❑ **Alisa K. Ward, M.D.** ❑ **Christine V. Ku., M.D.** ❑ **Jennifer R. Gulick, M.D.**
3880 Parkwood Blvd. Suite 403, Frisco, Texas 75034 • Phone 214-618-2802 • Fax 214-618-3208

PATIENT NAME:_______________________ **DOB:**_______________

ADDRESS: _______________ CITY: _______________ STATE: ________ ZIP: ________

CELL: ___________ HOME: ___________ WORK: ___________ EMAIL: _______________

SOCIAL SECURITY #: ___________ PHARMACY: ___________ PHARMACY ADDRESS: _______________

HOW DID YOU HEAR ABOUT OUR PRACTICE? _______________

EMPLOYER: _______________

EMPLOYER ADDRESS: _______________ CITY: _______________ STATE: ________ ZIP: ________

EMERGENCY CONTACT #1: _______________ PHONE #: _______________ RELATIONSHIP: _______________

EMERGENCY CONTACT #2: _______________ PHONE #: _______________ RELATIONSHIP: _______________

INSURANCE POLICYHOLDER NAME: _______________
(If same as patient may leave the following blank)

DOB: _______________ SSN #: _______________ RELATION TO PATIENT: _______________

ADDRESS: _______________ CITY: _______________ STATE: ________ ZIP: ________

HOME PHONE: _______________ CELL PHONE: _______________

PRIMARY INSURANCE CARRIER: _______________

PLAN TYPE: ❑ HMO ❑ EPO ❑ PPO ❑ POS

BILLING ADDRESS: _______________ CITY: _______________ STATE: ________ ZIP: ________

PHONE NUMBER: _______________

POLICY #: _______________ GROUP # : _______________

COPAY/COINSURANCE AMOUNT: _______________

SECONDARY INSURANCE? ❑ Y ❑ N (IF YES, PLEASE PROVIDE A COPY OF ABOVE INFORMATION TO RECEPTIONIST)

Please complete entire form. If something does not apply, please mark N/A. Thank you!

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PATIENT NAME:______________________________________ **DOB:**____________________

REASON FOR VISIT: ❑ Annual Well Woman Exam (No Problems) **OR** ❑ Problem Visit (please list): ______________________

PREFERRED PRONOUN: ____

What is your ethnicity: ❑ Northern European (e.g. British/German) ❑ Southern European (e.g. Italian/Greek) ❑ French Canadian/Cajun

❑ Ashkenazi Jewish ❑ Other/Mixed Caucasian ❑ East Asian (e.g. Chinese/Japanese) ❑ South Asian (e.g. Indian/Pakistani) ❑ African/African American

❑ Southeast Asian (e.g. Filipino/Vietnamese) ❑ Hispanic ❑ Middle Eastern ❑ Native American ❑ Pacific Islander ❑ Unknown

***MEDICATION ALLERGIES (PLEASE LIST REACTION):** ____

____

***LIST ALL MEDICATIONS AND DOSAGES (INCLUDING OVER-THE-COUNTER MEDICATION):**

MEDICATION NAME	DOSAGE	DIRECTIONS

***LIST ANY SUPPLEMENTS/VITAMINS:** ____

____

MEDICAL HISTORY: ***(Please check if you have had any of the following)***

❑ GERD/Heartburn	❑ Irritable Bowel Syndrome	❑ Gastric Ulcers
❑ Hepatitis	❑ Hypertension	❑ Heart Murmur
❑ Heart Disease	❑ Blood Clot Disorder/DVT/PE	❑ High cholesterol
❑ Asthma	❑ Sleep Apnea	❑ Tuberculosis
❑ Kidney Infection	❑ Kidney Stones	❑ Recurrent UTI's
❑ Fibromyalgia	❑ Arthritis-Rheumatoid or Osteo	❑ Osteopenia/Osteoporosis
❑ Diabetes	❑ Thyroid Disorder	❑ Rheumatic Fever
❑ Migraines	❑ Dementia	❑ Stroke/TIA
❑ Epilepsy/Seizure Disorder	❑ Anemia	❑ Sickle Cell Disease/Trait
❑ Thalassemia/Trait	❑ Allergies	❑ Eczema/Psoriasis
❑ Depression/Anxiety/Other Mental Health	❑ HIV	❑ Genital Herpes
❑ Oral Herpes/Cold Sores	❑ Gonorrhea	❑ Chlamydia
❑ Trichomonas	❑ Syphilis	❑ Condyloma/Genital Warts
❑ Infertility	❑ Endometriosis	❑ Cancer______________

