Baylor Scott & White
RESIDENCY AT DALLAS

To Our Patients

Welcome to the Baylor Scott & White Residency at Dallas. This Clinic functions as an extension to the Graduate Medical Education program for physicians that recently graduated from medical school. The Clinic's goal is to provide our patients with high quality care while educating the resident physician to care for patients in the outpatient setting.

Since resident physicians are in training, please expect appointments to last longer than those in a traditional physician's office. The resident physicians often consult with a supervising physician about your care before giving the medical assistant orders or the next appointment. Please be patient for we are working as fast as we can to process your discharge instructions.

We ask that you call the Clinic early for requests to speak to your physician. The resident physicians are usually in the Clinic one day a week. However, the Clinic will make every effort to accommodate your medical needs while your doctor is not in the Clinic. Patients are seen by appointment only as this is not a walk-in clinic; however, we have urgent appointments available for some of our specialty clinics.

Clinic telephone number: 214-820-3275

Clinic fax number: 214-820-2530

Clinic hours: Monday – Thursday 8:30 am – 5:00 pm and Friday 8:30 am – 12:30 pm and closed during most holidays.

*Please note, when Dallas Independent School District closes for inclement (bad) weather, the Clinic is closed and your appointment will be rescheduled.

Appointments: We request you arrive 15 minutes prior to your scheduled appointment to complete the check-in process and reduce the waiting time for all our patients.

Prescription Refills: Please call your pharmacy for a refill request **2 weeks** before you run out of medicine. This will provide your doctor plenty of time to review and process your refill request.

Thank you for your understanding and choosing the Baylor Scott & White Residency at Dallas for your health care needs.

Sincerely,

The Baylor Scott & White Residency at Dallas Team

Gynecology Registration and Questionnaire

Date_____

Name	Date of Birth	Age	Occupation	Marital Status	Ethnic Origin
					☐ Caucasian ☐ Hispanic ☐ Asian ☐ Black ☐ American Indian ☐ Indian ☐ European ☐ Other
Home Address Street_____ Apartment number_____ City, State, Zip Code_____	Home Phone Cell Phone	Occupation, Employer and Work Address Employer_____ Work Address_____ Work Phone_____			

Have you been seen in this clinic before? _____ If yes, when? _____
Social Security Number: _____
Spouse's Name_____ Spouse's phone number: _____
Spouse's work address _____ Spouse's work phone: _____
In case of emergency, who should we contact? _____
Relationship: _____ Contact phone number _____
Private Insurance: _____ Name of insured: _____
Policy or Group Number_____ Insured's Social Security Number _____ Deductible: _____
Medicaid Number_____ Type of Medicaid _____

How old were you when you had your first period? _____

Are your periods normally: ☐ REGULAR or ☐ IRREGULAR?

Are your flows heavy, light or moderate?

How often do you usually get your period? Every _____ days.
For how long do you usually flow? For _____ days.

Pain or cramps with your period? ☐ YES ☐ NO ☐ SOMETIMES.

Describe the form of birth control you use _____

_____How many times have you been pregnant?
_____How many live births?
_____How many miscarriages or abortions?
_____How many children are at home?

How old were you when your periods stopped? ___

Are you taking Hormone Replacement Therapy?
___ Yes ___ No

Do you have any spotting? ___ Yes ___ No

Describe the gynecological problem you are having _____

How tall are you? _____ How much do you weigh? _____

Do you have a personal history of any of the following?

