

**Northeast Women's Healthcare  
Obstetrics and Gynecology  
Miles E. Mahan, MD, Board Certified  
Shan Biscette, MD, Board Certified**

PATIENT INFORMATION  
(please print)

DATE: \_\_\_\_\_

PATIENT'S LEGAL NAME: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ BIRTHDAY \_\_\_\_\_ AGE \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

E-Mail ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

NAME OF SPOUSE/GUARDIAN: \_\_\_\_\_

SOCIAL SECURITY # OF SPOUSE/GUARDIAN: \_\_\_\_\_ D.O.B. \_\_\_\_\_

EMPLOYER OF SPOUSE/GUARDIAN: \_\_\_\_\_ WORK#: \_\_\_\_\_

NAME OF CLOSEST LIVING RELATIVE: \_\_\_\_\_ PHONE: \_\_\_\_\_

IN CASE OF EMERGENCY, NOTIFY: \_\_\_\_\_ PHONE: \_\_\_\_\_

\*Lifetime Insurance Authorization: I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment to the Social Security Administration or its intermediaries or carriers involved in processing and collection of a claim. I understand that I am financially responsible for the charges not covered by this authorization.

X \_\_\_\_\_  
Signed patient, or parent if minor \_\_\_\_\_ Date \_\_\_\_\_

IF PATIENT IS A MINOR, PLEASE COMPLETE:

I, \_\_\_\_\_, give permission to Dr. Mahan, Dr. Biscette or the Nurse Practitioner to examine my daughter \_\_\_\_\_.

\_\_\_\_\_  
Parent or Guardian \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_

**Northeast Women's Healthcare, P.A.**  
**Miles E. Mahan, MD, FACOG, OB/GYN**  
**Shan Biscette, MD**  
 Obstetrics and Gynecology

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

CHIEF COMPLAINT \_\_\_\_\_

**OB HISTORY:** No. of Pregnancies \_\_\_\_\_ No. of Miscarriages \_\_\_\_\_ No. of Abortions \_\_\_\_\_

List any complications of pregnancies or deliveries \_\_\_\_\_  
 Method of birth control you are presenting using: \_\_\_\_\_ tubal \_\_\_\_\_ vasectomy \_\_\_\_\_ pills \_\_\_\_\_ list other \_\_\_\_\_

**GYN HISTORY:** Last menstrual period \_\_\_\_\_ Age at onset of period \_\_\_\_\_ Cycle regular? \_\_\_\_\_

Cycle \_\_\_\_\_ days (start to finish). Flow: Light Moderate Heavy  
 Do you have a history of: Abnormal pap smears \_\_\_\_\_ Sexually transmitted diseases \_\_\_\_\_ IUD \_\_\_\_\_  
 DES \_\_\_\_\_ Cramps \_\_\_\_\_ Painful intercourse \_\_\_\_\_ Anemia \_\_\_\_\_ Do you practice self breast exams? \_\_\_\_\_  
 Date of last mammogram \_\_\_\_\_

**INFERTILITY:** Temperature Charts \_\_\_\_\_ X-Ray of tubes \_\_\_\_\_ Semen Analysis \_\_\_\_\_ Cervical Mucous Test \_\_\_\_\_  
 Endometrial Biopsy \_\_\_\_\_ Hysteroscopy \_\_\_\_\_ Laparoscopy \_\_\_\_\_

**MEDICAL HISTORY:** \_\_\_\_\_

Depression/Related Illness	Y N	Ovarian/Uterine Cancer	Y N	Diabetes	Y N
Excessive loss of Urine	Y N	Shortness of Breath	Y N	Migraines	Y N
High Blood Pressure	Y N	Blood Transfusion	Y N	Colitis	Y N
Frequent Bladder Infections	Y N	Kidney Infections	Y N	Asthma	Y N
Urinary Frequency	Y N	Thyroid Problems	Y N	Tuberculosis	Y N
Bloody/Tarry Stools	Y N	Hepatitis/Jaundice	Y N	Heart	Y N
Change of Bowel Habits	Y N	Bone/Joint Problems	Y N		

**SURGICAL HISTORY:** List dates of all surgeries and name of physician who performed surgery: \_\_\_\_\_

**ALLERGIES TO MEDICATIONS:** \_\_\_\_\_

**MEDICATIONS TAKEN ON A REGULAR BASIS:** \_\_\_\_\_

**FAMILY HISTORY:** In your close family history (mother, brother, sister) is there a history of:  
 Heart attack under age 50 Y N Diabetes Y N Birth Defects Y N  
 High Blood Pressure Y N Breast Cancer Y N  
 Ovarian Cancer Y N Uterine Cancer Y N

**SOCIAL HISTORY:** Do you smoke? \_\_\_\_\_ Number per day \_\_\_\_\_ Do you use alcohol? \_\_\_\_\_ How many drinks per week? \_\_\_\_\_ Drug Abuse? \_\_\_\_\_

Are you presently being treated for any medical problems by your family physician? \_\_\_\_\_  
 Were you referred to this office by another physician? \_\_\_\_\_ Please list name of physician and address \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ~ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- ~ Obtain payment from third-party payers.
- ~ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand your Notice of Privacy Practices. I may request a copy of the Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

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**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices, but was unable to do so as documented below:

| Date | Initials | Reason |
|------|----------|--------|
|      |          |        |

**Northeast Women's Healthcare**  
**Obstetrics and Gynecology**  
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**Shan Biscette, MD, Board Certified**

Release of Information to another party.

I \_\_\_\_\_ give permission for any medical information regarding myself including lab results to be released to the following individual/s.

|      |              |
|------|--------------|
| Name | Relationship |
| Name | Relationship |
| Name | Relationship |
| Name | Relationship |

I am aware that this note is valid until I terminate my authorization in writing.

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

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**Consent for Patient Care Provided by a Nurse  
Practitioner**

**Northeast Women's Healthcare employs two highly qualified Nurse Practitioners. A Nurse Practitioner is a registered nurse with additional specialized training in diagnosing and treating illnesses and providing healthcare maintenance.**

**Penny Landers, RNC-WHCNP**

**Penny received her training at The University of Texas-Southwestern Medical School and specializes in Women's Health.**

**Susana Kataka, MSN-WHCNP**

**Susana received her training at The University of Texas-Houston and specializes in Women's Health.**

**You can schedule your appointment with Dr. Mahan, Dr. Biscette, Penny or Susana and every effort will be made to ensure that you see the provider of your choice. However, occasionally the doctors are called from the office for or delivery or an emergency. In those instances, you will be offered to wait, reschedule, or have a Nurse Practitioner see you at that time.**

**By signing below, you consent for care and treatment provided by Susana Kataka MSN WHNP and/or Penny Landers, RNC-WHNP.**

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**Patient's Signature**

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**Date**