walk thru the lobby to the right and take the 2nd set of elevators on your left to the 21st floor
We are in suite 2100. Our phone number is 713-464-4111.

KEEP THIS SHEET FOR YOUR RECORDS

Sherri S. Levin, M.D. & Associates

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OBSTETRICS • GYNECOLOGY • INFERTILITY

NAME: _____DATE OF BIRTH: _____ AGE: _____

ADDRESS:(**NoPOBox**)_____Apt:_____ CITY: _____STATE: _____ ZIP: _____

HOME PHONE: _____CELL PHONE: _____ MARITAL STATUS: S M W D

SOCIAL SECURITY#: _____WORK PHONE: _____

OCCUPATION: _____EMPLOYER: _____

SPOUSE'S NAME: _____ CELL PHONE: _____

OCCUPATION: _____EMPLOYER:_____ WORK PHONE: _____

NOTE: RESPONSIBLE PARTY IS **NOT** YOUR INSURANCE COMPANY!! IT IS THE PERSON RESPONSIBLE FOR FINANCES ON AN ACCOUNT.

RESPONSIBLE PARTY: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY INSURANCE: YES ( ) NO ( ) INSURED'S NAME: _____DATE OF BIRTH:_____

INSURANCE COMPANY: _____CUSTOMER SERVICE PH#:_____

INSURED'S SOCIAL SECURITY: _____GROUP#:_____

ID #: _____ RELATION TO PATIENT: _____

SECONDARY INSURANCE: YES ( ) NO ( ) INSURED'S NAME:_____DATE OF BIRTH:_____

INSURANCE COMPANY: _____CUSTOMER SERVICE PH#:_____

INSURED'S SOCIAL SECURITY: _____GROUP #:_____

ID #: _____ RELATION TO PATIENT: _____

ASSIGNMENT OF BENEFITS: I ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS TO WHICH I AM ENTITLED, TO SHERRI S. LEVIN, M.D. & ASSOCIATES. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE PAID BY MY INSURANCE. I AUTHORIZE THE RELEASE OF ALL INFORMATION NECESSARY IN ORDER TO OBTAIN PAYMENT FOR SERVICES PROVIDED TO ME BY DR. SHERRI LEVIN M.D. & ASSOCIATES.

SIGNATURE: _____DATE:_____

PARENT/GUARDIAN: _____DATE:_____

PHARMACY NAME AND PH#:_____

EMERGENCY CONTACT AND PH#:_____Rel to pt:_____

***** How did you hear about our practice?:_____

Patient's EMAIL ADDRESS for Portal Access: _____

PATIENT MEDICAL INFORMATION FORM

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

Reason for visit: _____

Current Medications: (list drug name and dose) _____

_____

Medical History: (circle if you have had any of the following)

Diabetes	Blood Clots in Legs / Lungs	Breast Disease
Hypertension	Bleeding Disorders	Ovarian Tumor / Cyst
Heart Disease	Stroke	Depression / Anxiety
Lung Disease / Asthma	Blood Transfusion	Seizure Disorder
Kidney Disease / UTI	Reflux / GI Ulcer	Migraine Headaches
Liver Disease / Hepatitis	Thyroid Dysfunction	

Explain items circled and list any other major medical issues: _____

_____

Allergies: (drug name and reaction) _____

Gynecologic History: Date of Last Menstrual Period: _____ Age period started? _____

Regular? YES NO Length of period ___ days Heavy? YES NO Cramping? YES NO

Have you ever been sexually active? YES NO New partner in the past 12 months? YES NO

Current Birth Control: Pills IUD Condoms Vasectomy Tubal/Essure Other: _____

History of Abnormal Pap Smear / Dysplasia / HPV? YES NO _____

History of STD? YES NO (circle) Gonorrhea / Chlamydia / Genital Warts / Herpes / Other: _____

Circle if you have you had: Hysterectomy Ablation Removal of tubes / ovaries Cone Biopsy/LEEP

Are you taking Hormones? YES NO Do you have bothersome Hot Flashes? YES NO

OB History: Total Pregnancies: ____ Living Children: ___ Miscarriages: ___ Abortions: ____ Ectopic: ____

Year	Vaginal birth or C-Section	Weight	Sex	Type of Anesthesia	Place of Delivery	Complications	Name

