North Texas Women's Healthcare Associates, P.A.

Welcome

Dedicated to the well-being of women throughout all stages of life

We at North Texas Women's Healthcare Associates appreciate the opportunity to provide you the highest in quality medical care. We are committed to building a lasting relationship with you to serve your continuing health care needs.

Name: _____

☐ **New Patient** ☒ **New OB Patient**

Clinician you are seeing:

☐ **Dr. Gagnon** ☐ **Dr. Vaughan** ☐ **Dr. White**

☐ **Dr. Kilianski** ☐ **Dr. Welsh**

☐ **NP Laurie** ☐ **NP Kandee**

Please tell us how you learned about us.

How did you hear about us?

☐ **Physician Referral- Name** _____

☐ **Family or friends – Name (s):** _____

☐ **Our website: www.myobg.com**

☐ **Insurance website**

☐ **Other website: wellness.com, etc.-** _____

☐ **Our staff – Name:** _____

☐ **Hospital**

☐ **Newspaper/advertisement**

Would you briefly tell us why you chose us? _____

_____

_____

Please give us your zip code. _____

Once again thank you for choosing us! We appreciate you taking the time to give us this information. Our goal is to use your comments to make this a better practice. If you have any questions, concerns, please feel free to contact us at (817) 741-2601.

TEXAS HEALTH CARE, P.L.L.C.

P.O. Box 961205
Fort Worth, Texas 76161-1205

PHYSICIAN: _____ BEING SEEN TODAY

LOCATION: _____ DATE: _____

PATIENT REGISTRATION INFORMATION

If Patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.

Social Security #: _____ Driver's License # _____ State: _____

Name: _____ (LAST) _____ (FIRST) ____ (MI) ____ (SEX) ___/___/___ (MM / DD / YY DATE OF BIRTH) ____ (AGE) S M D W O (MARITAL STATUS)

Address: _____ (MAILING ADDRESS) _____ (APARTMENT) _____ (CITY) ____ (ST) _____ (ZIP) (____) _____ (HOME PHONE)

Alt/Cell Phone: (____) _____ Day Phone: (____) _____ Email: _____

Race _____ Language _____ Ethnicity ❒ Hispanic/Latin ❒ Non Hispanic/Latin

Full-Time Part-Time Retired Unemployed Student (EMPLOYMENT STATUS (PLEASE CIRCLE ONE)) Employer's Name: or School _____

Employer's Address: _____ (MAILING ADDRESS) _____ (CITY) ____ (ST) _____ (ZIP)

Occupation: _____

Emergency Contact: *(Please indicate a friend or relative not living at the same address.)*

_____ (NAME) _____ (RELATIONSHIP) (____) _____ (EMERGENCY CONTACT #)

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient is responsible unless a minor child or guardian. RESPONSIBLE PARTY SECTION must be completed.

Patient Relationship to Responsible Party: Child ____ Other _____ (SPECIFY) Resp. Party SS #: _____

Name: _____ (LAST) _____ (FIRST) ____ (MI) ____ (SEX) ___/___/___ (MM / DD / YY DATE OF BIRTH) ____ (AGE) S M D W O (MARITAL STATUS)

Address: _____ (MAILING ADDRESS) _____ (APARTMENT) _____ (CITY) ____ (ST) _____ (ZIP) (____) _____ (HOME PHONE)

Full-Time Part-Time Retired Unemployed Student (EMPLOYMENT STATUS (PLEASE CIRCLE ONE)) Employer's Name: or School _____

Employer's Address: _____ (MAILING ADDRESS) _____ (CITY) ____ (ST) _____ (ZIP)

Occupation: _____ (____) _____ (WORK PHONE) (____) (EXT)

OTHER PATIENT INFORMATION

Spouse's Name: _____ Employer: _____

Spouse's Work Phone: (____) _____ (EXT) Occupation: _____

PRIMARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (STREET or P.O. BOX) (____) _____ (PHONE)

Co-Pay Amount: (if applicable) _____ _____ (CITY) ____ (ST) _____ (ZIP)

Primary Care Physician: _____

Policy Holder: _____ (LAST) _____ (FIRST) ____ (MI) ____ (SEX) ___/___/___ (DATE OF BIRTH) _____ (SS #)

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other _____ (SPECIFY)

Employer's Name: _____ _____ (INSUREDS ID) _____ (GROUP NAME AND/OR NUMBER)

