

**FEM Centre**  
**Joseph McWherter, M.D., P.A. and Associates**  
709 West Leuda, Fort Worth, TX 76104  
6221 Colleyville Blvd., Suite 150, Colleyville, TX 76034  
[www.femcentre.com](http://www.femcentre.com)

Patient Name _____		Date of birth _____	
Address _____		City _____	State _____ Zip _____
Home Phone _____		Alternate phone _____	
Soc. Sec. # _____		Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
Employer _____		Position _____	
Street Address _____			
City _____		State _____	Zip _____ Work phone _____
Notify in an Emergency _____		Phone _____	
Referred by _____		Religion _____	
Drug Allergies _____			
Email address: _____			

<b>Spouse Information</b>			
Name _____			
Address _____		City _____	State _____ Zip _____
Home Phone _____		Date of Birth _____	
Employer _____		Position _____	
Street Address _____			
City _____		State _____	Zip _____ Work phone _____

<b>Insurance Plan Information</b>			
1. Plan Name _____		Ins. Effective Date _____	
Street Address _____		City _____	State _____ Zip _____
Policy ID _____		Policy Owner _____	Group No. _____
Telephone No. _____			
2. Plan Name _____		Ins. Effective Date _____	
Street Address _____		City _____	State _____ Zip _____
Policy ID _____		Policy Owner _____	Group No. _____
Telephone No. _____			

"I verify the accuracy of the above information and I authorize the release of any medical information necessary to process any and all claims."	
_____	_____
<b>Patient or Authorized Signature</b>	<b>Date</b>
"I request payment of this claim and, if the payer accepts assignment, I authorize payment directly to the physician or supplier for the services described."	
_____	_____
<b>Insured Signature</b>	<b>Date</b>

# Patient Intake History

Patient name:	Birth date:    /    /	Age:	Date:    /    /
Address:			
City:	State/Zip:		
Home telephone: (        )	Work telephone: (        )		
Employer:	Insurance company:		
Insurance policy number:	Insurance group number:		
Emergency contact:			
Relationship:			
Home telephone: (        )	Work telephone: (        )		
Why have you come to the office today?			
Is this a new problem?			
Please describe your problem, including where it is, how severe it is, and how long it has lasted:			

## Current Medications

(Including hormones, vitamins, herbs, nonprescription and prescription medications)

Drug name	Dosage	Who prescribed	Drug name	Dosage	Who prescribed

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

## Gynecological History

	Physician's Notes
Last normal menstrual period (First Day):    /    /	
Age periods began:	
Length of periods (number of days of bleeding):	
Number of days between periods:	
Any recent changes in periods?	
Are you currently sexually active?	
Have you ever had sex?	
Number of sexual partners (lifetime):	
Sexual partners are: <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both	
Present method of birth control:	
Have you ever used an intrauterine device (IUD) or birth control pills?	
If yes, for how long?	
When was your last Pap Test?	
What was the result?	
Have you ever had an abnormal Pap Test?	
Do you do regular breast self-examinations?	

Patient name:	Birth date: / /	Age:	Date: / /
---------------	-----------------	------	-----------

### Obstetric History

	<b>Number</b>		<b>Number</b>		<b>Number</b>	
Pregnancies		Abortions		Miscarriages		
Premature births (>37 weeks)		Live births		Living children		
<b>No.</b>	<b>Birth date</b>	<b>Weight at birth</b>	<b>Baby's sex</b>	<b>Weeks pregnant</b>	<b>Type of delivery (Vaginal, Cesarean, etc.)</b>	<b>Complications?</b>
1.						
2.						
3.						
4.						
Physician's notes on obstetric history:						

