JENNIFER L. WALDEN, M.D., F.A.C.S.
300 Beardsley Lane, Building C, Suite 101, Austin, TX 78746 • Tel: 512-328-4100 Fax: 512-302-1216

Date: _____

PATIENT INFORMATION

LAST NAME FIRST NAME MIDDLE INITIAL

STREET ADDRESS APT CITY STATE ZIP CODE

BIRTHDATE SOCIAL SECURITY HOME PHONE CELL PHONE (CIRCLE PREFERRED)

EMAIL ADDRESS

OCCUPATION EMPLOYER WORK PHONE

REFERRED BY

EMERGENCY CONTACT RELATIONSHIP TO PATIENT TELEPHONE

PRIMARY CARE PHYSICIAN TELEPHONE

INSURANCE INFORMATION

SUBSCRIBER'S NAME (IF DIFFERENT FROM ABOVE) BIRTHDATE

STREET ADDRESS APT CITY STATE ZIP CODE

SOCIAL SECURITY HOME PHONE CELL PHONE

PATIENT'S RELATIONSHIP TO SUBSCRIBER

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All professional services rendered are charged to the patient and due at the time of service. Necessary forms will be completed to help expedite payment for non-cosmetic procedures. However, the patient is responsible for all FEES, regardless of insurance coverage.

Insurance authorization and assignment: I hereby authorize Jennifer L. Walden, M.D. to furnish information to insurance carriers concerning my illness and treatment and hereby assign her to all payments of medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Dr. Walden reserves the right to refuse to perform surgery on anyone who is not deemed an appropriate surgical candidate (whether physically, medically or psychologically).

_____

DATE SIGNATURE

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Date: _____

PATIENT HISTORY

_____
NAME

_____
REASON FOR VISIT

_____
AGE HEIGHT WEIGHT MARITAL STATUS SMWD

ALLERGIES: List ANY reactions you have had to medications and describe the symptoms:

_____
_____

MEDICATIONS: List ALL prescription, over the counter, and herbal medications you have taken recently with dosages:

_____
_____

PAST MEDICAL HISTORY: List ANY medical conditions for which you have been treated:

_____
_____

PAST SURGICAL HISTORY: List ALL previous surgery; include complications or abnormal reaction to anesthetics:

_____
_____

SOCIAL HISTORY:

_____
OCCUPATION

_____
EXERCISE HABITS

CIGARETTE SMOKING: ___ YES or ___ NO _____ PACKS PER DAY

ALCOHOL: ___ NONE ___ OCCASIONAL ___ MODERATE ___ EXCESSIVE

_____
DRUG USE

FAMILY HISTORY: Check any of the following that effect first-degree relatives:
___ Anesthetic Problems ___ High Blood Pressure ___ Heart Disease ___ Breast Cancer
___ Diabetes ___ Bleeding Disorders ___ Mental Illness ___ Hereditary Disease ___ Other

MD Initial_____

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Date: _____

REVIEW OF SYSTEMS

_____
NAME

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOU:

GENERAL: weight changes fatigue fever chills

EYES: eye pain excessive tearing visual changes double visions eye irritation dry eyes red eyes glaucoma contact lenses sensitivity to light

EARS: ear pain ringing in the ears dizziness hearing loss

NOSE: past nasal trauma past nasal surgery difficulty breathing through nose sinus problems

MOUTH: dental problems tooth pain difficulty swallowing oral cancers dentures capped teeth

CARDIOVASCULAR: high blood pressure heart attacks heart surgery irregular heartbeat murmur chest pain congestive heart failure foot swelling Rheumatic fever pacemaker

RESPIRATORY: asthma shortness of breath bronchitis pneumonia recent cough TB

GASTROINTESTINAL: peptic ulcers reflux indigestion vomiting diarrhea constipation blood in stools black stools change in bowel habits hepatitis jaundice liver cirrhosis

GENITOURINARY: urinary tract infections yeast infections difficulty urinating STD frequent urination

MUSCULOSKELETAL: injuries swelling extremity pain joint pain arthritis leg cramps difficulty walking

NEUROLOGIC: seizures stroke dizziness sensory loss weakness

PSYCHIATRIC: depression alcoholism drug abuse anxiety marital problems

HEMATOLOGIC: bleeding disorders anemia easy bruising bleeding gums swollen lymph nodes

IMMUNOLOGIC: HIV high risk behavior transfusions

ENDOCRINE: diabetes thyroid disorder hypoglycemia adrenal disorders

SKIN DISEASE: rashes new or changing lesions skin cancers

ALLERGIES: food allergies latex allergies steroid use environmental allergies

DRUG USE: diet aides aspirin herbal remedies blood thinners steroids chemotherapy

WOMENS HEALTH: Pregnancies:_____ Live Births:_____ Miscarriages/Abortions:_____
Last menstrual period:_____ Are you pregnant?_____
Last mammogram:_____ Result:_____

MD Initial_____

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Effective Date: April 2003

PRIVACY POLICY

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO).

To that end, our practice and its physicians and staff will—
1. Adhere to the standards set forth in the Notice of Privacy Practices.
2. Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment life insurance applications, etc. without an authorization from the patient.
3. Use and disclose PHI to remind patients of their appointments unless they instruct us not to.
4. Recognize that PHI collected about patients must be accurate, timely, complete and available when needed. Our practice and its physicians and staff will: Implement reasonable measures to protect the integrity of all PHI maintained about patients.
5. Recognize that patients have a right to privacy. Our practice and its physicians and staff respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
6. Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will: a. Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements. b. Not disclose PHI data unless the patient (or his or her authorized representative) has properly authorized the release or the release is otherwise authorized by law.
7. Recognize that although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its physicians and staff will— a. Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals. b. Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
8. All patients and staff of our practice will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as their requests are in writing.
9. All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.

Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

ACKNOWLEDGMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the physician private practice listed at the beginning of this notice, and how I may obtain access to and control this information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice, its physicians, and staff.

_____
Signature of Patient or Patient's Personal Representative

_____
Print Name of Patient or Patient's Personal Representative

_____
Date