Address: _____ (STREET) _____ (CITY) _____ (ST) _____ (ZIP)

SECONDARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (____) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ _____ _____ _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ ____ ____ ____/____/____ _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other _____
(SPECIFY)

Employer's Name: _____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Employer's Address: _____ _____ _____ _____
STREET CITY ST ZIP

WORKER'S COMPENSATION

Worker's Compensation Insurance Name: _____ Adj. _____

Address: _____ City: _____ State _____ Zip _____ Phone _____

Claim #: _____ DOI _____

What Employer: _____

ACCIDENT INFORMATION

Was this the result of an accident? ___Yes ___No Where did it occur? ___At Work ___Auto Accident ___Other

Date of Accident_____Have you reported this injury to your employer? ___Yes ___No When _____

Describe accident briefly: _____

Do you have an attorney representing you? ___Yes ___No Who is the attorney? _____

REFERRAL INFORMATION

Who referred you? _____ Address: _____ Phone: _____

Family Physician _____ Address: _____ Phone: _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ

Texas Health Care, P.L.L.C. (THC), and it's physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that THC has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to THC, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint THC to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

_____ _____ _____ _____
PATIENT SIGNATURE DATE WITNESS SIGNATURE DATE

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Suite A
Keller, Texas 76248

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www.myobg.com

1600 West College
Suite 190
Grapevine, Texas 76051

Name _____ Age _____ Date of Birth _____

Email Address _____

What is the reason for your office visit today? _____

_____

Primary Care Dr. _____ Pharmacy _____

PAST MEDICAL HISTORY

	Self	Family		Self	Family
Headaches/Migraines	☐	☐	Cancer	☐	☐
High Blood Pressure	☐	☐	Breast Disease	☐	☐
Diabetes Mellitus	☐	☐	Kidney Disease	☐	☐
Heart Disease	☐	☐	Seizure Disorder	☐	☐
Rheumatic Fever	☐	☐	Anemia/Blood Disorder	☐	☐
Lung Disease/ Asthma	☐	☐	Blood Transfusion	☐	☐
Jaundice/Hepatitis/Ulcers	☐	☐	Mental Disorder	☐	☐

Are there any diseases that "run in the family"? ☐ Yes ☐ No If Yes, list below:

_____

Are you currently taking any medications (including over the counter medications)? ☐ Yes ☐ N If Yes, list below:

_____

Are you allergic to any medications, foods, etc? ☐ Yes ☐ No If Yes, list below:

Describe any reactions: _____

_____

Do you smoke? ☐ Yes ☐ No How much? _____

Do you drink alcohol? ☐ Yes ☐ No How often? _____

OVER ⟶

HOSPITALIZATIONS

Mo/Yr	Reason	Mo/Yr	Reason
1.		4.	
2.		5.	
3.		6.	

MENSTRUAL/SEXUAL HISTORY

Date last menstrual period began _____ Age at 1st menstruation _____

A normal period lasts _____ days. Menstrual periods occur every _____ days.

Menstrual periods are: ☐ Regular ☐ Irregular ☐ Painful ☐ Light ☐ Moderate ☐ Heavy

Do you bleed or spot between periods? ☐ Yes ☐ No

Do you pass clots? ☐ Yes ☐ No

What is your current method of birth control? _____

Do you bleed during or after intercourse? ☐ Yes ☐ No

Is intercourse painful? ☐ Yes ☐ No

Do you have any other problems with intercourse? _____

_____

PREGNANCY HISTORY

Total number of pregnancies _____ Age at 1st pregnancy _____ Number of living children _____

Did you have any of the following during pregnancy?

☐ High blood pressure ☐ Infections in uterus or breast

☐ Diabetes ☐ Infections in urine

☐ Blood clots in legs ☐ Other problems (Describe below)

_____

If Pregnant how many:

Live Births	_____	Tubal/Ectopic Pregnancy	_____
Still Births	_____	Cesarean Section	_____
Miscarriages	_____	Premature Births	_____
Abortions	_____		

Are there any birth defects or special needs in the family? ☐ Yes ☐ No If Yes, list below:

_____

Do you have any questions, problems, or concerns that you would like to discuss with us today? _____

_____

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PT NAME: CHART #:

Past Pregnancies:

1. Date _____ Wks Gst: _____ Length Labor: _____
   Anes: _____ Hosp: _____ Sex: _____ Wt: _____
   Remarks: _____ Type of Del: _____

