CENTRALTEXAS
UROGYNECOLOGY AND CONTINENCE CENTER

Tomas Antonini, MD, FACOG, FACS
Carolyn Hansen, PA-C

Welcome to Central Texas Urogynecology & Continence Center !!!

We are committed to our patients and are ready to help you in a dedicated, friendly and courteous office environment.

Enclosed is a New Patient Registration packet. This packet includes a Patient Information form, Medical History form, and Financial Policy form. These forms are essential for treatment and billing. Please complete these forms as thoroughly as possible, and if possible, forward them to our office by one of these options below:

- Fax the forms to: 866-765-3913,
- Scan & email the forms to: info@centraltexasurogyn.com,
- Mail the forms to: 3407 Glenview Ave Austin, TX 78703,
- Bring them to your appointment (Please arrive 30 minutes prior to your scheduled appointment).

We ask you to please arrive 15 minutes prior to your appointment. At the time of your appointment, you will need to bring:

- Identification,
- Insurance card,
- Referral (only if needed).

This will help expedite your registration process and allow us to spend more time with you on your initial visit. If you are unable to make your appointment, please contact our office as soon as possible to reschedule. We value your time and consideration in your promptness.

If you have had previous incontinence surgery, prolapse surgery, or previous work up, please notify our staff, and they will direct you on getting your medical record(s) to our office.

Your initial visit consists of a discussion of your symptoms, a physical examination, and recommendations regarding your evaluation and treatment options. Some urogynecologic problems associated with the female bladder, bowel and vagina are not easily diagnosed. Specialized office tests may be recommended to ensure the most accurate diagnosis of your problem. We offer expert skill and state-of-the-art treatments that are customized for you particular problem. Your individualized treatment plans may involve lifestyle and dietary changes, pelvic muscle training programs, bladder and bowel re-education, medications, surgery and other highly individualized treatments.

We want to ensure that your experience is positive and comfortable in a confidential and private setting. We are committed to you through every stage of your care. In addition, we value your feedback regarding your experience.

We look forward to meeting you at your scheduled appointment on_____at _____am/pm.

3407 Glenview Ave Austin, TX 78703
Ph: 512.716.0861 Fax: 866.765.3913
www. CentralTexasUrogyn.com

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Today's date:	Referred by:
Main reason for visit:	

PATIENT INFORMATION

Name:	DOB:	Marital Status:
Street address:		SSN:

P.O. Box:	City:	State:	ZIP Code:
Home phone #:	Cel phone #:	Email:	
Occupation:	Employer:	Employer #:	
Languages:	Race:	Ethnicity:	

INSURANCE INFORMATION

Please give your insurance card and Driver's License (or picture ID) to the receptionist

Insurance Company:	Policy #:	Group #:	Phone #:
Subscriber's name:		Subscriber's SSN:	Subscriber's DOB:
Employer:		Employer's phone #:	
Employer's address:			

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Policy#:	Group #:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other:

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone :	Work phone :

Do you have an Advanced Directive? ❑YES ❑NO	If yes, would you like us to have a copy on file? ❑YES ❑NO

Preferred Pharmacy:	Location:	Phone #: ( )

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MEDICAL HISTORY

☐ **NONE** ☐ Arrhythmia ☐ Arthritis ☐ Asthma ☐ Blood Transfusion(s) ☐ CHD (Coronary Heart Disease) ☐ COPD ☐ CHF (Congestive Heart Failure ☐ Cancer – Type:_____	☐ Depression/Anxiety ☐ Diabetes – Type:_____ ☐ Glaucoma ☐ GI Problems – Type:_____ ☐ HIV ☐ Hypertension ☐ Hepatitis – Type:_____ ☐ Kidney infections ☐ Kidney stones	☐ Kidney failure ☐ Migraines ☐ Pneumonia ☐ Seizures/Convulsions ☐ SLE ☐ Stroke ☐ Thyroid Disease – Type:_____ ☐ Tuberculosis ☐ Other:_____