Other: ____

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PATIENT NAME:_______________________________ **DOB:**_______________________

TOTAL PREGNANCIES: ________ TERM: ________ PRETERM: ________ MISCARRIAGE: ________ ABORTION: ________ ECTOPIC: ________

DATE	SEX	WEIGHT	VAGINAL/VACUUM/FORCEPS/CESAREAN SECTION	LIVING	EPIDURAL	COMPLICATIONS
	❑ M ❑ F			❑ Y ❑ N	❑ Y ❑ N	
	❑ M ❑ F			❑ Y ❑ N	❑ Y ❑ N	
	❑ M ❑ F			❑ Y ❑ N	❑ Y ❑ N	
	❑ M ❑ F			❑ Y ❑ N	❑ Y ❑ N	

ANY PROBLEMS W/MENSTRUAL CYCLE: ❑ Y ❑ N 1ST DAY OF LAST MENSTRUAL CYCLE: ________ DAYS BETWEEN 1ST DAY OF 1 CYCLE & 1ST DAY OF NEXT CYCLE: ___

ARE YOUR CYCLES REGULAR? ❑ Y ❑ N HOW MANY PADS/TAMPONS USED ON HEAVIEST DAY? ________ HOW MANY DAYS OF FLOW? ________

ARE YOU CURRENTLY SEXUALLY ACTIVE? ❑ Y ❑ N ❑ NEVER WITH: ❑ MALE ❑ FEMALE ❑ BOTH HISTORY OF SEXUAL ABUSE: ❑ Y ❑ N

AGE AT FIRST MENSTRUATION: ____________ AGE AT MENOPAUSE IF APPLICABLE: ____________ ANY BLEEDING AFTER MENOPAUSE? ❑ Y ❑ N

BIRTH CONTROL: ❑ PILL ❑ IUD ❑ TUBAL ❑ RING ❑ PATCH ❑ DEPO INJECTION ❑ NEXPLANON ❑ VASECTOMY ❑ CONDOMS ❑ OTHER

DATE OF LAST PAP SMEAR: __________ NORMAL? ❑ Y ❑ N HISTORY OF ABNORMAL PAP? ❑ Y ❑ N YEAR(S) OF ABNORMAL PAP(S): __________

TREATMENT: ❑ ONLY REPEAT PAP SMEAR ❑ COLPO ❑ CRYO/FREEZE ❑ LEEP ❑ CONE

DATE OF LAST MAMMOGRAM: ________ NORMAL? ❑ Y ❑ N HISTORY OF ABNORMAL MAMMOGRAM? ❑ Y ❑ N DATE: ________ BIOPSY DONE? ❑ Y ❑ N

DO YOU PERFORM SELF-BREAST EXAMS? ❑ MONTHLY ❑ OCCASIONALLY ❑ NEVER WHO IS YOUR PRIMARY CARE PHYSICIAN? ____________________

DATE OF LAST COLONOSCOPY: ________ NORMAL? ❑ Y ❑ N DATE OF LAST BONE DENSITY SCAN: ________ NORMAL? ❑ Y ❑ N

IMMUNIZATION DATES: TETANUS/TDAP: ________ HPV/GARDASIL: ________ FLU: ________ COVID: ________ SHINGLES: ________ HEPATITIS B: ________