Surgical History: (include cosmetic surgery) _____

Hospitalizations: _____

Family History: Breast Cancer: _____ Ovarian Cancer: _____ Colon Cancer: _____

Other: (list condition and person affected)_____

Social History: Tobacco _____(cigs/day) Alcohol_____ (drinks/day) Other Drugs: _____

Marital Status: Single Married Race: _____ Religion: _____

Highest level of education: _____ Occupation: _____

Health Maintenance: Have you received the HPV vaccine? YES NO Date: _____

Have you received the flu vaccine this year? (October – March) YES NO Date: _____

Date of last Pap Smear? _____ Normal / Abnormal Mammogram? _____ Normal / Abnormal

Colonoscopy? _____ Normal / Abnormal Bone Density Scan? _____ Normal / Abnormal

Do you have any of the following problems or symptoms?

	YES	NO	COMMENTS
Fever			
Chills			
Weight loss			
Loss of hearing/vision			
Shortness of breath			
Chest pain			
Abdominal pain			
Change in bowel habits			
Incontinence			
Blood in urine			
Muscle aches			
Headache			
Depression			
Anxiety			
Pain of hands/feet			
Swelling of hands/feet			

OB QUESTIONAIRE

Will you be 35 years or older by your due date? YES NO

Name of baby's Father: _____

Have you, the baby's father, or a family member ever had the following disorders?

Down Syndrome	YES	NO	Huntington Chorea	YES	NO
Other Genetic Disorder	YES	NO	Mental Retardation / Autism	YES	NO
Neural Tube Defect (spina bifida)	YES	NO	Congenital Heart Defect	YES	NO
Hemophilia or other blood disorder	YES	NO	Other Birth Defect	YES	NO
Muscular Dystrophy	YES	NO	Recurrent Miscarriage (2+)	YES	NO
Cystic Fibrosis	YES	NO	Stillbirth	YES	NO

If YES, indicate affected person's relationship to you: _____

What is your Race: White Black Hispanic Asian Other: _____

What is your Ethnic Background / Ancestry? _____

Are you or the baby's father of Jewish ancestry? YES NO

If yes, have either of you been screened for Tay Sachs? YES NO

Are you or the baby's father of African, African-American, or black descent? YES NO

If yes, have either of you been screened for Sickle Cell trait? YES NO

Are you or the baby's father of Italian, Greek, or Mediterranean descent? YES NO

If yes, have either of you been screened for Beta-Thalassemia? YES NO

Are you or the baby's father of Southeast Asian or South Asian ancestry? YES NO

If yes, have either of you been screened for Alpha-Thalassemia? YES NO

Have you taken any medications / recreational drugs since being pregnant? YES NO

Please explain: _____

Have you had chicken pox or were you vaccinated for chicken pox? YES NO

Have you or the baby's father ever had Genital Herpes? YES NO

Have you lived or traveled outside this country in the past 5 years? YES NO

Have you lived with someone or been exposed to anyone with Tuberculosis? YES NO

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Financial Policy

Thank you for choosing us as your Ob/Gyn healthcare provider. We ask that all patients read and sign our financial policy. If you have questions concerning these policies please feel free to contact our business office at 713-464-4111.

We participate in most **insurance plans** but occasionally there is a plan we do not participate with. It is your responsibility to make sure our physicians are in-network with your particular plan. . We frequently order labs during your visit. We do NOT verify that various labs are covered on your plan. You will receive a lab bill directly from the lab company.

We collect all **co-pays, deductibles, coinsurances** and services that are not covered by your insurance at the time of service. We accept Visa, Mastercard, American Express, Discover Card, checks and cash. All returned checks and stop payment fee is $25.00.

New patients must provide one form of identification along with your insurance card. **Returning patients** must bring your insurance card to each visit. We will ask you to verify your insurance information and contact information at each visit.

If you are scheduling **surgery** with our physicians, we will call your insurance and provide information to them about the surgery. They will advise us of any financial responsibility you have for the surgery. We require a deposit before surgery, which is an estimated amount of your responsibility based on the information your insurance provided to us and our fee schedule for that insurance company. Benefits quoted by your insurance company are not a guarantee of payment by them. You may have an additional amount due once your insurance processes your claim.