Last menstrual cycle:	Menopause? ☐ Yes ☐ No	Menses monthly? ☐ Yes ☐ No	Menstrual flow: ☐ Heavy ☐ Normal ☐ Light Duration of flow:_____ days	
Total # of pregnancies:	Total # of deliveries:	# of vaginal deliveries:	# of Cesarean Sections:	# of ectopic pregnancies:

Date of last mammogram:	Results: ☐ Normal ☐Abnormal	Delivery or pregnancy complications? ☐ Yes ☐ No Please explain:
Date of last pap:	Results: ☐ Normal ☐Abnormal	If abnormal, explain treatment:

SURGICAL HISTORY

☐ **NONE**
Previous incontinence surgery? ☐ No ☐ Yes - Type:_____
Previous prolapse surgery? ☐ No ☐ Yes - Type:_____
Anesthesia complications? ☐ No ☐ Yes - Type:_____
Any abdominal surgery? ☐ No ☐ Yes - Type:_____
Previous hernia surgery? ☐ No ☐ Yes - Type:_____
Hysterectomy? ☐ No ☐ Yes - Type:_____
Ovaries removed? ☐ No ☐ Yes - both ☐ Yes - right ☐ Yes - left
☐ Tonsils ☐ Diagnostic Laparoscopy ☐ Appendectomy ☐ C-sections (how many?_____)
☐ Gallbladder ☐ D&C ☐ Tubal Ligation ☐ Back Surgery ☐ Hip Surgery ☐ Foot Surgery

☐ OTHER SURGERIES:_____

FAMILY HISTORY	Significant problems:	
Father	☐ NONE	
Mother	☐ NONE	
Brother	☐ NONE	
Sister	☐ NONE	
Maternal Grandmother	☐ NONE	
Maternal Grandfather	☐ NONE	
Paternal Grandmother	☐ NONE	
Paternal Grandfather	☐ NONE	

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HEALTH HABITS					
Exercise	☐ No exercise ☐ Daily exercise ☐ Couple of times per week ☐ Once a week				
Caffeine	☐ NONE	☐ Coffee _____cups/ day	☐ Tea _____cups/day	☐ Cola _____cans / day	
Alcohol	Do you drink alcohol? ☐Yes ☐No	How many drinks per week?			
Tobacco	Do you smoke? ☐ Yes ☐ No	How many packs / day?	# of yrs.	Year quit:	

PLEASE LIST ALL YOUR MEDICATIONS (INCLUDING OVER-THE-COUNTER DRUGS)		
MEDICATION	DOSAGE	FREQUENCY TAKEN

ALLERGIES / REACTION

☐NONE ☐ Penicillin ☐ Sulfa ☐ IV dye ☐ Iodine/ Betadine

☐ Other:

CIRCLE IF YOU HAVE ANY SYMPTOMS IN THE FOLLOWING AREAS:		
General	☐ NONE	Chills Fatigue Fever Insomnia Loss of appetite Night sweats
Eyes	☐ NONE	Glaucoma Blurring Cataracts Tearing Vision loss Contacts Eyeglasses
Ears, Nose, Throat	☐ NONE	Decreased hearing Earache Hearing aid Nosebleeds Bleeding gums
Cardiovascular	☐ NONE	Chest discomfort / pain Fainting Murmur Palpitations Varicose veins
Pulmonary	☐ NONE	Asthma Bronchitis Short of Breath Pneumonia Wheezing
Gastrointestinal	☐ NONE	Diarrhea Fecal incontinence Nausea/Vomiting Bloody Stools
Genitourinary	☐ NONE	Pain with urination Blood in urine Frequent urinary infections
Musculoskeletal	☐ NONE	Neck pain Back pain Muscle Cramps weakness Arthritis
Integumentary	☐ NONE	Hair loss Easy bruising Non-healing sores Skin Rash
Neurological	☐ NONE	Blackouts Neuropathy Seizures Vertigo Weakness
Psychiatric	☐ NONE	Anxiety Depression Insomnia Mood swings Memory loss
Endocrine	☐ NONE	Diabetes Thyroid Condition Excessive thirst/sweating Hot flashes
Hematologic, Lymphatic	☐ NONE	Bruising easily Bleeding Anemia History of transfusion
Immunologic	☐ NONE	Hay fever Persistent infections Seasonal allergies HIV exposure