### Family History

Mother: <input type="checkbox"/> Living <input type="checkbox"/> Deceased – Cause:			Father: <input type="checkbox"/> Living <input type="checkbox"/> Deceased – Cause:		
Siblings: Number living:		Number deceased:		Cause(s)/Age(s):	
Children: Number living:		Number deceased:		Cause(s)/Age(s):	
<b>Illness</b>	<b>Yes</b>	<b>Which relative(s) and age of onset</b>		<b>Physician's Notes</b>	
Diabetes	<input type="checkbox"/>				
Stroke	<input type="checkbox"/>				
Heart disease	<input type="checkbox"/>				
Blood clots in lungs or legs	<input type="checkbox"/>				
High blood pressure	<input type="checkbox"/>				
High cholesterol	<input type="checkbox"/>				
Osteoporosis (weak bones)	<input type="checkbox"/>				
Hepatitis	<input type="checkbox"/>				
HIV/AIDS	<input type="checkbox"/>				
Tuberculosis	<input type="checkbox"/>				
Birth defects	<input type="checkbox"/>				
Drinking or drug problems	<input type="checkbox"/>				
Breast cancer	<input type="checkbox"/>				
Colon cancer	<input type="checkbox"/>				
Ovarian cancer	<input type="checkbox"/>				
Uterine cancer	<input type="checkbox"/>				
Mental illness/depression	<input type="checkbox"/>				
Alzheimer's disease	<input type="checkbox"/>				
Other	<input type="checkbox"/>				
Other	<input type="checkbox"/>				

Patient name:	Birth date:    /    /	Age:	Date:    /    /
---------------	-----------------------	------	-----------------

### Social History

	Yes	No	Physician's Notes
Ever smoked? Current smoking: Packs per day:    Years:	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol: Drinks per day:    Drinks per week:	<input type="checkbox"/>	<input type="checkbox"/>	
Recreational drug use?	<input type="checkbox"/>	<input type="checkbox"/>	
Seat belt use?	<input type="checkbox"/>	<input type="checkbox"/>	
Regular exercise: How long and how often?	<input type="checkbox"/>	<input type="checkbox"/>	
Dairy product intake/calcium supplements:    Quantity?	<input type="checkbox"/>	<input type="checkbox"/>	
Health hazards at home or work?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you been sexually abused, threatened, or hurt by anyone?	<input type="checkbox"/>	<input type="checkbox"/>	

### Personal Profile

Sexual Orientation: <input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Bisexual
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Living with partner <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
Number of people in household:
School completed: <input type="checkbox"/> High school <input type="checkbox"/> Some college/AA degree <input type="checkbox"/> College <input type="checkbox"/> Graduate degree <input type="checkbox"/> Other
Current or most recent job:
Travel outside of the US?

### Operations/Hospitalizations

Reason	Date	Hospital

### Injuries

Type	Date	Type	Date

### Immunizations/Test

	Date		Date
Tetanus – Diphtheria booster		Influenza vaccine (flu shot)	
Hepatitis A vaccine		Hepatitis B vaccine	
Varicella vaccine		Pneumococcal vaccine	
Measles-Mumps-Rubella (MMR) vaccine		Tuberculosis (TB) skin test:    Result:	

<b>Physician's Notes:</b>

Patient name:	Birth date: / /	Age:	Date: / /
---------------	-----------------	------	-----------

### Personal Past History of Illness

Major Illness	Yes (Date)	No	Not sure	Physician's Notes
Asthma				
Pneumonia/lung disease				
Kidney infections/stones				
Tuberculosis				
Sexually transmitted disease				
HIV/AIDS				
Heart attack/problems				
Diabetes				
High blood pressure				
Stroke				
Rheumatic fever				
Blood clots in lungs or legs				
Eating disorders				
Collagen vascular disease (Lupus)				
Chickenpox				
Cancer				
Reflux/hiatal hernia/ulcers				
Depression/anxiety				
Anemia				
Blood transfusions				
Seizures/convulsions/epilepsy				
Bowel problems				
Glaucoma				
Cataracts				
Arthritis/joint pain/back problems				
Broken bones				
Hepatitis/Yellow jaundice/liver disease				
Thyroid disease				
Gallbladder disease				
Headaches				
Other				