If you are pregnant, an **OB deposit** will be required before your 20th week. Our financial counselors will review the benefits with you that are provided by your insurance company.

We require a 24 hour notice for all **appointment cancellations** so that patients needing appointments can be put into the schedule upon your cancellation. If you fail to give proper notice you will be charged a no-show fee of $25.00 for the first missed appointment, $55.00 for the second and $75.00 for any appointments after the 2nd. No-show fees cannot be billed to your insurance company.

If you are requesting a **copy of your medical records** or you would like for us to send them to someone else, we require your authorization and we charge a fee for copying the records. We use the guidelines set forth by the Texas State Board of Medical Examiners for our fees for copying medical records.

We charge $15.00 for completing all **health forms**, this includes but is not limited to FMLA, School health forms, Disability forms, Work health forms, and pre-certification forms for medications. We do not charge for the simple return to work form that is provided for office visits.

We send **patient statements** for all balances due after your insurance processes your claim. All payments are due within 25 days of the date on the statement. After **90 days we refer our accounts to an outside collection agency. If you cannot pay within 25 days please contact our office to keep your account in good standing.**

I certify the insurance information I have provided is accurate and I agree to pay all balances due at the time of service plus any additional balance my insurance deems my responsibility once my claims have been processed. I also certify I have read and understand the financial policies for Sherri S. Levin, MD & Associates.

PATIENT SIGNATURE_____DATE_____

PRINT NAME_____

PARENT OR LEGAL GUARDIAN_____DATE_____

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Well Woman Exam

What is a well woman annual exam?

A well woman annual exam is a once-a-year visit to your gynecologist or primary care provider for a general health check, including a breast and pelvic exam, pap smear and birth control. An annual exam does not include discussion of new problems or detailed review of chronic conditions such as thyroid, acne, missing periods, irregular bleeding, hormone replacement, etc. Annual exams are also called routine check-up, yearly exam, annual pap and preventive visit.

According to the American College of Obstetricians and Gynecologists the preventive annual exam should include the annual ob-gyn exam, including assessing current health status, nutrition, physical activity, sexual practices, and tobacco, alcohol, and drug use. Across age groups, the standard physical exam also includes height, weight, body mass index (BMI), and blood pressure. Information will also be provided regarding which vaccinations are recommended by age and risk group, including the flu shot and HPV. Annual testing for chlamydia and gonorrhea is recommended for all sexually active adolescents and young women up to age 25.

If you have scheduled a “well woman” visit but also want to address a problem or other health issues at the same time as your “well woman” exam, there will be an **additional billing** for the discussion and or treatment of this problem or health issue. According to Current Procedural Terminology (CPT) coding guidelines which we follow, a problem is not included in a “well woman” exam and should be billed separately.

If you prefer, you may schedule a separate visit on another day to address the problems you are having or the problems that arise in your annual exam. However, we are happy to provide treatment for problems on the same day as your “well woman” with the understanding that your insurance may require a co-pay or apply this additional billing to your deductible. Sometimes it makes more sense to address issues during the well woman to save you time and keep you from having to see another physician for the problems our physicians can address.

I have read the above information concerning “well woman” visits.

_____ _____

Signature Date

_____

Printed Name

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Insurance Disclosure

Please read and acknowledge below:

We are ONLY contracted with a few plans on the Healthcare Exchange or Individual Healthcare Market. Some employer plans are also using the Healthcare Exchange Networks indicated by Gold…Silver….Platinum and we are OUT OF NETWORK for these plans also. Please complete the form below to indicate which insurance plan you have.

_____ I have insurance through my/my spouses employer that does not have a limited network like gold, silver etc. I have verified with my insurance carrier that Dr. Sherri Levin is on my plan. If Dr. Levin is on the plan then all of our physicians are on the plan.

_____ I have purchased my insurance on the individual or Marketplace Insurance and I have contacted my insurance to confirm Sherri Levin, MD is on my plan. Indicate below which plan you are on:

____ Aetna Leep Everyday Memorial Hermann
____ Community Health Choice Silver..HMO
____ Memorial Hermann direct contract

_____ I have purchased my individual insurance or Marketplace insurance and I understand you are not contracted and today's charges will be self pay.

_____ _____
Signature Date

_____
Printed Name