2. Date _____ Wks Gst: _____ Length Labor: _____
   Anes: _____ Hosp: _____ Sex: _____ Wt: _____
   Remarks: _____ Type of Del: _____

3. Date _____ Wks Gst: _____ Length Labor: _____
   Anes: _____ Hosp: _____ Sex: _____ Wt: _____
   Remarks: _____ Type of Del: _____

4. Date _____ Wks Gst: _____ Length Labor: _____
   Anes: _____ Hosp: _____ Sex: _____ Wt: _____
   Remarks: _____ Type of Del: _____

5. Date _____ Wks Gst: _____ Length Labor: _____
   Anes: _____ Hosp: _____ Sex: _____ Wt: _____
   Remarks: _____ Type of Del: _____

6. Date _____ Wks Gst: _____ Length Labor: _____
   Anes: _____ Hosp: _____ Sex: _____ Wt: _____
   Remarks: _____ Type of Del: _____

7. Date _____ Wks Gst: _____ Length Labor: _____
   Anes: _____ Hosp: _____ Sex: _____ Wt: _____
   Remarks: _____ Type of Del: _____

8. Date _____ Wks Gst: _____ Length Labor: _____
   Anes: _____ Hosp: _____ Sex: _____ Wt: _____
   Remarks: _____ Type of Del: _____

9. Date _____ Wks Gst: _____ Length Labor: _____
   Anes: _____ Hosp: _____ Sex: _____ Wt: _____
   Remarks: _____ Type of Del: _____

10. Date _____ Wks Gst: _____ Length Labor: _____
    Anes: _____ Hosp: _____ Sex: _____ Wt: _____
    Remarks: _____ Type of Del: _____

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OB QUESTIONNAIRE

NAME: _____ DATE: _____

Please check any of the following that apply:

1. Have you ever had:
   - ☐ Incompetent Cervix
   - ☐ Postpartum Hemorrhage
   - ☐ Pregnancy Induced Hypertension
   - ☐ Fetal Demise/Stillbirth

2. Have you ever had:
   - ☐ Gynecologic Surgeries.
     If so, what type, and when? _____
     _____
   - ☐ Abnormal PAP Smears.
     If so, when, and was any follow-up done? _____
     _____
   - ☐ History of Infertility.

3. Have you ever had:
   - ☐ Herpes
   - ☐ Gonorrhea
   - ☐ Syphilis
   - ☐ Chlamydia
   - ☐ Condyloma
   - ☐ HIV

   Do you have any questions regarding safer sex? _____
   _____

4. Have you ever had:
   - ☐ Hepatitis
   - ☐ Group B Strep

5. Do you have cats? ☐ Yes ☐ No
   If so, do you change the litter box? ☐ Yes ☐ No

6. Have you had:
   - ☐ Rubella (German Measles)
   - ☐ Mitral Valve Prolapse
   - ☐ Heart Murmur
   - ☐ High Blood Pressure
   - ☐ Asthma
   - ☐ Recurring Bladder Infections
   - ☐ Chicken Pox
   - ☐ Rheumatic Fever
   - ☐ Heart Disease
   - ☐ Blood Transfusions
   - ☐ Tuberculosis
   - ☐ Blood in the urine

7. Have you ever had:

- ☐ Depression/Emotional Disorders
- ☐ Addiction to Drugs
- ☐ Excessive use of Alcohol
- ☐ Been abused Verbally/Physically/Sexually

8. Have you or any of you family members had any of the following:

- ☐ Heart Disease
  If so, who? _____
- ☐ Hypertension
  If so, who? _____
- ☐ Bleeding Disorders
  If so, who? _____
- ☐ Diabetes
  If so, who? _____
- ☐ Endocrine Disorders
  If so, who? _____
- ☐ Cancer
  If so, who? _____
- ☐ Stroke
  If so, who? _____
- ☐ Neurological Disorders
  If so, who? _____

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PRENATAL GENETIC SCREEN

NAME: _____ DATE: _____

I. Will you be 35 years of older when the baby is due? ☐ Yes ☐ No

Have you, the baby's father or anyone in either of your families ever had any of the following disorders?