### Review of Systems

Please check (x) if any of the following symptoms apply to you now or since adulthood

	Now	Past	Not sure	Physician's Notes
<b>1. Constitutional</b>				
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>		
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>		
Fever	<input type="checkbox"/>	<input type="checkbox"/>		
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>		
Change in height	<input type="checkbox"/>	<input type="checkbox"/>		

Patient name:	Birth date: / /	Age:	Date: / /
---------------	-----------------	------	-----------

### Review of Systems (continued)

	Now	Past	Not sure	Physician's Notes
<b>2. Eyes</b>				
Double vision	<input type="checkbox"/>	<input type="checkbox"/>		
Spots before eyes	<input type="checkbox"/>	<input type="checkbox"/>		
Vision changes	<input type="checkbox"/>	<input type="checkbox"/>		
Glasses/contacts	<input type="checkbox"/>	<input type="checkbox"/>		
<b>3. Ear, Nose, and Throat</b>				
Earaches	<input type="checkbox"/>	<input type="checkbox"/>		
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>		
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>		
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>		
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>		
Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>		
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>		
<b>4. Cardiovascular</b>				
Painful breathing	<input type="checkbox"/>	<input type="checkbox"/>		
Chest pain or pressure	<input type="checkbox"/>	<input type="checkbox"/>		
Difficulty breathing on exertion	<input type="checkbox"/>	<input type="checkbox"/>		
Rapid or irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>		
<b>5. Respiratory</b>				
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>		
Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>		
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>		
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>		
<b>6. Gastrointestinal</b>				
Frequent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>		
Bloody stool	<input type="checkbox"/>	<input type="checkbox"/>		
Nausea/vomiting/indigestion	<input type="checkbox"/>	<input type="checkbox"/>		
Constipation	<input type="checkbox"/>	<input type="checkbox"/>		
Involuntary loss of gas or stool	<input type="checkbox"/>	<input type="checkbox"/>		
<b>7. Genitourinary</b>				
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>		
Pain with urination	<input type="checkbox"/>	<input type="checkbox"/>		
Strong urgency to urinate	<input type="checkbox"/>	<input type="checkbox"/>		
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>		
Incomplete emptying	<input type="checkbox"/>	<input type="checkbox"/>		
Involuntary/unintended urine loss	<input type="checkbox"/>	<input type="checkbox"/>		
Urine loss when coughing or lifting	<input type="checkbox"/>	<input type="checkbox"/>		
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>		
Painful periods	<input type="checkbox"/>	<input type="checkbox"/>		
Premenstrual Syndrome (PMS)	<input type="checkbox"/>	<input type="checkbox"/>		
Painful intercourse	<input type="checkbox"/>	<input type="checkbox"/>		
Fibroids	<input type="checkbox"/>	<input type="checkbox"/>		
Infertility	<input type="checkbox"/>	<input type="checkbox"/>		
DES exposure	<input type="checkbox"/>	<input type="checkbox"/>		
Abnormal vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>		

Patient name:	Birth date: / /	Age:	Date: / /
---------------	-----------------	------	-----------