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FINANCIAL POLICY AND HIPPA CONSENT FORM

Financial Responsibility

I have requested medical services from Lone Star Urogynecology and Continence Center, PLLC and/or Tomas Antonini, MD on behalf of myself and understand by making this request, I become fully financial responsible for any and all charges incurred in the course of the treatment authorized.

I understand these fees are due and payable on the date that services are rendered and agree to pay all charges incurred in full, immediately upon presentation of the appropriate statement.

Assignment of Benefits

I hereby assign all medical and surgical benefits to Lone Star Urogynecology and Continence Center, PLLC and/or Tomas Antonini, MD. I authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payments directly to Tomas Antonini, MD, for medical services rendered to myself. I understand that I am responsible for any amount not covered by insurance.

Surgical Assistant

If you are undergoing surgery, it may be necessary, at Dr. Antonini's discretion, to use an assistant surgeon to safely complete your surgery. Any assistant surgeon fees will be billed by the assistant surgeon and not by our office. Assistant surgeon fees that are not covered by your insurance will be your responsibility.

Missed Appointments

Appointments not cancelled within 24 hours, will incur a $35 charge if not kept. Please help us serve you better by keeping scheduled appointments.

Co Payments

Co-Payments are due at time of medical services. We accept Mastercard, Visa, AMEX, Checks, and Cash.

Returned Check Fees

We will charge any bank charges incurred by our practice as well as a $30 fee, for returned checks.

Medical Records

Please be aware that there is a $30.00 fee for release of medical records. Also, there is a $20.00 fee for the completion of paperwork for your employer, school, attorney, disability paperwork, etc… We do not charge for return to work or school letters.

Past Due Accounts

Overdue accounts will be referred to a collection agency.

CONSENT TO USE AND DISCLOSURE OF INFORMATION FOR TREATMENT, PAYMENT OR OPERATIONS

I hereby consent to the use and disclosure of information in my medical records for treatment, payment and health care operations purposes. I understand that information in my medical records may be used and disclosed to persons other than Lone Star Urogynecology & Continence Center to carry out their responsibilities in connection with my medical treatment, in payment for health care services rendered to me and in activities related to health care operations.

I acknowledge that I have been provided the Central Texas Urogynecology & Continence Center's Notice of Privacy Practices.

If you have any questions regarding your account, please contact our office: **(512) 716-0861.**

My signature below acknowledges that I have read this policy, understand and agree to my consent for treatment and financial responsibility.

Date:	**DOB:**	**SSN:**
Patient's Legal Name:		
Signature: (Patient's or Legally Authorized Representative)		
Relationship of Legally Authorized Representative to patient:		

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Restrictions & Release of Personal Healthcare Information

Please list anyone that ***is allowed*** to be present during your exam and/or medical treatment

1. _____
2. _____
3. _____

Please list any person(s) that ***we may discuss*** your medical treatment or condition with.

1. _____
2. _____
3. _____

Please list any person(s) that we are ***not to discuss*** your medical treatment or condition with.

1. _____
2. _____
3. _____

We will need to contact you from time to time regarding appointments and/or your care. The information may be confidential. Please check the method of contact allowed by you.

[ ] Home Telephone	[ ] Cell Phone	[ ] Work Telephone
[ ] Fax Machine	[ ] Leave Message	[ ] Email

I understand all precautions will be taken to protect my privacy. I will notify this office in writing of any changes to this document.

Printed Name	Patient Signature	Date

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