OPERATIONS/HOSPITALIZATIONS	YEAR	OPERATIONS/HOSPITALIZATIONS	YEAR

FAMILY HISTORY: (***Please list family members that are affected***) ❑ Adopted

❑ Breast Cancer	❑ Colon Cancer	❑ Endometrial Cancer
❑ Leukemia/Lymphoma	❑ Melanoma	❑ Ovarian Cancer
❑ Pancreatic Cancer	❑ Prostate Cancer	❑ Heart Disease
❑ Blood Clot Disorder/DVT/PE	❑ High Cholesterol	❑ Hypertension
❑ Diabetes	❑ Thyroid Disorder	❑ Osteoporosis
❑ Seizure Disorder	❑ Stroke/TIA	❑ Mental Illness
❑ Spina Bifida/Heart Defect	❑ Chromosomal Disorder	❑ Down Syndrome/Trisomy
❑ Tay Sachs	❑ Fragile X Syndrome	❑ Hemophilia
❑ Cystic Fibrosis	❑ Muscular Dystrophy	❑ Other Birth Defect
❑ Canavan Disease	❑ Spinal Muscular Atrophy	❑ Familial Dysautonomia
❑ Huntington's Disease	❑ Sickle Cell/Thalassemia	❑ Developmental Delay

OTHER FAMILY ILLNESSES/CANCERS: ____

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PATIENT NAME:______________________________ **DOB:**____________________

SOCIAL HISTORY:

OCCUPATION: ____________________ MARITAL STATUS: ❑ SINGLE ❑ SIGNIFICANT OTHER ❑ MARRIED ❑ DIVORCED ❑ WIDOWED ❑ SEPARATED

TOBACCO USE: ❑ Y ❑ N CIGARETTES/DAY: ______ HOW LONG? ____________ VAPING: ❑ Y ❑ N HOW LONG? ____________

ILLICIT DRUG USE: ❑ Y ❑ N ALCOHOL USE: ❑ Y ❑ N DRINKS/WEEK: __________ CAFFEINE USE: ❑ Y ❑ N SERVINGS/DAY: __________

EXERCISE REGULARLY? ❑ Y ❑ N TYPE: ________________________________ DAYS/WEEK: ______________

SPECIAL DIET: ________________ EDUCATION LEVEL: ❑ GRADE SCHOOL ❑ HIGH SCHOOL/GED ❑ TRADE SCHOOL ❑ COLLEGE ❑ POST-GRADUATE

DO YOU FEEL SAFE IN YOUR CURRENT RELATIONSHIP? ❑ Y ❑ N

IS A BLOOD TRANSFUSION ACCEPTABLE IN CASE OF A LIFE-THREATENING EMERGENCY? ❑ Y ❑ N

ARE YOU *CURRENTLY EXPERIENCING* ANY OF THE FOLLOWING?

❑ Fatigue	❑ Fever	❑ Night sweats
❑ Weight gain	❑ Weight loss	❑ Palpitations
❑ Chest pain	❑ Shortness of breath	❑ Bloating
❑ Constipation	❑ Diarrhea	❑ Hemorrhoids
❑ Bloody stools	❑ Nausea	❑ Vomiting
❑ Pain with urination	❑ Blood in urine	❑ Frequency
❑ Incontinence	❑ Painful intercourse	❑ Painful periods
❑ Vaginal discharge	❑ Vaginal itching	❑ Vaginal dryness
❑ Back pain	❑ Joint pain	❑ Breast mass
❑ Breast tenderness	❑ Nipple discharge	❑ Acne
❑ Rash	❑ Warts	❑ Dizziness
❑ Headaches	❑ Easy bruising	❑ Easy bleeding
❑ Enlarged lymph node	❑ History of blood transfusion	❑ Hair loss
❑ Cold intolerance	❑ Heat intolerance	❑ Hot flashes
❑ Excessive hair growth	❑ Seasonal allergies	❑ Anxiety
❑ Depression	❑ PMS	❑ Insomnia