### Review of Systems (continued)

	Now	Past	Not Sure	Physician's Notes
<b>8. Musculoskeletal</b>				
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>		
Muscle or joint pain	<input type="checkbox"/>	<input type="checkbox"/>		
<b>9. Skin</b>				
Rash	<input type="checkbox"/>	<input type="checkbox"/>		
Sores	<input type="checkbox"/>	<input type="checkbox"/>		
Dry skin	<input type="checkbox"/>	<input type="checkbox"/>		
Moles	<input type="checkbox"/>	<input type="checkbox"/>		
<b>10. Breasts</b>				
Pain in breast	<input type="checkbox"/>	<input type="checkbox"/>		
Nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>		
Lumps	<input type="checkbox"/>	<input type="checkbox"/>		
<b>11. Neurologic</b>				
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>		
Seizures	<input type="checkbox"/>	<input type="checkbox"/>		
Numbness	<input type="checkbox"/>	<input type="checkbox"/>		
Trouble walking	<input type="checkbox"/>	<input type="checkbox"/>		
Severe memory problems	<input type="checkbox"/>	<input type="checkbox"/>		
Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>		
<b>12. Psychiatric</b>				
Depression or frequent crying	<input type="checkbox"/>	<input type="checkbox"/>		
Severe anxiety	<input type="checkbox"/>	<input type="checkbox"/>		
<b>13. Endocrine</b>				
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>		
Heat/cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>		
Abnormal thirst	<input type="checkbox"/>	<input type="checkbox"/>		
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>		
<b>14. Hematologic/Lymphatic</b>				
Frequent bruises	<input type="checkbox"/>	<input type="checkbox"/>		
Cuts do not stop bleeding	<input type="checkbox"/>	<input type="checkbox"/>		
Enlarged lymph nodes (glands)	<input type="checkbox"/>	<input type="checkbox"/>		
<b>15. Allergic/Immunologic</b>				
Medication allergies	<input type="checkbox"/>	<input type="checkbox"/>		
If any, please list allergy and type of reaction:				
Other allergies	<input type="checkbox"/>	<input type="checkbox"/>		
Please list allergy and type of reaction:				
Form Completed By: <input type="checkbox"/> Patient <input type="checkbox"/> Office Nurse/MA <input type="checkbox"/> Physician <input type="checkbox"/> Other				
Signature of patient:				
Date reviewed by physician with patient: / /			Physician signature:	
<b>Annual review of history:</b>				
Date: / /	Phys. sign:		Date: / /	Phys. sign:
Date: / /	Phys. sign:		Date: / /	Phys. sign:

## **Patient Policy**

**Arriving for your appointment:** We understand that situations arise that might cause you to arrive late for your scheduled appointment. The courtesy of a phone call informing us that you may be late is appreciated. Efforts will be made to still see a patient who arrives late. However, you may have to wait until you can be worked in. In some situations, it may be necessary to reschedule.

New patients are expected to arrive at least 30 minutes prior to your scheduled time to complete paperwork. If paperwork has been completed prior to the appointment day, new patients should arrive at least 15 minutes early.

**Appointment confirmations:** Confirmation calls are made in advance of scheduled appointments. If necessary, a message will be left requesting a return call. The courtesy of a response is appreciated. If you fail to confirm an appointment, that time could be given to another patient or you may be assessed a “No Show” fee.

**No Show/Late Cancellation fee:** We make every effort to make appointments for patients as requested. Therefore, all appointment times are precious. In the event that your confirmed or pending appointment needs to be rescheduled, we request 24 hours notice so we may offer the appointment time to a patient on our waiting list. Cancellations less than 24 hours in advance or “No Shows” are subject to a fee. This fee must be paid before a new appointment is scheduled.

**Insurance cards/Personal information forms:** It is necessary for us to keep all of our patient information current for insurance and other reasons. Because of this, you will be asked to update personal information and present your insurance card at least every 3 months. A photo ID will also be requested if none is present in the chart. It is suggested that you arrive 10 minutes prior to your scheduled appointment time to update forms.

**Supplements:** Unopened products may be exchanged or returned for a credit within 30 days of purchase.

## **Payment Policy**

**Insurance:** Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in the bill for services becoming your responsibility.

**Payment options if you have insurance:** As a courtesy, we will file insurance claims for patients who present a valid insurance card.

We request that payment for co-pays, deductibles, and any out-of-pocket portions be paid at the time services are rendered by cash, check, or credit card (Master Card, Visa, American Express, and Discover are accepted).

You may choose to pay for all of your treatment by cash, check, or credit card and submit the claim to the insurance company yourself. If you choose this option, we will supply you with a copy of your Super Bill to submit your insurance carrier and they will send their payment directly to you.

