BAY AREA OBSTETRICS & GYNECOLOGY, P.A.

STEPHEN FALK, M.D., F.A.C.O.G., F.A.C.S.
MARY POAG, M.D., F.A.C.O.G.
LAUREN MILLET, M.D., F.A.C.O.G.

LAKEISHA DEMERSON, M.D., F.A.C.O.G.
CAROLYN KENNEY, D.O., F.A.C.O.G.
MELANIE CHRISTOFFERSON, D.O.

Diplomates of The American Board of Obstetrics and Gynecology

#17 PROFESSIONAL PARK
WEBSTER, TX 77598
TELEPHONE (281) 332-9511
FAX (281) 332-6685

Due to privacy regulations we can no longer ask you questions from the check in window or out open in the lab. To expedite your visit, please complete the following:

Date: _____

1. Name: _____ DOB: _____
2. Address: _____
3. City: _____ State: _____ Zip code: _____
4. Mobile Phone: _____ Home Phone: _____
5. Pharmacy Name & number: _____
6. Email Address: _____
7. Reason for your visit: _____

_____

8. Last menstrual cycle: _____ Drug allergies: _____
9. Medications: _____

_____

10. Have you had any recent bloodwork in the past year: _____

_____

If yes, please specify with what doctor and when it was done: _____

_____

11. Major illness and or surgery since your last visit: _____

If yes, please specify: _____

_____

Please provide a current insurance card and driver's license

Dear Patient:

Your physician may order labwork as part of your routine exam. Your insurance may or may not cover the labs under a routine diagnosis. You have the option to contact your insurance company prior to having labs run. If you prefer to have your labs drawn today please understand you may receive a bill from Labcorp or Quest and you will be responsible for payment.

By signing below, you are *authorizing* the ordered tests and understand you may receive a bill.

Patient Signature_____Date_____

Bay Area Obstetrics and Gynecology

Bay Area Obstetrics & Gynecology, PA, Inc
17 Professional Park Dr
Webster, Texas 77598
281-332-9511
www.baobgyn.com

Privacy Officer: Reata Baker
Office Manager
rabaker@baobgyn.com

Bay Area OB/GYN

*Date*_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

The undersigned understands that Bay Area Obstetrics and Gynecology, PA, Inc. is required by law to maintain privacy of protected health information and has provided the patient/patient's representative with a notice of its privacy practices regarding health information.

Patient's name_____ Date of birth_____

Patient signature_____

Patient's representative (if applicable) _____Relationship to patient_____

Please list below the person(s) we can release your health information to. (Please note: In an emergency or other situation outlined in our Notice of Privacy Practices, we may share information with others who are not specifically listed on this form.)

_____ _____

_____ _____

_____ _____

What is the best phone number for us to contact you? _____

From time to time we will leave a message for you (as stated in our Notice of Privacy practices) on an answering machine, voice mail, or with another individual in your absence. (Such as diagnosis and medication).
Is it ok to leave a ***detailed message on*** the above phone number? _____

For Bay Area Ob-Gyn office use only:

An attempt was made to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained due to:

The individual refused to sign_____
Communication barriers prevented us from obtaining the acknowledgement_____
An emergency situation prevented us from receiving the acknowledgment_____
Other (please specify)_____