Thomas Sudela, M.D., P.A.

Tom S. Sudela, M.D., F.A.C.O.G.

Rachel Sudela Colón, R.N., W.H.N.P.-B.C.

Financial Responsibility and Consent for Treatment

General Consent:

I hereby authorize consent employees and agents of Tom Sudela, M.D., P.A. (including physicians, nurse practitioners, and other employees/staff) to render medical evaluations and care to the patient indicated below. I understand that in connection with the patient's treatment, photo or videos may be taken. This includes needed lab work and HIV testing. By law, I understand that if there is an at-risk exposure to my blood or body fluids, I may be tested for HIV, Hepatitis B or C virus. Those test results will be shared with the healthcare worker who was exposed. I am aware that healthcare is not an exact science. No guarantees have been made. If I am hospitalized, I agree to send any valuables home. I agree that Tom Sudela, M.D., P.A. is not responsible for any loss or damage to my property. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of an emergency.

Financial Responsibility:

I agree to pay for all medical services provided. I understand that I may need to call my insurance company to see if they will approve and pay for the medical care. I am aware that the doctors and others providing care may not be employees of Tom Sudela, M.D., P.A.. They are acting on their own and not at the direction of Tom Sudela, M.D., P.A.. I understand I will receive a separate bill for their services. Please bill my health insurance plan as a service to me. I am aware that this does not mean that they will agree to pay for any services. I agree to pay whatever amount is not covered. Please apply for any health insurance coverage that may be available to me. I agree to help in this process. I assign all of my rights and claims for payment under any health insurance plan to Tom Sudela, M.D., P.A. and any other treating providers. I appoint Tom Sudela, M.D., P.A., the other treating providers and/or their agents as my "authorized representative" to act for me in getting payment for services provided. If I pay more than what I owe for this medical visit, I agree that it can be used to pay for any unpaid bills I have with any Tom Sudela, M.D., P.A. facility. I give permission to be contacted for treatment or payment purposes via any of the telephone numbers or email addresses I have given. This includes contact with a pre-recorded message, automatic dialing system, artificial voice, email message, or text message. Contact may also be made by businesses helping my providers collect money that I owe.

I understand and agree with the above information.

Printed Name of Patient: _____ Date of Birth: _____

Signature: _____ Date: _____

Relationship to Patient: _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent *Note: If patient declines to participate in HIE, patient must follow the appropriate procedure outlined on the Tom Sudela, M.D., P.A. HIE Opt-Out Request Form and/or contact the HIE directly.

2504 Ridge Road, Suite 201 Rockwall, Tx 75087 Phone: (972) 722-0404 Fax: (972)722-7082

Patient Name: Account #: Date:

New Patient Demographic Sheet

Patient Information

First Name:_____ Middle Initial: _____Last Name:_____

Date of Birth:_____Email Address: _____ Sex: Female Male

Street:_____City: _____State: _____Zip:_____

Phone #:_____ Mobile #: _____ Work #: _____

Emergency Contact: _____Emergency Phone #:_____

Preferred Pharmacy Name: _____Phone Number: _____

Responsible Party

First Name:_____ Middle Initial: _____Last Name:_____

Date of Birth:_____ Sex: Female Male

Street:_____City: _____State: _____Zip:_____

Phone #:_____ Mobile #: _____ Work #: _____

Primary Insurance

Subscriber First Name: _____ Middle Initial: _____Last Name:_____

Street:_____City: _____State: _____Zip:_____

Employer Name: _____Address: _____

Date of Birth: _____ Subscriber SSN: _____

Patient Relationship to Subscriber: Self Spouse Child Dependent Other

Insurance Company: _____ Ins Phone Number: _____

ID/Policy Number: _____Group/Contract Number: _____

Secondary Insurance

Subscriber First Name: _____ Middle Initial: _____Last Name:_____

Street:_____City: _____State: _____Zip:_____

Employer Name: _____Address: _____

Date of Birth: _____ Subscriber SSN: _____

Patient Relationship to Subscriber: Self Spouse Child Dependent Other

Insurance Company: _____ Ins Phone Number: _____

ID/Policy Number: _____Group/Contract Number: _____

Patient Signature: _____ Date: _____

THOMAS SUDELA MD,PA

Please list who you want to have access to your pertinent medical information.
(i.e.: family member, spouse, significant other) **If you are under the age of 18 your parent / guardian has the right to ALL medical information without your consent.**

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

( ) Do not allow access to my medical information to anyone.

May we leave a message on an answering machine?

Home	Yes	No
Cell	Yes	No
Work	Yes	No

What is the best way for our office to contact **YOU** for test results or appointment reminders?

E-mail:_____

_____ home / work / cell
Primary Phone Number (please circle)

_____ home / work / cell
Secondary Phone Number (please circle)

_____ home / work / cell
Alternate Phone Number (please circle)

Signature_____ Date_____

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Notice of Privacy Practices

By signing below, I acknowledge that I have been provided with a copy of the Thomas Sudela M.D.,P.A. Notice of Privacy Practices and have been advised of how health information about me may be used and disclosed by Thomas Sudela M.D., P.A. and how I may obtain access to and control this information.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Print Name of Patient or Personal Representative **Date**

_____

Description of Personal Representatives Authority

2504 Ridge Road, Suite 201 Rockwall, Tx 75087 Phone: (972) 722-0404 Fax: (972)722-7082

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This will become a part of your medical record.

Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Primary Care Physician: _____ Phone number: _____

Pharmacy: _____ Phone number: _____

How did you hear about us? _____

Menstrual History:

First day of last menstrual period: ____/____/____ Age at first menstrual periods: _____ years

Number of days from the start of one period to the start of the next? _____ days

Number of days that you bleed: _____ days

Describe the amount of menstrual flow ☐ Light ☐ Moderate ☐ Heavy ☐ Clots

How many tampons or pads do you use on your heaviest days? _____

Describe the amount of menstrual discomfort ☐ None ☐ Mild ☐ Moderate ☐ Severe

Do you bleed in between your periods? ☐ Yes ☐ No

Do you bleed after intercourse? ☐ Yes ☐ No

If you stopped menstruating, at what age did you stop? _____ years

Have you had bleeding or spotting since your periods stopped? ☐ Yes ☐ No

Contraceptive and Sexual History:

Present birth control method: _____

Birth control methods used in the past: _____

Method	Length of Use	Reason for Discontinuation

Have you ever been sexually active (had intercourse)? ☐ Yes ☐ No

Have you had a new partner in the past 3 months? ☐ Yes ☐ No

How many sexual partners have you had in the past 3 months? _____

Is/Are you partner(s) male, female, or both? ☐ Male ☐ Female ☐ Both

Do you experience pain or discomfort with sexual intercourse? ☐ Yes ☐ No

Would you like to discuss sexual activity or birth control today? ☐ Yes ☐ No

******MORE QUESTIONS ON THE OTHER SIDE OF THIS SHEET*******

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Gynecological History:

Have you been vaccinated for Human Papilloma Virus (HPV)- Gardasil? ☐ Yes ☐ No

Last Pap Smear: ____/____/____ Last Mammogram: ____/____/____

Last Bone Density (DEXA) : ____/____/____ Last Colonoscopy: ____/____/____

Have you ever been on hormone therapy (estrogen/progesterone)? ☐ Yes ☐ No

Any Personal History of:

Abnormal Pap Smear	☐ Yes	☐ No
Infertility	☐ Yes	☐ No
Urinary incontinence	☐ Yes	☐ No
Sexually transmitted diseases	☐ Yes	☐ No

List: _____

Obstetrical History: Please record number of:

Pregnancies: _____ Vaginal Births: _____ Ectopic: _____ Abortions: _____

Living Children: _____ C-Sections: _____ Miscarriages: _____

List any complications of pregnancies: _____

Medical History: *Please check if you or a blood relative have had any of the following:*

	Myself	Family		Myself	Family		Myself	Family
Anemia	☐	☐	Mental Illness	☐	☐	Liver Disease/Hepatitis	☐	☐
High Blood Pressure	☐	☐	Depression	☐	☐	Gall Bladder Disease	☐	☐
High Cholesterol	☐	☐	Anxiety	☐	☐	Blood Clots in veins/lungs	☐	☐
Heart Disease	☐	☐	Eating Disorder	☐	☐	Blood Transfusion	☐	☐
Stroke	☐	☐	Migraine headaches	☐	☐	Breast Cancer	☐	☐
Diabetes	☐	☐	Urinary Tract Infection	☐	☐	Colon Cancer	☐	☐
COPD/Emphysema	☐	☐	Lupus	☐	☐	Uterine Cancer	☐	☐
Asthma	☐	☐	Arthritis	☐	☐	Ovarian Cancer	☐	☐
Seizures	☐	☐	Back injury	☐	☐	Other Cancer, Specify: _____		
Thyroid Problems	☐	☐	Osteoporosis	☐	☐	_____		

Other Medical Problems (list all): _____

Surgical History: *Please list any operations, including the year, or your age when you had it:*

_____

_____

Personal/Social history:

Occupation: _____ Marital Status: ☐M ☐S ☐D ☐W

Do/Did you use tobacco products:	☐ Yes	☐ No	How much? _____
Do/Did drink alcohol:	☐ Yes	☐ No	How many drinks per week? _____
Do/Did you use illicit/street drugs:	☐ Yes	☐ No	Which Drug? _____
Have you ever been tested for HIV?	☐ Yes	☐ No	Year and result: _____

Have you been a victim of physical, verbal, emotional, or sexual abuse? ☐ Yes ☐ No

****A FEW MORE QUESTIONS ON THE NEXT PAGE*****

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Patient Name: _____

Medications: Please list any medications you take, including over-the-counter medicines:

Medicine	Dose	How Often

Medicine	Dose	How Often

Please list any allergies to medications: _____

Current Medical Concerns: Please circle if you have had any of the following this week:

Weight changes	☐ Yes	☐ No	Nausea/Vomiting	☐ Yes	☐ No	Trouble sleeping	☐ Yes	☐ No
Abnormal Bleeding	☐ Yes	☐ No	Bowel changes	☐ Yes	☐ No	Night sweats/Hot flashes	☐ Yes	☐ No
Abnormal hair growth	☐ Yes	☐ No	Anxiety/Panic	☐ Yes	☐ No	Breast Problems	☐ Yes	☐ No
Problems with urination	☐ Yes	☐ No	Depression	☐ Yes	☐ No			

Is there any other information you feel we should have?

_____ _____

Signature of Patient Date

_____ _____ _____

Printed Name Provider Signature Date