Charleston House Gynecology Patient Registration

Demographic Information

First Name: _____ Last Name: _____

Preferred First Name: _____ Date of Birth: _____ Age: _____ Last 4 of SSN: _____

Home Address: _____ City, State, Zip Code: _____

Cell Phone: _____ Email: _____ Occupation: _____

Marital Status: ____ Married ____ Single ____ Engaged ____ Partner ____ Divorced ____ Widowed

Race: _____ Ethnicity: _____ Primary Language: _____

Significant other/Parent name: _____ Cell Phone: _____

Emergency contact: _____ Cell Phone: _____

Pharmacy Name : _____ Location: _____ Phone: _____

How did you hear about us (mark all that apply):

____ Physician: _____ ____ Patient/Friend: _____

____ Website ____ Social Media (Facebook/Instagram): _____ ____ Publication: _____

____ Event: _____ ____ Other: _____

Insurance Information

Primary Insurance:

Insurance Company Name: _____ ID/Policy Number: _____

Group/Code: _____ Policyholder Social Security Number: _____

Insurance Company Address: _____

Policyholder's Name: _____ Policyholder DOB: _____ Sex: _____

Policyholder Address: _____

Secondary Insurance:

Insurance Company Name: _____ ID/Policy Number: _____

Group/Code: _____ Policyholder Social Security Number: _____

Insurance Company Address: _____

Policyholder's Name: _____ Policyholder DOB: _____ Sex: _____

Policyholder Address: _____

Charleston House Gynecology Questionnaire

Full Name: _____ **Date of Birth:** _____ **Date:** _____

Well Woman Information

Primary Care Provider: _____

Last Pap Smear: _____ (month/year) Any Abnormal Pap Smears? ____ No ____ Yes
Cervical Dysplasia (precancerous cells of the cervix)____ No ____ Yes

If yes, any procedures listed below?

Procedure	Dates
LEEP	
Laser	
Cryo (freezing)	
Cone Biopsy	

Testing	Last Date Performed	Testing Facility/Physician
Mammogram		
Bone Density (DEXA) Exam		
Colonoscopy		

Medical History:
Do you now have or have you ever had (mark with x):

____ Asthma
____ Autoimmune Disorder (type)
_____
____ Anxiety
____ Bleeding Disorder
____ Bone/Joint Disease
____ Cancer (type)
_____
____ Chicken Pox
____ Chlamydia
____ COVID
____ Deep Vein Thrombosis
____ Depression
____ Diabetes – Gestational
____ Diabetes - Type I
____ Diabetes - Type II
____ Eating Disorder (type)
_____
____ Elevated Cholesterol
____ Headaches
____ HIV
____ Endometriosis
____ Fibroids (type)
_____
____ GERD/Reflux
____ GI Illness (type)
_____
____ Gonorrhea
____ Heart Disease
____ Hepatitis A
____ Hepatitis B
____ Hepatitis C
____ Herpes
____ Infertility
____ Insomnia
____ Irritable Bowel Syndrome
____ HPV/Genital Warts
____ High Blood Pressure
____ Hyperthyroidism
____ Hypothyroidism
____ Liver Disease
____ Migraines
____ Osteopenia
____ Osteoporosis
____ Pain/discomfort with intercourse
____ Pelvic Inflammatory Disease
____ Postpartum Depression
____ Recurring Bacterial Vaginitis
____ Recurring UTI
____ Recurring Yeast Infection
____ Seizures
____ Shingles
____ Sleep Apnea
____ Syphilis
____ Trauma
____ Tuberculosis

Other:
_____
_____
_____
_____
_____

Family History: Include age of onset and type of cancer

Illness	Mother	Father	Sister	Brother	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Other Relative
Cancer (type)									
Diabetes (type)									
DVT									
Heart Disease									
Osteoporosis									

Charleston House Gynecology Questionnaire

Medication and Vitamin List

Current Medication/Vitamin	Dose	How often taken per day/week

Do you have drug allergies? ____ No ____ Yes: Type & Reaction: _____
Do you have other allergies (i.e. bee stings, nuts)? ____ No ____ Yes: Type & Reaction: _____

Vaccination History

Have you had any of the following vaccinations? If yes, please include month/year and all dates if it was part of a series (i.e. COVID, Hep A/B, HPV)

Vaccine	No	Yes	Date(s)
COVID-19			
Flu (Influenza)			
HPV (Gardasil)			
TDAP (Tetanus Diphtheria Pertussis)			
Shingles			
Hepatitis A			
Hepatitis B			
Pneumococcal			
Varicella (Chicken Pox)			

List of Physicians

Please list any physicians that are part of your care team. List can include but is not limited to, primary care physician, endocrinologist, mental health provider, dermatologist, gastroenterologist, etc.

Specialty	Physician Name	Phone Number	Address/Location

Charleston House Gynecology Questionnaire

Reproductive History: Menstrual Cycle

Age at first period? _____ How often do you get your menstrual cycle? Every _____ days, lasting _____ days

Are your cycles (mark with x)? ____ Regular ____ Irregular ____ N/A If menopausal, age of menopause: _____

Are you sexually active (mark with x)? ____ Never ____ Not Currently ____ Yes

Method of contraception (mark with x):

____ Not Needed ____ Vasectomy ____ Rhythm Method ____ Nexplanon ____ Tubal Ligation

____ None ____ Condoms. ____ NuvaRing ____ Essure ____ Depo Provera

____ Pill ____ Patch ____ Other _____

____ IUD: ____ Kyleena ____ Liletta ____ Mirena ____ Paragard ____ Skyla IUD insertion Date: _____

Obstetrical History

Age at first live birth: ____ If preterm, were medications used? ____ No ____ Yes

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Type of Delivery: vaginal, c-section, forceps, or vacuum **Anesthesia:** epidural, local, general, spinal
Complications: Preterm labor, diabetes, bleeding, high blood pressure, postpartum depression.

