PATIENT INFORMATION & AUTHORIZATION

This form is confidential. We appreciate your cooperation in completing this form thoroughly.

Patient Demographics

Patient's Name: ______________________________

Address: ___________________________________

City: _________________ State: ____ Zip: ________

Email Address: ______________________________

Employer: __________________________________

Employer's Address: ___________________________

City: _________________ State: ____ Zip: ________

Referred by: ________________________________

Date of Birth: ________________________________

SS#: _______________________________________

Occupation: _________________________________

□ Home Phone: (_____)_________________________

□ Cell Phone (_____)___________________________

□ Work Phone (_____)__________________________

Please check which phone you would prefer to receive calls.

Okay to leave messages? Yes No

Spouse or Responsible Party

Name: ____________________________________

Address: ___________________________________

City: _________________ State: ____ Zip:________

Employer: __________________________________

Employer's Address: ___________________________

City: _________________ State: ____ Zip: ________

Relationship to Patient: _______________________

Date of Birth: ________________________________

SS#: _______________________________________

Occupation: _________________________________

Telephone (___)__________Which type: ___________

Work Phone (____)_____________________________

Emergency Contact

Name: ____________________________________

Address: ___________________________________

City: _________________ State: ____ Zip:_________

Relationship to Patient: _________________________

Telephone (____)_______________________________

Authorization

A. I authorize my physician to discuss all aspects of my medical condition and treatment with the following person(s). I understand that I can rescind this authorization at any time by submitting a written request.

Name: ____ Relationship: ____________________________

Name: ____ Relationship: ____________________________

B. I authorize and consent to treatment of the minor child.

Signature of Parent or Guardian: ___________________________ Relationship: ____________________________

C. Co-payments are always due at the time services are rendered. We are happy to bill your insurance for services; however, the patient or the patient's responsible party is ultimately responsible for payment of any medical services rendered. **I authorize the payment of medical/surgical benefits to the physician. I acknowledge that I am responsible for payment of all charges.**

Signature: ____ Date: _________________________________

PATIENT INFORMATION

Name: ____ Date of Birth:__________________

Marital Status:

☐ Single ☐ Decline to Answer

☐ Married ☐ Separated

☐ Divorced ☐ Widowed

☐ Domestic Partner ☐ Other: _______________________________________

Religion: ____

Race:

☐ American Indian ☐ Pacific Islander

☐ Alaska Native ☐ Two or more races

☐ Asian ☐ White

☐ Black / African American ☐ Unknown

☐ Middle Eastern ☐ Decline to respond

☐ Native Hawaiian ☐ Other: _____________________________________

Ethnicity:

☐ Cambodian ☐ Mexican, Mexican American, Chicano/a ☐ Non-Hispanic

☐ Cuban ☐ Other Hispanic, Latino/a or Spanish origin ☐ Unknown

☐ Filipino ☐ Puerto Rican ☐ Decline to respond

☐ Other: ____

FINANCIAL POLICY

We are committed to providing you with the best possible care and are happy to discuss our professional fees and payment policies with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibilities.

Payment and Insurance
Together we can work collaboratively to keep healthcare costs down.

If you are enrolled in an HMO, you must provide the required prior authorization at your scheduled appointment. Should there be a remaining balance after the insurance payment, you will receive a statement. You are responsible for the timely payment of your account.

Insurance is a contract between you and the insurance company. As a party to your insurance contract, we will handle your claims according to our agreement with your insurance company. We will not get involved in disputes between you and your insurance company regarding deductibles, co-payments, non-covered services, secondary insurance, etc.

It is your responsibility to know the details of your health plan. Some insurance plans do not cover certain procedures. If you are in doubt as to whether a procedure, lab test, or x-ray is covered or unsure as to where it must be performed, please call your plan's member services department to clarify.

Full payment is due at the time of services, but if you are enrolled in a non-contracted insurance plan we will bill them as a courtesy for you if you provide us your current enrollment information. For patients paying cash, we require payment in full at the time of service.

- We accept cash, check, debit card, and all major credit cards.
- If your check is returned for non-sufficient funds (NSF), we will add a service charge to your account.

Financial Hardship
If you are having financial difficulty, our business office will be happy to work with you. If we establish a payment plan, we ask that payments be made as scheduled, each month and on time.

Tests and Surgery Charges
If your visits include laboratory tests, radiology, biopsies, pap smears, or cultures, you will receive separate billings from the company performing the processing and evaluation of those tests, e.g. Hoag Imaging, LabCorp, Quest, etc.

Prior to a surgery, we will obtain insurance coverage information and determine what portion, if any, of the fee will be your responsibility. You will be required to pay a percentage of that portion prior to surgery. If your insurance pays more than the balance due, we will refund your prepaid portion.

Cancellations & No-Shows
Please keep the appointments you have requested. We have reserved that time for you in order to take care of your healthcare needs. If you miss an appointment and do not reschedule, you run the risk that your physician will not be able to detect and treat a serious health condition. Please call us at least 24 hours prior to your appointment if you need to reschedule. This helps us fill your spot with another patient in need of an appointment. If you do not notify us you may be charged a $50 fee. This fee is not covered by insurance carriers and will be your responsibility. If you fail to call us to reschedule your appointment, you will be considered a no-show. You will be charged the $50 fee. If you have three no-shows, this may result in dismissal from our practice.