**Payment options if you DO NOT have insurance:** We request that payment for all office visits and procedures be paid at time/date of service. You may choose to pay by cash, check, or credit card (Master Card, Visa, American Express, and Discover are accepted).

On extensive treatment (i.e. surgery), you may discuss with our billing department the option of a payment schedule.

**Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, and any payments or credits applied to your account during the month. Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within 30 days.

**Re-billing Fee:** A re-billing fee of \$10 will be imposed on each account that is over sixty (60) days past due. We determine your account is past due by taking the balance owed sixty (60) days ago, and then subtracting any payments or credits applied to the account during that time.

**Returned checks:** There is a fee (currently \$25) for any checks returned by the bank.

**Past due accounts:** If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency or attorney, we will do so.

**FEM Centre**  
**Joseph McWherter, M.D., P.A. and Associates**  
709 West Leuda, Fort Worth, TX 76104  
6221 Colleyville Blvd., Suite 150, Colleyville, TX 76034  
[www.femcentre.com](http://www.femcentre.com)

**Waiver of confidentiality:** You understand if this account is submitted to a collection agency or attorney, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

**Divorce:** In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

**Co-signature:** If another person signs this or another Financial Policy, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

**Effective Date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's name: \_\_\_\_\_

Responsible party  
(if not the patient): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Co-Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FEM Centre**  
**Joseph McWherter, M.D., P.A. and Associates**  
709 West Leuda, Fort Worth, TX 76104  
6221 Colleyville Blvd., Suite 150, Colleyville, TX 76034  
[www.femcentre.com](http://www.femcentre.com)

## Disclosure of Patient Information

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

---

---

---

---

Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

Name _____	Phone # _____
Name _____	Phone # _____

Please print the telephone number where you want to receive calls about your appointments, lab, and x-rays results, or other health care information if other than your home or work number (such as a cell phone number\*): \_\_\_\_\_

\* I am fully aware that a cell phone is not a secure and private line.

Patient name \_\_\_\_\_  
Please print

\_\_\_\_\_  
Patient/Guardian signature

Date \_\_\_\_\_

**FEM Centre**  
**Joseph McWherter, M.D., P.A. and Associates**  
709 West Leuda, Fort Worth, TX 76104  
6221 Colleyville Blvd., Suite 150, Colleyville, TX 76034  
[www.femcentre.com](http://www.femcentre.com)