YES	NO	CONDITION	YES	NO	CONDITION
		GENERAL HEALTH			**EARS**
		OBESITY			EAR INFECTIONS
		UNDERWEIGHT			HEARING LOSS
		ANY CHRONIC ILLNESS			WEAR HEARING AIDS
		MENTAL OR PHYSICAL LIMITATIONS			RUPTURED EAR DRUM
		POOR DENTAL CONDITION			
YES	NO	CONDITION	YES	NO	CONDITION
		HEAD			**NOSE**
		CHRONIC HEADACHES			SINUS INFECTIONS
		MIGRAINE HEADACHES			FREQUENT NOSE BLEEDS
		CONCUSSION OR BLACKOUTS			NASAL SEPTAL DEFECT

		EPILEPSY OR SEIZURES			NOSE SURGERY
		TUMORS			BROKEN NOSE
		EYES			**THROAT**
		WEAR GLASSES OR CONTACT LENSES			TONSILLITIS OR TONSILLECTOMY
		BLURRED VISION			ADENOIDECTOMY
		POOR NIGHT VISION			STREP THROAT
		MOVING SPOTS OR BLIND SPOTS			LARYNGITIS (LOSS OF VOICE)
		NECK			**GASTROINTESTINAL (STOMACH)**
		LYMPH NODE ABNORMALITIES			DIABETES
		THYROID PROBLEMS OR SURGERY			ULCERS, STOMACH PROBLEMS
		INJURY FROM ACCIDENT			COLITIS, IRRITABLE BOWEL SYNDROME
		LIMITATION OF MOVEMENT			CHRONIC DIARRHEA
		RESPIRATORY			CHRONIC CONSTIPATION
		LUNG PROBLEMS			EATING DISORDER (BULIMIA, ANOREXIA)
		TUBERCULOSIS (OR INH MEDICATION)			HEMORRHOIDS OR RECTAL PROBLEMS
		POSITIVE PPD (TUBERCULOSIS TEST)			GALL BLADDER PROBLEMS
		PNEUMONIA OR BRONCHITIS			VEGETARIAN
		ASTHMA			**URINARY**
		PNEUMOTHORAX (COLLAPSED LUNG)			BLADDER INFECTIONS (UTI'S)
		CARDIAC (HEART)			KIDNEY INFECTION (PYELONEPHRITIS)
		HEART DISEASE, PROBLEMS, OR IRREGULAR HEART RATE			KIDNEY STONES
		HYPERTENSION (HIGH BLOOD PRESSURE)			BLADDER OR KIDNEY SURGERY
		HYPOTENSION (LOW BLOOD PRESSURE)			LEAKING OF URINE (INCONTINENCE)
		HEART MURMUR			IVP'S (INTRAVENOUS PYELOGRAM)

		HEMATOLOGY			**LYMPHATIC**
		HEPATITIS			ABNORMAL LYMPH NODES
		BLOOD CLOTS OR STROKE			HODGKIN'S DISEASE
		VARICOSE VEINS			ERYTHEMA NODOSUM
		SICKLE CELL DISEASE OR TRAIT			VEGETARIAN
		ABNORMAL BLOOD TYPE (HEMOGLOBINOPATHY)			**NEUROPSYCHIATRIC**
		BLOOD TRANSFUSION			EMOTIONAL PROBLEMS
		LEUKEMIA			PSYCHIATRIC HOSPITAL
		ANEMIA (LOW BLOOD COUNT OR LOW IRON)			DEPRESSION OR ANXIETY
		HEMORRHAGE (EXCESSIVE BLOOD LOSS)			CHILDHOOD SEXUAL ABUSE
		POSITIVE HIV TEST OR AIDS			MARITAL PROBLEMS
		POSITIVE ANTIBODY SCREEN			SEEING A PSYCHIATRIST, PSYCHOLOGIST

Please explain any yes answers:

YES	NO	CONDITION	YES	NO	CONDITION
		GYNECOLOGY			**GYNECOLOGY (Cont)**
		PROBLEMS WITH BIRTH CONTROL PILLS			MISCARRIAGE

		ABNORMAL PAP SMEAR (DYSPLASIA OR CIN)			ABORTIONS (ELECTIVE)
		COLPOSCOPY (MICROSCOPIC EVALUATION OF THE CERVIX)			MUSCULOSKELETAL
		CRYOSURGERY (FREEZING OF THE CERVIX)			MUSCLE ACHES, PAINS, OR STRAINS
		CONE BIOPSY (REMOVAL OF PART OF THE CERVIX)			BROKEN BONES OR INJURY TO MUSCLES OR BONES
		INFERTILITY WORK-UP			SKELETAL ABNORMALITIES (SCOLIOSIS)
		PAINFUL INTERCOURSE			BIRTH DEFECTS OR GENETIC DEFORMITIES
		SEXUAL MOLESTATION, ABUSE, RAPE			PHYSICAL RESTRICTIONS TO MOVEMENT
		FIBROID TUMORS OF THE UTERUS			CARPAL TUNNEL SYNDROME
		OVARIAN CYSTS			FREQUENTLY SEE A CHIROPRACTER
		RECURRENT (FREQUENT) VAGINAL INFECTIONS			ALLERGIES
		PELVIC INFLAMMATORY DISEASE (PID)			MEDICINE:
		SEXUALLY-TRANSMITTED DISEASE (SYPHILIS, GONORRHEA, CHLAMYDIA, HERPES, TRICHOMONAS)			
		GENITAL WARTS			FOODS:
YES	NO	CONDITION	YES	NO	CONDITION
		OTHER CONDITIONS			
		DO YOU SMOKE OR DIP TOBACCO?			DO YOU DRINK ALCHOLIC BEVERAGES?
		HAVE YOU EVER USED MARIJUANA, SPEED, COCAINE, HEROIN, CRACK, LSD, ACID OR OTHER MIND-ALTERING DRUGS?			DO YOU EAT UNUSUAL SUBSTANCES (STARCH, PAINT, CLAY)?

Please explain any yes answers:

Have you had any of the following childhood illness or surgeries?

YES	NO	CONDITION	YES	NO	CONDITION
		CHICKENPOX (VARICELLA) (OR WAS VACCINATED)			APPENDIX REMOVED
		MEASLES (RBEOLA) (OR WAS VACCINATED)			BREAST BIOPSY
		RHEUMATIC FEVER			BREAST ENLARGEMENT OR REDUCTION SURGERY
		SCARLET FEVER			ORAL SURGERY
		MUMPS (OR WAS VACCINATED)			PLASTIC SURGERY
		GERMAN MEASLES (RUBELLA) (OR WAS VACCINATED)			LAPAROSCOPY
		GALLBLADDER REMOVAL			D & C (DILATATION AND CURETTAGE)
					ANY OTHER SURGERY?

Please explain any yes answers:

Does any member of your immediate family have any of the following?

YES	NO	CONDITION	YES	NO	CONDITION
		HEART DISEASE OR HEART ATTACK			MUSCULAR DYSTROPHY OR CYSTIC FIBROSIS
		HIGH BLOOD PRESSURE			HUNTINGTON CHOREA
		KIDNEY OR BLADDER DISEASE			TAY-SACHS DISEASE
		TUBERCULOSIS			TWINS OR MULTIPLE BIRTHS
		DIABETES			CANCER
		EMOTIONAL OR MENTAL DISORDER			CHRONIC ILLNESSES
		STROKE, BLOOD CLOTS OR PHLEBITIS			DRUG ABUSE

		BLOOD VARIATIONS (SICKLE CELL, THALASSEMIA)			MAJOR OPERATIONS
		HEMOPHILIA			PREGNANCY COMPLICATIONS
		BIRTH DEFECTS, DOWN SYNDROME, NEURAL TUBE DEFECTS			DID YOUR MOTHER TAKE ANY HORMONES WHILE CARRYING YOU?

Please explain any yes answers:

List Current Medicines you take: _____

_____

How do you best learn new information? (Check all that apply):

___ Verbal Instruction ___ Written Instruction ___ Demonstration ___ Practice

___ Other: Explain _____

_____

PSYCHOSOCIAL NEEDS ASSESSMENT

The purpose of this assessment is to determine if you may need the assistance of our social service staff. Upon review, you may be referred to our social worker, who may wish to meet with you to discuss some of your answers or concerns.