Please list all pregnancies, including miscarriages, abortions, and ectopic pregnancies with full birthdate

Birthdate	Weeks	Length of Labor	Baby's Weight	Sex	Type of Delivery	Anesthesia	Complications	Location
07/15/2009	41	9	7 lb 2 oz	F	C-Section	Epidural	HBP	HCGH

Surgical History:

Surgery	Date(s) of Surgery
Ablation	
C-Section	
Hysteroscopy D&C	
Total Abdominal Hysterectomy (TAH)	
Ovarian/Tubal Removal (BSO)	
Tubal Ligation	

Other:
_____
_____

Anesthesia Complications:
____ Excessive difficulty waking up
____ Malignant Hyperthermia
____ Difficult intubation

Social History:

Tobacco/Nicotine Use: ____ Never ____ Current: Type of nicotine/# per day _____ ____ Former: Quit at age ____
Alcohol Use: ____ No ____ Yes: Average # of drinks per week _____
Recreational Drug Use: ____ No ____ Yes: Type of drug and last use _____
Exercise: ____ No ____ Yes: What type of exercise(s) _____
How often do you exercise per week? ____ 1x ____ 2x ____ 3x ____ 4x ____ 5+ How long per session? _____ min
Do you eat a healthy diet? ____ No ____ Sometimes ____ Yes What type of diet are you following? _____
Any history or violence or abuse in your current household or in your past? ____ No ____ Yes
Do you have any cultural or religious considerations that need special attention? ____ No ____ Yes

DR. KAMILIA SMITH

CHARLESTON HOUSE

WOMEN'S HEALTH & WELLNESS

Charleston House Gynecology Acknowledgement and Review of Assignment of Benefits, Financial Responsibility and Release of Information

Assignment of Benefits:

I, the undersigned, hereby assign the rights and benefits of the applicable medical payments to Kamilia Tagi Smith MD, PLLC for the services and supplies rendered for my treatment. I understand and agree that the Assignment of Benefits will have continuing effect for so long as I am being treated and cared for by Kamilia Tagi Smith MD, PLLC of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies, and care provided to me by Kamilia Tagi Smith MD, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this statement is to be considered as valid as an original.

Financial Responsibility:

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Kamilia Tagi Smith MD, PLLC and its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify the office of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the practice if the submitted claims or any part of them are denied for payment. I understand that by signing this format that I am accepting financial responsibility as explained for all payment for medical services and supplies received.

Release of Information:

I hereby authorize Kamilia Tagi Smith MD, PLLC to release any and all medical records including medical, surgical, psychiatric, substance abuse, HIV and genetic information which may be found in my records needed to secure payment or determine benefits from insurance payer and other third administrators.

I have read and understand the Assignment of Benefits, Financial Responsibility, and Release of Information policies contained herein.

Signature of Patient/Representative Date

Print Name Date of Birth

DR. KAMILIA SMITH

CHARLESTON HOUSE

WOMEN'S HEALTH & WELLNESS

Charleston House Gynecology HIPAA Authorization for Release of Patient Health Information

HIPAA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI made by alternative means. The information will remain in effect until revoked in writing.

Full Legal Name: _____

I wish to be contacted in the following manner (check all that apply):

____ **Cell Phone:**
- ____ Ok to leave message with detailed message
- ____ Leave name and doctor with call back number only
- ____ Ok to text message with detailed message
- ____ Do not text

____ **Home Phone:**
- ____ Ok to leave message with detailed message
- ____ Leave name and doctor with call back number only

____ **Work Phone:**
- ____ Ok to leave message with detailed message
- ____ Leave name and doctor with call back number only

____ **Other:** _____

I consent and authorize the release of medical information, including diagnosis, treatment, and results, to the following:

____ **Only Myself**

____ **My Spouse/Partner:** _____ ____ **My Children:** _____

____ **My Parents:** _____ ____ **Other:** _____

Signature of Patient/Representative **Date**

DR. KAMILIA SMITH

CHARLESTON HOUSE

WOMEN'S HEALTH & WELLNESS

Acknowledgement and Review of
Charleston House Gynecology Privacy Practice and Financial Policy

Full Legal Name: _____

I have reviewed this office's notice of privacy practices/HIPAA, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient/Representative **Date**

I have read and understand the Financial Policy for Kamilia Tagi Smith MD, PLLC.

Signature of Patient/Representative **Date**

I authorize Kamilia Tagi Smith MD, PLLC. to obtain/have access to my medication history.

Signature of Patient/Representative **Date**

DR. KAMILIA SMITH

CHARLESTON HOUSE

WOMEN'S HEALTH & WELLNESS

Charleston House Gynecology Request for Private Health Information

Patient Information (Please print)

Full Legal Name (First, Middle, Last):	
Date of Birth:	Phone:
Address (include City, State & Zip):	

What records are being requested?

Name of Physician: _____

Phone: _____ **Fax:** _____

Date of Service(s): _____ **to** _____

___ ALL RECORDS ___ H&P ___ Lab Results

___ Imaging Studies ___ GI Studies ___ Cardiac Studies

___ Other _____

Please send records to:

Fax: 214-247-1160
Mail (if needed): **Charleston House Gynecology**
Attn: Dr. Kamilia Smith
3611 Swiss Ave, Suite 201
Dallas, TX 75204

Please sign and print your name below:

Signature: _____

Name of Patient: _____

Relationship to Patient: ___ Self ___ Other: _____

Date: _____