Dr. Michelle Chouteau
Dr. Jo Bess Hammer
2911 Medical Arts St, Ste 19
Austin, TX 78705
512-477-1954-Phone 512-477-1383-Fax

Last Name ______________________
First Name ______________________ MI ____
Address ______________________
City ______________________
State ______________________
Zip ______________________
Home Phone ______________________
Cell Phone ______________________
Work Phone ______________________
PCP on Card ______
Referring Provider ______________________
Physician for this Office
____

Date of Birth ______________________
Gender: Male Female
Marital Status S M Sep D W
Social Security # ______________________
Employer Name ______________________
Employment Status: FT PT R U
Student Status: FT PT N/A
If Under 18 Responsible Party for Bill:
Responsible Name ________
Responsible Address ________
Responsible City ______________________
Responsible State/Zip ______________________
Responsible Phone number ______________________

If OB patient, Child's Pediatrician ______________

Holder of Insurance

Last Name ______________________
First Name ______________________ MI ____
DOB ______________________
Social Security # ______________________
Gender: Male Female
Phone ______________________
Relation of patient to holder of insurance:
Child Spouse Parent Other

Emergency Contact

Last Name ______________________
First Name ______________________ MI ____
Relation ______________________
Address ______________________
City ______________________
State/Zip ______________________
Home Phone ______________________
Work Phone ______________________

Insurance: give cards to receptionist

Primary Insurance ______________________ Secondary Insurance ______________________
________No Insurance: Self Pay

Local Pharmacy:
Name ______________________
Address ______________________

Mail Away Pharmacy:
Name ______________________
Address ______________________

Patient email address ______________________
Patient's Race _
Patient's Ethnicity: Hispanic Non-Hispanic
Patient's Language: English Spanish Other: ______________
How did you hear about us:
Family Friend Neighbor Insurance Article Yellow Pages Advertising Other ______________
Best Way to Contact you:
Home Phone Cell Phone Text Letter Email

Reason for visit: ____

Current Medications & Supplements
Including OTC and dosages

____
____
____
____
____

Drug Allergies

____
____

Hospitalization or Surgery

Reason/Type of Surgery	Date	Reason/Type of Surgery	Date

Medical History **Check all that apply:**

- ❑Headaches
- ❑Shortness of Breath
- ❑Heart Palpitations
- ❑Heart Murmur
- ❑Chest pain
- ❑Dizziness/Fainting
- ❑Heartburns
- ❑Allergies/Hay fever
- ❑Asthma
- ❑Bloody, Tarry Stools
- ❑Bruises easily
- ❑Ulcer
- ❑Hypertension (high blood pressure)
- ❑Gallbladder disease
- ❑Cancer Type________
- ❑Bowel irregularity
- ❑Incontinence
- ❑Diabetes
- ❑Frequent UTI
- ❑Hepatitis
- ❑Anemia
- ❑Arthritis
- ❑Osteoporosis
- ❑Depression
- ❑Kidney Stones
- ❑Thyroid Disease

Gynecological History

Have you had a pap smear in last two years? Yes _ No _ When?______
Have you ever had an abnormal pap? Yes _ No _
At what age did you start your first period?_______Are you still menstruating? Yes _ No _
Date of LMP?_____________ Are your periods? _Regular _Irregular
Do you have cramping? Yes _ No _ Headaches? Yes _ No _
Do you currently use birth control? Yes _ No _ Method? _______________
Have you ever been treated for any of the following?
_ Vaginosis _Genital Warts _ Chlamydia _HPV _ Herpes _Trichomoniasis _ Gonorrhea _Syphilis
Are you sexually active? Yes _ No _ Have you had more than 5 partners? Yes____No
Did you begin sexual activity before you were 16 years of age? _ Yes _ No
Do you examine your breast regularly? Yes _ No _
Have you had a mammogram in last year? Yes _ No _ Where?_______Normal? Yes _ No _
Have you had a bone density in last year? Yes _ No _ Where?________Normal? Yes _ No _
Have you had a colonoscopy? Yes _ No _ Where?________Normal? Yes _ No _
Did your mother take DES during pregnancy with you? Yes _ No _
Are you HIV positive? _ Yes _ No

OB History

Total Pregnancies	Full term	Premature	AB induced	AB Spontaneous	Ectopic	Multi Birth	Living

Please complete the following information about your past pregnancies:

Date	GA Weeks	Length of Labor	Birth Wt	Sex M/F	Type of Delivery	Anesthesia	Place of Delivery	Preterm Labor Y/N

Family History: **Check if applies**

	Father	Mother	Father's parents		Mother's parents		Siblings	Children
			Grandmother	Grandfather	Grandmother	Grandfather		
Heart Disease								
High Blood Pressure								
Stroke								
Cancer, Type:								
Glaucoma								
Diabetes								
Epilepsy/Convulsion								
Bleeding Disorder								
Kidney Disease								
Thyroid Disease								
Mental Illness								
Osteoporosis								

Habits:

Alcohol: Type__________________Amount____________________________________

Do you wear a seat belt? Have you been a victim of domestic abuse: _

Do you use recreational drugs?____________

Have you smoked in the past? ____________ If yes, How long since quitting/__________________

Do you currently smoke:________; if yes, Packs daily______How long?___________Interested in stopping?________

Coffee: Cups daily______Other caffeine____

Exercise routine:____

How often:____

Have you had any of the following symptoms in the last 30 days?