## **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.

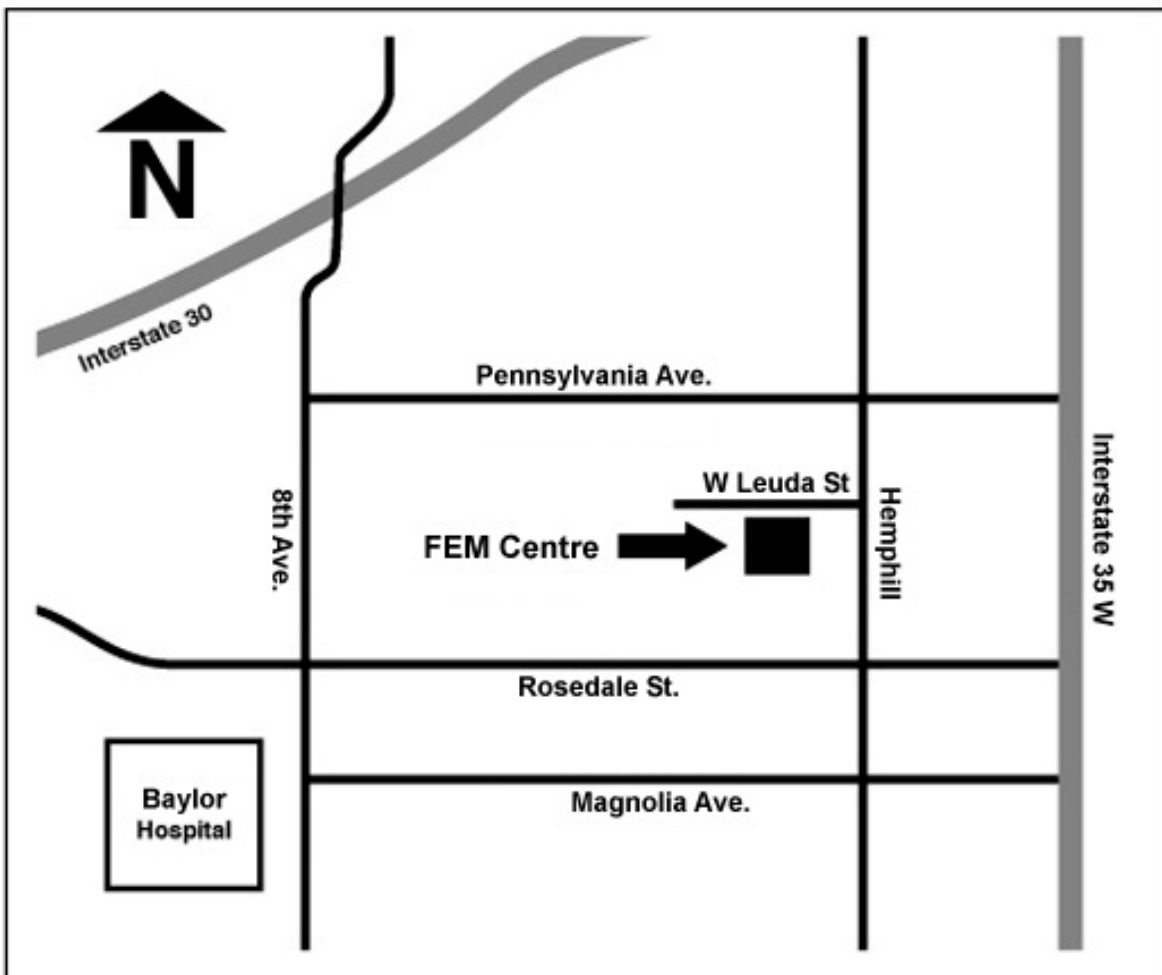
\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

**FEM Centre**  
**Joseph McWherter, M.D., P.A. and Associates**  
709 West Leuda, Fort Worth, TX 76104  
6221 Colleyville Blvd., Suite 150, Colleyville, TX 76034  
[www.femcentre.com](http://www.femcentre.com)

## Locating FEM Centre – Fort Worth

Our office is located in a freestanding building at 709 West Leuda, three blocks north of Rosedale off Hemphill in Fort Worth, Texas. The map below shows you can reach our office from Interstate 35 by taking the Rosedale exit and going west to Hemphill.



**FEM Centre**  
**Joseph McWherter, M.D., P.A. and Associates**  
709 West Leuda, Fort Worth, TX 76104  
6221 Colleyville Blvd., Suite 150, Colleyville, TX 76034  
[www.femcentre.com](http://www.femcentre.com)

## Locating FEM Centre – Colleyville

Our office is located in the Colleyville Square Office Park in Colleyville, Texas. The map below shows you can reach us from:

- Highway 114: take the Ira E. Woods Ave. (Hwy. 26) exit south. Woods Ave. becomes Colleyville Blvd. when you enter the city of Colleyville. The Colleyville Square Office Park is 4 miles south of Highway 114 on your left.
- Highway 121: take the Hall-Johnson exit west to Colleyville Blvd., turn north and the Colleyville Square Office Park will be on your right.
- Northeast Loop 820: Take the Grapevine Highway (Hwy. 26) exit north. Grapevine Highway becomes Colleyville Blvd. when you enter Colleyville. The Colleyville Square Office Park is 6 miles north of Loop 820 on your right.

Our office is in Suite 100 at the northwest corner of the office park facing Colleyville Blvd.

