BHRT CHECKLIST FOR WOMEN

Name: _____ **Date:** _____

E-Mail Address: _____

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Depressive mood (feeling down/sad/lack of drive)				
Memory Loss (forgetfulness)				
Mental confusion (feeling in a mental fog)				
Decreased sex drive/libido (decreased desire for sex)				
Sleep problems (difficulty falling/staying asleep/wake up tired)				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Other symptoms that concern you:

Rebecca L. Dorsett, M.D.

1101 Satellite View
Suite 304
Round Rock, TX 78665

Phone (512) 733-5800
Fax (512) 377-1180

BOARD CERTIFIED IN OBSTETRICS AND GYNECOLOGY

Board Certified in Obstetrics & Gynecology

U P D A T E T O H I P A A / R E G I S T R A T I O N

PLEASE FILL OUT ALL FIELDS. **VALID FOR 1 YEAR FROM DATE OF SIGNATURE**

Today's Date: _____

Printed Patient's Name: _____

e-mail address_____

Primary Care Physician: _____
First & Last name please!

I understand the HIPAA rights, and understand my physician follows the HIPAA direction as written in the Kennedy-Kassellbahum Act of 1996.

Has your address changed in the past 12 months? _____yes _____no

If yes: _____

_____

Has your insurance changed? Company: yes___no____
ID#_____yes____no____

*****Please list your current phone numbers: ***May we leave a message on these phone numbers? Yes or No *** Please check preferred******

- **Home: (____) _____**
- **Work: (_____) _____ (Ext)_____**
- **Cell: (_____) _____**

Emergency Contact_____Phone_____

What Pharmacy do you use most often:_____Location:_____

Patient Signature:_____Date:_____

UPDATE REQUIRED BY TEXAS HEALTH & HUMAN SERVICES DEPARTMENT

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AUTHORIZATION FOR VERBAL RECORDS RELEASE

I, _____, authorize the office staff and/or Rebecca L. Dorsett, M.D. to release any or all of my medical information to the following individuals:

SPOUSE/PARENT Release / Do Not Release

Full Names: _____

_____

PHYSICIANS BEING REFERRED TO: Release / Do Not Release

MEDICAL FACILITIES: Release / Do Not Release

CURRENT EMPLOYERS: Release / Do Not Release

OTHERS: Release / Do Not Release

Specify:_____

Signature of Patient:_____ Date:_____

Witness:_____ Date:_____

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Dear Patient.

I am happy to announce that we have a new EMR system and will now be able to communicate with you via email, text message and voice mail. We will be using this to remind you of your appointments, help you with prescription refills, and give you lab results and educational material. Soon we will have a patient portal where you can access your medical information.

Printed Patient Name: _____

Email address: _____

Preferred phone # for text messages and voicemail: _____

Preferred time to call: morning afternoon evening

Thank you.

Rebecca L. Dorsett, M.D.