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PATIENT NAME:____ **DOB:**_______________________________

Appointment Policy

We value our patients and the time we spend with each of you, and we would like to set aside appointments that work well for your schedule. If there is a conflict with your scheduled appointment time, we ask that you call the office at least 24 hours in advance to cancel or reschedule your appointment. ***Appointments cancelled without a 24 hour advanced notice will be charged $25. If you miss more than 3 appointments, you may be dismissed from the practice.***

HIPAA (Health Insurance Portability and Accountability Act)

You have been given a secure a copy of our Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of your protected health information and your rights under HIPAA. You understand that we reserve the right to change the terms of this notice from time to time and that you may contact us at any time to obtain the most current copy of this notice.

Clarification of Medical Visits

In our office, we want to put the patient first by providing outstanding medical care. In order for us to do this, we want to make sure our patients understand our policy for billing your medical visits. If you are scheduled to come in for your annual well woman exam, the doctors will only discuss details or perform services regarding that visit. If there are other medical issues that you would like to discuss that are not considered part of an annual well woman exam, we ask that you schedule another appointment for those issues. If you have an emergent problem, we will address that problem and you will need to reschedule your annual well woman exam. If the problem visit and annual well woman exam are done on the same day, you will be billed for each service separately. Depending on your insurance benefits, you will be responsible for any out of pocket expenses associated with both services, as problems addressed are usually subject to a copay and/or deductible. If you have any questions or concerns regarding these policies, please ask our staff.

Policy on Insurance Coverage

We are enrolled in numerous insurance programs. While we are pleased to be able to provide this service to you, it is difficult for us to keep track of all the individual requirements of each plan. Each plan has different stipulations and restrictions. Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated. Your medical insurance is a benefit that your employer provides for you or you purchase for yourself. During the course of treatment, charges will be accumulated and routinely filed with your insurance company. Charges not covered by your insurance, such as copays, deductibles, and co-insurance will be your responsibility and are due at the time of service. Understanding your benefits can be confusing, and we will do our best to assist you in this area, but keep in mind we have limited access to your medical benefits. Your employer or you have chosen this plan and benefits, not your physician. If you do not inform us of any special requirements in your contract, and we subsequently order services, such as labs, pathology, or hospitalization that are not covered, we or the selected medical facility will bill YOU directly for those charges.
Your insurance company will never guarantee your benefits to you or to this office. Therefore, we can only estimate your portion. Regardless of what we calculate as your medical plan benefit, ultimately ***YOU are responsible for the TOTAL cost of your medical treatment.*** If you are unable to pay the estimated portion for your appointment today, we will be happy to reschedule it to a later date.
If your insurance company requires a “referral” from your primary care physician, you will be responsible for contacting your primary care physician for the referral (this is NOT the responsibility of our office). Treatment rendered by this office without the required referral will serve as your consent for treatment not covered by insurance and will be payable by you. If your insurance requires a referral and one was not obtained by you prior to your appointment, you may pay a cash fee for your visit or reschedule your appointment.

Please check the appropriate boxes:

- ❑ I certify that I have **no insurance** and will be solely responsible for payment in full.
  (Payment is expected at the time of service)
- ❑ I certify that the insurance reported to this office is a complete and current listing. I understand the office will not submit a claim for any insurance not reported at the time of service.
- ❑ I **DO NOT** have any other insurance coverage other than that which has been provided upon submission of this authorization.

***** You are responsible for providing the correct information regarding which insurance is PRIMARY and SECONDARY. *****

I have read and understood the office policy stated above and agree to accept responsibility as described.