Down Syndrome (mongolism)	☐ Yes	☐ No
Other chromosomal abnormality	☐ Yes	☐ No
Anencephaly, Neural tube defect, spina bifida	☐ Yes	☐ No
(meningomyelocele or open spine)	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Muscular Dystrophy	☐ Yes	☐ No
Cystic Fibrosis	☐ Yes	☐ No

If you answered yes to any of the above, please indicate the relationship of affected person to you or the baby's father:

_____

_____

II. Do you or the baby's father have a birth defect? ☐ Yes ☐ No
If yes, who has the defect, and what is it? _____

In any previous marriages, have you or the baby's father had a child born dead or alive with a birth defect not listed above? ☐ Yes ☐ No
If yes, who had the defect, and what is it? _____

Do you or the baby's father have any close relatives with mental retardation? ☐ Yes ☐ No
If yes, indicate the relationship of the affected person to you or the to the baby's father: _____
Indicate the cause if known: _____

Do you, the baby's father, or a close relative in either of your families have a birth defect, any familial disorder, or a chromosomal abnormality not listed above? ☐ Yes ☐ No
If yes, indicate the condition and relationship of the affected person to you or to the baby's father: _____
Are you and the father of the baby blood relatives? ☐ Yes ☐ No

In any previous marriages, have you or the baby's father had a stillborn child or three or more first trimester spontaneous pregnancy losses? ☐ Yes ☐ No
If yes, have either of you had a chromosomal study? ☐ Yes ☐ No
If yes, indicate who and the result: _____

III.

Are you or the baby's father of Jewish ancestry? ☐ Yes ☐ No
Have either of you been screened for Tay-Sachs disease? ☐ Yes ☐ No
If yes, indicate who and the results: _____

Are you or the baby's father black? ☐ Yes ☐ No
Have either of you been screened for sickle cell trait? ☐ Yes ☐ No
If yes, indicate who and the results: _____

Are you or the baby's father Italian, Greek, or of Mediterranean background? ☐ Yes ☐ No
Have either of you been tested for B-thalassemia? ☐ Yes ☐ No
If yes, indicate who and the results: _____

Are you or the baby's father Philippine or Southeast Asian ancestry? ☐ Yes ☐ No
Have either of you been tested for A-thalassemia? ☐ Yes ☐ No
If yes, indicate who and the results: _____

IV.

Excluding iron and vitamins, have you taken any medications or recreational drugs in the past six months?
This includes non-prescription drugs ☐ Yes ☐ No
If yes, give name of medication and time taken during pregnancy:

1. _____
2. _____
3. _____
4. _____
5. _____

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Prenatal Testing for Cystic Fibrosis

Cystic fibrosis is a life-long metabolic illness that usually appears in the early years of a child's life. The disease affects breathing and digestion often leading to life-long problems and need for care; it DOES NOT affect your baby's appearance or INTELLIGENCE. Cystic fibrosis is inherited, as a recessive disorder, in other words both of the parents, you and your husband;must be carriers to pass the gene on to your baby. If both you and your husband test positive as carriers, neither of you have any signs or symptoms of the disease, and then the chance of your baby inheriting the disease is ~ or twenty-five percent. Unfortunately the testing does not tell you now much the cystic fibrosis will affect your infant/child. The chance of you or your husband being a carrier depends on your family background:

Race:	Chance of being a carrier:	Chance of both Parents being carriers:
European Caucasian	1 in 29	1 in 841
Askenazi Jewish	1 in 29	1 in 841
Hispanic American	1 in 46	1 in 2116
African American	1 in 65	1 in 4225
Asian American	1 in 90	1 in 8100

Recently testing has been developed to test for the 25 most common carrier mutations. The American Board of Obstetrics and Gynecology has recommended, that each patient be offered screening during her early prenatal care. A negative test on you is not a guarantee that your child will not have Cystic fibrosis but your chances are very small. If both parents are shown to be carriers then GENETIC COUNSELING and an AMNIOCENTESIS is recommended to determine the status of your baby. Finally cystic fibrosis can not be treated before birth ~ therefore the results of screening is to allow you to terminate your pregnancy or to allow yourself time to prepare for a child with special health care needs.

INFORMED CONSENT/DECLINE

1. I understand that the decision to be tested for Cystic Fibrosis (CF) carrier status is completely mine.
2. I understand that the test does not detect all CF carriers.
3. I understand that if I am a carrier, testing of the baby~ s father will be necessary to determine the chance that my baby could have CF.
4. I understand that if one parent is a carrier and the other is not, it is still possible that the baby will have CF, but the chance is very small.
5. I understand that if both parents are carriers, additional testing will be required to determine whether your baby will have CF.
6. I understand that if my baby is shown to have CF, the only way to avoid the birth of a baby with CF is to terminate my pregnancy.