I AGREE	I DISAGREE	I'M UNCERTAIN	STATEMENT
			I am happy with my life
			My living conditions are satisfactory
			I am familiar with the neighborhood I live in
			My marriage/relationship is a happy one
			My husband has never abused me and/or my children
			When my husband/partner is away, I am OK and can manage my life
			I have friends and family to help me
			I have transportation to make my appointments and go shopping
			I do not find life stressful most of the time
			I am rarely depressed
			Most of the time I have enough money for food and expenses
			I don't depend on my husband/partner for everything
			I do not take drugs or drink alcoholic beverages
			I have never been physically or emotionally abused
			I speak and understand English well I primarily speak : _____ language
			I do not need financial assistance

ADDITIONAL COMMENTS:

ASSESSMENT OF NUTRITIONAL STATUS

The purpose of this assessment is to determine if you may need the assistance of our dietician staff. Please answer the following questions and make additional comments below.

YES	NO	SOMETIMES	STATEMENT
			I am taking a multivitamin every day
			I skip meals or regularly go long periods without eating
			I have a history of diabetes
			I have a history of anemia
			I have a history of eating disorders, such as bulimia or anorexia
			I have a history of high blood pressure
			I am currently having problems with nausea and vomiting
			I am currently having problems with constipation or diarrhea
			I am currently having problems with leg cramps
			I am currently having problems with heartburn
			I am currently having problems with milk allergy
			I am currently age 18 or younger
			I am currently craving non-food items such as clay or dirt
			I am currently following a special diet
			I am currently underweight
			I am currently overweight
			I am having problems with not eating enough
			I feel I need individual nutritional counseling

PLEASE PLACE A CHECK (√) BY THE FOODS YOU EAT RGULARLY

__ Non-fat or 1% skim milk	__ Fish	__ Fruit	__ Margarine	__ Water
__ Low-Fat milk	__ Chicken/Turkey	__ Vegetables	__ Mayonnaise	__ Juice
__ Whole milk	__ Lean red meat	__ Grain cereal	__ Salad Dressing	__ Soda
__ Yogurt (Regular or Frozen)	__ Eggs	__ Sugar cereal	__ Nuts	__ Kool-Aid
__ Cottage cheese	__ Beans	__ White bread	__ Cooking Oil	__ Desserts
__ Cheese	__ Hamburger	__ Wheat bread	__ Chocolate	__ Candy
__ "Creames" (ice, sour, cheese, whipped)	__ Hot dogs	__ Brown rice	__ Fast/Fried Foods	__ Cookies
	__ Fried chicken	__ White rice	__ Gravy, sauces	__ Pastries

ADDITIONAL COMMENTS:

Have you been seen by any other physician for this gynecological problem? ___ Yes ___ No

If yes, who did you see, (Please provide name, address and telephone number) _____

_____

OFFICE USE ONLY:

Accepted Denied Signature: _____

Assign to: 1st year 2nd year 3rd year 4th year Specific: _____

BaylorScott&White
HEALTHTEXAS PROVIDER NETWORK

Financial Assistance Confirmation

According to our records, you were approved to qualify for Baylor Scott & White HealthTexas Provider Network ("HTPN") financial assistance on _____. This form will allow us to confirm your status has not changed since your last determination and that you are still eligible to receive financial assistance in accordance with the Financial Assistance Policy. If at any time your income or insurance coverage changes, you must provide that information to HTPN in order to update your account.

_____ _____

Full Patient Name HTPN EPIC Account # Date of Birth

To Be Completed by Patient or Guardian:

I understand that by signing below I am stating that my income and/or insurance coverage has not changed since the date of my original application and that I may still be considered for financial assistance according to the HTPN guidelines. I also agree to inform the practice of any changes to my income and/or insurance coverage so that my status in the program can be re-evaluated.

I understand that my approved financial assistance application is effective until _____ to allow for any necessary follow up visits where applicable. At the end of that time frame I may be required to reapply for assistance.