______________________	______________________	______________
Signature of Patient/Guardian	Printed Name of Guardian if under 18	Date

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PATIENT NAME:____ **DOB:**________________________________

Authorization to Discuss Medical Information

Drs. Ward, Ku and Gulick are committed to quality patient care. We are advocates of maintaining patient confidentiality. Our policy is to speak only to patients and/or guardians in regards to their medical information. We will not leave any confidential medical information on a voicemail system without permission. By filling out this form and signing below, you are giving the physicians permission to communicate more detailed information on your voicemail and/or to individuals that you designate below. Examples include but are not limited to your lab and test results, information about your condition, prescription refills or changes, appointment scheduling, and/or insurance details.

Our office will keep this consent form in your chart. **THIS FORM WILL BE EFFECTIVE UNTIL OTHERWISE NOTIFIED BY YOU WITH A WRITTEN REQUEST**.

Patient Name: ____ Date of Birth: _______________________

Patient Signature: ____ Date: ______________________________

I_____(initial) authorize the physicians and staff to leave a detailed voice message regarding my medical care at the following phone number(s).

Patient Phone #1 ____

Instructions: ____

Patient Phone #2 ____

Instructions: ____

I_____(initial) authorize the physician and staff to speak with the following individual(s) about my medical care.

Name: ___________________________________Relationship: ___________________Date: ______________

Instructions: ____

Name: ___________________________________Relationship: ___________________Date: ______________

Instructions: ____

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PATIENT NAME:____ **DOB:**_________________________________

Consent to Treat Patient

I, ___________________________ (name of patient) have an appointment for an examination and treatment, and I give permission to be examined and treated by the following physicians. By signing this form, you are giving consent to be examined and treated by the physicians below. This consent is valid for one year from the date signed below.

❑ **Alisa K. Ward, M.D.** ❑ **Christine V. Ku., M.D.** ❑ **Jennifer R. Gulick , M.D.**

PLEASE INITIAL EACH OF THE FOLLOWING SECTIONS TO ACKNOWLDEGE YOU HAVE READ THE INFORMATION AND SIGN BELOW:

_______ **Assignment of Benefits:**
By signing this form, you authorize payment of medical benefits, including private insurance benefits, directly to Alisa K. Ward, M.D., P.A., Christine V. Ku, M.D., P.L.L.C., and Jennifer Gulick, M.D., P.L.L.C. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete your insurance claim. The duration of this consent is definite and continues until revoked in writing.

_______ **Acknowledgement of Receipt of Notice of Health Information Practices**
The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. Alisa K. Ward, M.D., P.A., Christine V. Ku, M.D., P.L.L.C.,and Jennifer Gulick, M.D., P.L.L.C. are furnishing you with the attached notice, which provides information about how our office may use and/or disclose protected health information about your for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of this office's notice of Health Information Practices.

_______ **Acknowledgement of Receipt of Notice of Office Policies and Procedures**
Alisa K. Ward, M.D., P.A., Christine V. Ku, P.L.L.C., and Jennifer Gulick, M.D., P.L.L.C. are furnishing you with the attached notice, which provides information regarding our office protocols and policies which we have developed in order to optimize our ability to deliver you care. By signing this form, you acknowledge that you have received a copy of our office policies.

_______ **Acknowledgement of Physician Ownership**
To further our commitment to the quality of care for our patients, both Dr. Ward and Dr. Gulick have chosen to participate in ownership at Baylor Medical Center at Frisco. Their ownership enhances their ability to direct the manner in which your care is delivered at this facility. This information is being provided to you to help you make an informed decision regarding your health care. You have the right to choose your healthcare provider and the option of obtaining care at a different facility. If you choose care at a facility outside of Baylor Medical Center Frisco, your physician will be unable to treat you. By signing this form, you acknowledge that you have read and understand this disclosure.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: ____ **DATE**: ____________________

Consent to Treat a Minor

_____________________________ (name of minor) has an appointment for examination and treatment. I, _____________________________ (parent/legal guardian) give permission for _____________________ (name of minor) to be examined & treated by the following physicians. By signing this form, you are giving consent for the above named minor to be examined and treated by the physicians below. This consent is valid for one year from the date signed below.
Signature of parent/legal guardian: ____ **Date**: ______________________

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