I have read and understand the preceding information and:

_____ I decline CF carrier testing

_____ I desire CF carrier testing

Signed: _____

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The Texas Legislature passed Grayson's Law (House Bill 1795) making it mandatory for healthcare providers treating pregnant patients to carry out two HIV tests - one at the first prenatal visit and one in the 3rd trimester unless the patient specifically refuses. Should the patient refuse, HIV testing will be offered at the time of delivery and can be done on either the mother or newborn. Research has shown that maternal transmission from mother to infant can be significantly reduced following a three step protocol administering Zidouvudine (AVT). In a nationwide study conducted by the AIDS clinical trial group, maternal-fetal transmission of HIV was reduced by 2/3 in cases where women were treated orally with AZT during pregnancy, intravenously during labor/delivery and when their newborns were treated orally for six weeks after birth. This benefits children of patients whose HIV positive status is known because AZT administered during pregnancy significantly reduces the chances of transmission to the baby.

Three important facts regarding HIV testing are as follows:

* Testing is a routine part of our practice.
* Testing is routine because the latency period for HIV infection can be as long as 15 years.
* However unlikely HIV infection is, if you are positive, you can greatly reduce the chance of transmission to your baby with AZT treatment.

The results of HIV testing are confidential, but not anonymous. The Texas Statute governing HIV information allows confidentiality to be broken in order to release the results to the health department, a local health authority, for reporting purposes, to the physician who ordered the test, or a healthcare provider who has a legitimate need to know the tests results in order to provide for his/her own protection and to provide for the patient's health and welfare. Additionally, HIV test results may be released to a spouse if the results are positive. You may also voluntarily release or disclose tests results to any other person; however, such authorization must be in writing and signed by you.

___ I have received written material developed by the Texas Department of Heath regarding HIV testing prior to test being drawn.

___ I have received verbal notification regarding HIV testing and this has been explained to me.

___ I give permission for HIV testing today and during the 3rd trimester.

___ I refuse HIV testing today and during the 3rd trimester.

Should you refuse HIV testing you may seek anonymous testing through the Tarrant County Health Department. Although the results are anonymous they must be made available to your physician so you will receive appropriate treatment during your pregnancy.

_____ _____

Signature Date

TEXAS HEALTH CARE, P.L.L.C.

RELEASE OF PATIENT INFORMATION

I CONSENT AND AUTHORIZE THE RELEASE OF ANY NORMAL TEST RESULTS TO THE FOLLOWING PERSONS:

- ❑ MYSELF
- ❑ VOICE MAIL_____
- ❑ MY SPOUSE: _____
- ❑ MY CHILD(REN): _____
- ❑ MY PARENT(S): _____
- ❑ OTHER: _____

I CONSENT AND AUTHORIZE THE RELEASE OF ANY ABNORMAL TEST RESULTS TO THE FOLLOWING PERSONS:

- ❑ MYSELF
- ❑ VOICE MAIL_____
- ❑ MY SPOUSE: _____
- ❑ MY CHILD(REN): _____
- ❑ MY PARENT(S): _____
- ❑ OTHER: _____

PRINTED NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

SIGNATURE: _____

DATE: _____

PATIENT RECORD OF DISCLOSURES

IN GENERAL, THE HIPAA PRIVACY RULE GIVES PATIENT THE RIGHT TO REQUEST ON USES AND DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION (PHI). THE PATIENT IS ALSO PROVIDED THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS OR THAT A COMMUNICATION OF PHI BE MADE BY ALTERNATIVE MEANS, SUCH AS SENDING CORRESPONDENCE TO THE INDIVIDUAL'S OFFICE INSTEAD OF THE INDIVIDUAL'S HOME. THIS INFORMATION WILL REMAIN IN EFFECT UNTIL REVOKED IN WRITING.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

- ❒ HOME TELEPHONE _____
- ❒ O.K. TO LEAVE MESSAGE WITH DETAILED INFORMATION
- ❒ LEAVE NAME/DOCTOR WITH CALL BACK NUMBER ONLY
- ❒ WORK TELEPHONE _____
- ❒ LEAVE DETAILED MESSAGE ON WORK VOICE MAIL
- ❒ LEAVE MESSAGE WITH NAME/DOCTOR & CALL BACK NUMBER ONLY
- ❒ WHEN UNABLE TO CONTACT ME BY PHONE, A WRITTEN COMMUNICATION MAY BE SENT TO MY HOME ADDRESS
- ❒ OTHER _____

_____

PATIENT SIGNATURE DATE

_____

PRINT NAME BIRTHDATE

_____

SOCIAL SECURITY #

HEALTHCARE PROVIDERS MUST KEEP RECORDS OF PHI DISCLOSURES. INFORMATION PROVIDED WILL BE DOCUMENTED ON THE TEST RESULT, PROGRESS NOTE OR PATIENT COMMUNICATION IN QUESTION.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Print Name

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

TEXAS HEALTH CARE, P.L.L.C.