❑Weight Loss ❑Weight Gain ❑Fever ❑Fatigue ❑Weakness
❑Dizziness ❑Short of Breath ❑Leg Swelling ❑ Irregular Pulse ❑ Chest Pain
❑Wheezing ❑Short of Breath ❑Cough ❑Difficulty Breathing
❑Abdominal Pain ❑Difficulty Swallowing ❑Diarrhea ❑ Bloody Stool
❑Nausea ❑Vomiting ❑Constipation ❑Heartburn
❑Bloating/belching ❑Blood in urine ❑Pain with urination ❑Urgency
❑Frequency ❑ Incontinence ❑Nocturia
❑Breast Pain ❑Nipple Discharge ❑ Lump
❑ Eating Disorder ❑Mental/physical Abuse ❑Anxiety ❑Depression
❑Crying ❑ Memory Loss ❑ Insomnia
❑Excessive Sweating ❑ Excessive Thirst ❑ Excessive Urination
❑Cold Intolerance ❑Heat Intolerance ❑Hot flashes
❑Bruises ❑ Bleeding ❑Enlarged Lymph Nodes ❑Varicose Veins
❑ Loss of Appetite

By signing below, I give Dr. Chouteau or Dr. Hammer permission to treat me. I also authorize payment of any medical services render to Dr. Chouteau or Dr. Hammer but I acknowledge that I am financially responsible for services. I have read and understand all office policies below.

______________________________ ____

Patient name *Date*

Medical Information Release Form
(HIPAA Release Form)

Name:___________________________________Date of Birth:_____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examinations and claims information.

This information may be released to:

[ ] Spouse____
[ ] Child(ren)______________________________________
[ ] Other____
[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my email address [ ] my cell Number:___________________
If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call
[ ] ____

The best time to reach me is (*day*)___________________between (*time*)__________

Signed:______________________________________Date:____/____/_____

Witness:______________________________________Date:____/____/______

Welcome to the offices of Dr. Michelle Chouteau and Dr. Jo Bess Hammer. The following is a list of guidelines for our practice.

Phone calls:
Our phones are answered Monday thru Friday from 8 am until 12 noon and from 1:15 pm to 5:00 pm. Please listen to the prompts carefully to direct your call to the appropriate staff member. If during non business hours you have an emergency or need to speak with the doctor on call please call our after-hours number at 458-1121. A true emergency is defined as the onset of labor, post-op complications, severe pain, high fever, intractable vomiting, or bleeding during pregnancy.
If you must leave a message during normal business hours, please leave your first and last name, date of birth, a brief message and a return phone number. All calls received before 4:00pm will be returned the same business day.
You may also send a secure message through our patient portal. These messages are checked several times during the day and will be followed-up on the same business day. The portal messages are for non-emergency messages only.
Test results are posted to the patient portal. Please ask at the front desk for instructions to sign up for the patient portal. Test results are posted 5-7 business days. Our website is www.drchouteau.com or www.drjohammer.com.

Appointments:
Dr. Hammer sees patients Monday, Wednesday and Thursday mornings from 9 -11 am and Tuesday afternoons from 1:15 until 3:00 pm.
Dr. Chouteau sees patients Mondays from 1:15pm until 5:00pm, Tuesday from 8:15 am until 11:00 am Wednesday and Thursdays from 1:15 until 4:15 pm and Fridays from 8:15 until 4:15 pm.
As a courtesy, to our other patients we ask that you be on time for your appointment and to call if you need to cancel or reschedule. Dr. Chouteau may be called away during normal clinic hours; we will try to keep you informed if she is running late.

Refills
We now electronically prescribe all medications; we ask that you call your pharmacy to request a refill. Please allow at least 2 business days for refills. On call doctors do not refill routine medications. Please keep the office updated with your current pharmacy information.

Required forms
Dr. Chouteau will be glad to complete all FMLA and Disability Forms for you. We will complete one form free of charge all other forms there will be a $10 charger. Please allow 3-5 business days for our office to complete these forms.

Medical Records
All recent labs, and visit summaries are available on our secured patient portal. If you wish other records released a HIPPA required release can be found under office forms on our website. Records released to the patient, other insurance companies or attorneys will be assessed a fee of $35 payable prior to the release. A fax number or email address is required to send medical records.

Financial policies
We file all claims with your insurance company. All copays and fees are due at time of service. All estimated co-insurance for elective surgery are due prior to your scheduled surgery date. All estimated OB co-insurance is due no later than your 32nd week of pregnancy.
We try to accommodate all needs and request of our patients; however, it is not possible for us to know benefits for all individual insurance plans or drug formulary. Please contact your insurance company if you have any questions regarding copays, providers, or medication cost.