New Patient Paperwork

Legal Name: _____ Preferred Name: _____

DOB: _____ Social Security Number: _____-_____-_____

Mailing Address: _____ Zip Code: _____

Phone: _____ Can we text you about *normal* lab results? Yes No

Email address: _____Can we email you? Yes No

Who referred you to us? _____

Pharmacy Name: _____ Phone: _____

Sex assigned at birth (circle one): Female Male Intersex

Preferred pronouns (circle one): She/her He/him They/them Other _____

What is the purpose of your visit today? _____

_____

Please list any drug allergies and their reactions: _____

_____

Please list any medications you are currently taking (include drug, dose, & frequency):

_____

_____

_____

_____

_____

Pertinent Past Medical History

Please check if you have ever had any of the following:

____ Migraines w/ visual changes

____ Blood clots/clotting disorders

____ Pulmonary embolism

____ Cancer; Type _____

____ Stroke/TIA

____ High blood pressure

____ Ischemic heart disease

____ Peripartum cardiomyopathy

____ Sickle cell disease

____ Gallbladder problems

____ Liver tumors

____ Breast disease

____ Solid organ transplantation

____ Hepatitis

____ High cholesterol

____ Hypothyroid

____ Hyperthyroid

____ Epilepsy or seizures

____ Valvular heart disease

____ History of bariatric surgery

____ Ulcerative colitis or Crohn's disease

____ Lupus

____ Unexplained vaginal bleeding

____ Diabetes

____ Cervical cancer

____ Chronic kidney disease

____ Depression/anxiety

____ Mood disorders

____ Schizophrenia or psychosis

____ Gonorrhea/chlamydia

____ Syphilis

____ HIV

Please list any previous surgeries and the dates that they were performed:

_____

_____

Lawton Women's Clinic (p) (580) 400-7997 (f) (580) 400-7998 5107 West Gore Blvd., Lawton, OK

LAWTON WOMEN'S CLINIC

REQUEST & CONSENT FOR MEDICAL SERVICES & TREATMENT

Please carefully read all of the information in this document before signing. If you have any questions, please discuss them with your clinician.

By signing this form, I affirm that the information I have provided is true, accurate, and complete. I am aware that the choices about my health care depend on the information I have provided.

I have been given information about the services to be provided, including risks, benefits, alternatives, and possible complications. I understand that there is a risk of side effects with any service performed and those side effects will be explained to me. I agree to ask questions about any part of the service that I do not understand and I am aware that a clinician is available to answer questions that may arise.

I agree that it is my decision to have this service performed and I am aware that I can change my mind about receiving this service at any time.

I understand that if I choose to have care delivered via telehealth that I will not physically be in the presence of a clinician. I have the right to an in-person appointment and can request to be scheduled in the presence of a clinician at any time. If I opt to receive telehealth services, I am agreeing to be contacted through Lawton Women's Clinic, PLLC's privacy-protected secure messages within the telehealth system.

_____ _____

Signature of Patient Date

_____ _____

Signature of Witness Date

_____ _____

Signature of legal guardian or authorized representative Date