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician(s) and/or order another person to perform all exams, tests, procedures, injections, phlebotomy, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Dr. _____ , with Texas Health Care, P.L.L.C. unless revoked by me in writing.

Social Security # _____

_____ _____

Date *Patient/Legal Representative*

THCOBP12

IF YOU ARE PREGNANT OR THINK YOU MAY BE PREGNANT, YOU NEED TO KNOW ABOUT HIV.

You need to take care of yourself and get regular medical checkups for your health and your baby's health. Your health care provider will ask you questions and check you for conditions that can harm you and your baby. As part of your routine care, you should have a confidential HIV test.

WHAT IS HIV?

- ☐ Human Immunodeficiency Virus (HIV) is a disease that weakens the immune system, making it hard for the body to fight infections.

HAVE YOU RECENTLY HAD AN HIV TEST?

- ☐ For your health and your baby's, you should know if you're infected with HIV - the virus that causes AIDS. If you are infected, there are things you can do to protect your baby.
- ☐ A confidential HIV test will be performed on every pregnant woman in Texas at the first prenatal care visit and at delivery. **You may refuse the test, but there are benefits to knowing your HIV status.**
- ☐ If you refuse testing, your health care provider will let you know about where to get an anonymous test done.
- ☐ A "confidential test" means information about the test results will be written in your medical record. An "anonymous test" means your real name won't be used and the test results won't be written in your medical record.

HOW WILL A TEST HELP ME?

- ☐ If you are infected with HIV, there are medicines that may prevent your baby from becoming infected and help you stay healthier. You will need to start taking the medicine early in your pregnancy.

HOW WILL A TEST HELP MY BABY?

- ☐ The test will help your baby by alerting you to the need for treatment. If you have HIV, you might give it to your baby during pregnancy, at delivery, or by breastfeeding. Without treatment, about one out of every four babies born to HIV-infected mothers are born with HIV.
- ☐ Doctors have learned that the drug AZT can greatly reduce your chances of giving HIV to your baby. You may want to discuss this treatment with your health care provider.

WHERE CAN I GET MEDICAL HELP?

Private doctor's office
Local health department
Texas Department of Health Regional Clinics

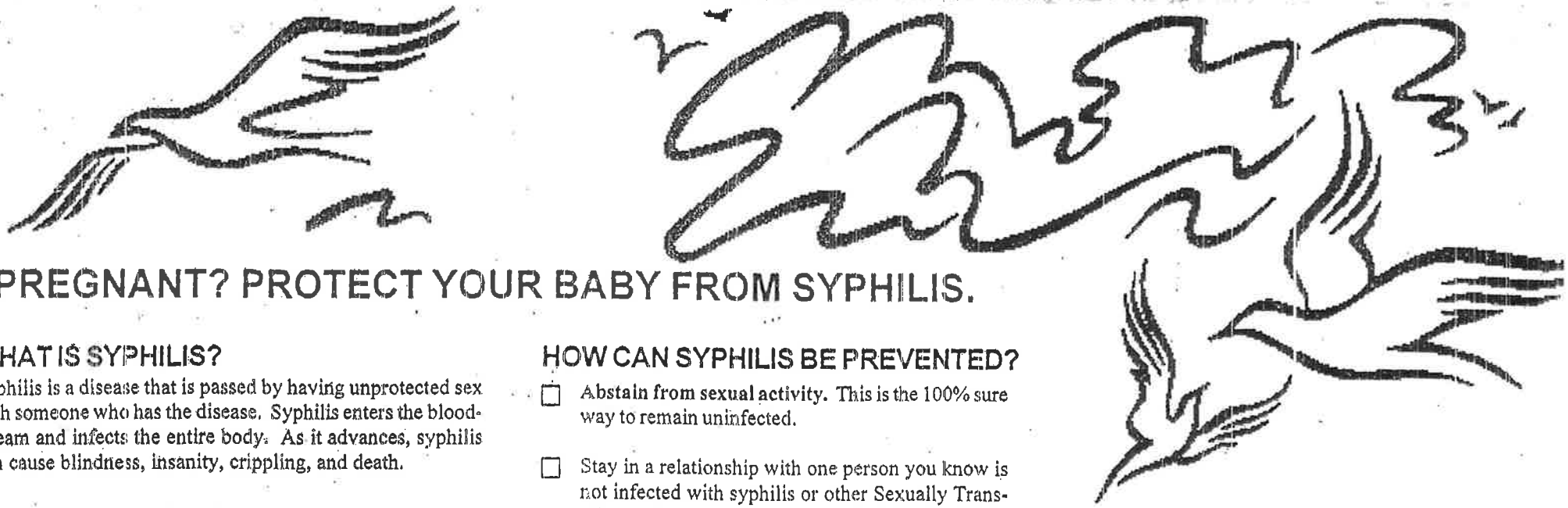
HOW CAN I AVOID HIV INFECTION?