_____

Signature of Patient or Responsible Party

_____ _____

Printed Full Name Date

To Be Completed by Practice Staff:

_____ _____

Date of first approval Approval extension date (no more than 90 days)

_____ _____

Signature of Authorized Approver (Manager or Administrator) Date

_____

Printed Name Practice Location

Baylor Scott & White HEALTH

Baylor Scott & White Health
Financial Assistance Application

Patient Account Number

Patient Name (Last, First, MI) _____ Social Security Number _____

Patient's Residential Address _____ City _____ State _____ Zip Code _____ County _____

Birth Date (Month/Date/Year) _____ Telephone Number _____

Marital Status: ☐ Married ☐ Separated ☐ Single ☐ Divorced ☐ Widowed

Spouse's Name _____

Employed ☐ Yes ☐ No

Patient's Employer _____

Telephone # _____

Employed ☐ Yes ☐ No

Spouse's Employer _____

Telephone # _____

Are the BSWH facilities you received services at the closest in network facilities to your primary residence? ☐ Yes ☐ No

If no, were the closest facilities unable or unwilling to provide your care? ☐ Yes ☐ No

If unemployed, please include the previous employer's name and telephone number*

A. *Income:* Please provide the income for each of the following persons in your household.

Patient ☐ Full Time ☐ Part Time - Hours/Week = _____

$ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year

$ _____ **Additional Income**

Spouse ☐ Full Time ☐ Part Time - Hours/Week = _____

$ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year

$ _____ **Additional Income**

Total Household Income $ _____

Please complete only if patient is a minor (if not leave blank)

Patient's Father ☐ Full Time ☐ Part Time - Hours/Week = _____

$ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year

$ _____ **Additional Income**

Patient's Mother ☐ Full Time ☐ Part Time - Hours/Week = _____

$ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year

$ _____ **Additional Income**

Total Household Income $ _____

B. *Income Verification:* Please provide verification ***(send only copies, no original documentation)*** for all sources of household income (acceptable documentation listed below). Check attached documents:

☐ Paycheck Remittance ☐ Employer Verification ☐ Credit Inquiry (completed by BSWH)

☐ IRS Form W-2 ☐ Tax Return ☐ Governmental Assistance (food stamps, CDIC, Medicaid, TANF)

☐ Bank Statements ☐ Other (describe below) ☐ Social Security, Workers Compensation or Unemployment Compensation Determination Letters

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:

_____

C. *Family Members:* **Please provide the total number of people in the patient's household.**
(This number should only include the patient, patient's spouse, and the patient's dependents)

D. *Assets and Other Resources:*

Do you have any assets or other resources available to you? *(Examples include savings accounts, trusts, stocks, bonds, retirement accounts, mutual funds, etc.)* ☐ Yes ☐ No If Yes, current amount available: $_____

Do you have medical insurance? ☐ Yes ☐ No If Yes, please list provider name: _____

Do you have a Health Savings Account or Flexible Spending Account? ☐ Yes ☐ No If Yes, current amount available: $_____

I understand Baylor Scott & White Health ("BSWH") may verify the financial information contained in this Financial Assistance Application ("Application") in connection with BSWH's evaluation of this Application, and by my signature hereby authorize my employer or any individual listed on this Application to certify or provide additional details with respect to the information provided in this Application. I also authorize BSWH to request reports from credit reporting agencies and the Social Security Administration. I certify that the statements made in this Application are true and correct, to the best of my knowledge and belief, and are made in good faith. I am aware that falsification or misrepresentation of information on this Application may result in denial of financial assistance.

I further understand that some physicians and providers may not be employees of BSWH. I understand that I may receive separate bills from those providers and this financial assistance application will not apply to those balances due.

_____ **Signature of Patient or Responsible Party**

_____ **Printed Name**

_____ **Date**

For Hospital Use Only

☐ Application information obtained by BSWH Employee in person or over the phone, no patient signature required.

_____ Electronic Signature of BSWH Employee or BSWH Representative

_____ Date

Notes Regarding Income Verification/Number in the Household: _____

☐ Patient is part of community care program Program Name _____ First Statement Date: _____