- ☐ **Abstain from sexual activity.** This is the 100% sure way to remain uninfected.
- ☐ **Stay in a relationship** with one person you know does not inject drugs and is not infected with HIV or other Sexually Transmitted Diseases.
- ☐ **Use latex condoms** every time you have sex unless you are sure your sex partner is not infected. Condoms are not just for preventing pregnancy. When used correctly, condoms can help prevent diseases like HIV and other Sexually Transmitted Diseases.
- ☐ **Do not use drugs!** Drugs can hurt you and your unborn baby. If you use drugs, ask about treatment programs to help you stop. If you can't stop, do not share needles or syringes. Be sure to clean needles with water and bleach between uses.

OTHER SOURCES OF HELP

Call the **Texas AIDSLINE at 1-800-299-AIDS,** to find out about HIV testing and medical services in your area.

Call the **Baby Love Hotline at 1-800-422-2956** to receive a referral for medical care for you and your baby.



PREGNANT? PROTECT YOUR BABY FROM SYPHILIS.

WHAT IS SYPHILIS?

Syphilis is a disease that is passed by having unprotected sex with someone who has the disease. Syphilis enters the bloodstream and infects the entire body. As it advances, syphilis can cause blindness, insanity, crippling, and death.

WHAT IS CONGENITAL SYPHILIS?

A mother infected with syphilis can pass the disease to her baby before birth. If the baby gets the disease this way, it is called congenital syphilis. Pregnant women should be tested for syphilis early and late in the pregnancy to detect and get treatment for infection.

WHAT ARE THE RISKS OF CONGENITAL SYPHILIS?

A baby born with congenital syphilis may be blind, deaf, mentally retarded, born with bone deformities, and/or stillborn.

CAN SYPHILIS BE CURED?

- ☐ YES! If the infection is caught early, the mother and her baby can receive treatment at the same time.
- ☐ See a health care provider immediately if you think that you have syphilis or another Sexually Transmitted Disease, if you have sex with someone you think may have a Sexually Transmitted Disease, or if someone you have had sex with tells you that they have a Sexually Transmitted Disease.

HOW CAN SYPHILIS BE PREVENTED?

- ☐ **Abstain from sexual activity.** This is the 100% sure way to remain uninfected.
- ☐ Stay in a relationship with one person you know is not infected with syphilis or other Sexually Transmitted Diseases.
- ☐ Use a latex condom every time you have sex if you are sure your sex partner is not infected with syphilis.
- ☐ See a health care provider as soon as possible if you think you are pregnant, and continue going to the doctor regularly until the baby has been born.
- ☐ See a health care provider if you notice unusual rashes or sores on your body.
- ☐ If you have been told that you have or have been exposed to syphilis or another Sexually Transmitted Disease, you should receive treatment immediately.
- ☐ If you are pregnant, you should be tested early and late in the pregnancy to detect and get treatment for infection.

WHERE CAN HELP BE FOUND?

Private doctor's office
Local health department
Texas Department of Health Regional Clinics

Treatment is always confidential and private. Person under 18 years of age that receive treatment for HIV and Sexually Transmitted Diseases do not have to tell the parents.

NORTH TEXAS WOMAN'S HEALTHCAR

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KELLER, TEXAS 76248
METRO 817-267-4565