I have read and understood the above information. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for all services rendered.

Patient Name: ______________________________ Responsible Party: ____________________________

Signature: ________________________________ Date: _______________________________________

NOTICE OF PRIVACY PRACTICES

The Practice reserves the right to modify the privacy practices outlined in this notice.

I have received a copy of the Notice of Privacy Practices to read.
I understand that if I wish to keep a copy, I will receive one upon request.

____
Name of Patient

____
Signature of Patient

____
Date

____
Signature of Patient Representative
(Required if patient is a minor or an adult who is unable to sign.)

____
Relationship of Representative

Documentation of Attempt to Obtain Acknowledgement of Receipt of Privacy Practices

An attempt was made to obtain an acknowledgement of the Notice of Privacy Practices on ____________.
The Acknowledgement was not obtained because:

□ The patient was undergoing emergency treatment.

□ The patient declined to sign the acknowledgement.

□ Other ____

Name of Patient: ____

Name of Staff Member: ____

Signature of Staff Member: ______________________________ Date: ________________

HEALTH QUESTIONNAIRE

Today's Date: ______________

Date of Last Menstrual Period: ______________

Patient Demographics

Name: ____ Date of Birth: ________________________

Referred by: ____

Reason for visit: ____

Current Medications- Including supplements, vitamins, herbal products, and over-the-counter medication

EXACT NAME OF DRUG	DOSAGE & FREQUENCY	PRESCRIBING PHYSICIAN	EXACT NAME OF DRUG	DOSAGE & FREQUENCY	PRESCRIBING PHYSICIAN

Please list additional medications on the back of this paper or attach a separate sheet.

Preferred Pharmacy

Address: ________________________ City: ____________________ Cross Streets: __________________________

Mail Order: ____

Allergies

DRUG/SUBSTANCE	REACTION	DRUG/SUBSTANCE	REACTION

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

Social History

Tobacco Use:

Current Everyday Smoker **Current Some Day Smoker** **Former Smoker** **Passive Smoker** **Never Smoker**

Type: **Cigarettes** **Pipe** **Cigars** **Snuff** **Chew**

Pack(s)/day: __________________ Years: ____________ Quit Date: _______________________

Do you drink alcohol? **Yes** **No** How many drinks per week? ______________________

Do you use drugs socially? **No** **Yes** Use/week: ______________________

Type: **IV** **Inhalant** **Pills** **Topical** **Marijuana** **Cocaine** **Meth** **Heroine** **Other:** ______________

Patient Name: Date of Birth:

Are you sexually active? **Yes** **Not Currently** **No** Sexual partners: **Men** **Women** **Both**
What method of contraception are you currently using? ___________________________________
What methods of contraception have you previously used (please include name of pills):
____

Activities of Daily Living

Are you on a special diet? **Yes** **No** If 'yes,' please explain: _______________________________
Do you exercise regularly? **Yes** **No** How many times per week? __________________
Do you do self breast exams? **Yes** **No** How often? _____________________

Socioeconomic

Occupation: ____________________________ Employer: _______________________________
Spouse/Partner's Name: __________________________________ # of children: _____________
(Include step and adopted children)
Education: **High School** **Some college** **AA Degree** **Bachelor's Degree** **Graduate Degree** **Other:** _______________

Relevant Dates

Date of last Pap Smear: ________ Was it normal? **Yes** **No** If 'no,' please explain: _______________
Date of last mammogram: __________ Was it normal? **Yes** **No** If 'no,' please explain: ____________
Have you had a bone density study? **Yes** **No** Date: __________ Result: _____________________
Have you had a colonoscopy? **Yes** **No** Date: ___________ Result: _________________________

Past Medical History

ILLNESS	YES (DATE)	NO	NOTES
Asthma			
Pneumonia/Lung Disease			
Kidney Infections/Stones			
Tuberculosis			
Fibroids			
Hypertension			
Elevated Cholesterol			
Eating Disorder			
Autoimmune Disease (Lupus)			
Chickenpox			
Cancer			
Reflux/Hiatal Hernia/Ulcers			
Migraine Headaches			
Hepatitis			

ILLNESS	YES (DATE)	NO	NOTES
Anemia			
Blood Transfusions			
Heart Disease			
Bowel Problems			
Seizures/Convulsions/Epilepsy			
Depression/Anxiety			
Glaucoma			
Bladder Problems			
Bleeding Disorders			
Diabetes			
Arthritis/Fibromyalgia			
Thyroid Problems			
Other:			

Do you accept blood transfusions? **Yes** **No**

Patient Name: Date of Birth:

Operations and Medical Procedures *Include colonoscopies*

REASON	DATE	RESULTS

Family History

Are you adopted? **Yes** **No**
Does anyone related to you have a history of the following illnesses?

ILLNESS	YES	RELATIVE (Ex. Maternal Aunt)	AGE OF ONSET	ILLNESS	YES	RELATIVE (Ex. Maternal Aunt)	AGE OF ONSET
Alcohol/ Drug				Elevated Lipids			
Anesthesia Problems				Genetic			
Arthritis				Gastrointestinal			
Birth Defects				Heart			
Blood clots in lungs/legs				Hypertension			
Blood Disorder				Osteoporosis			
Cancer:				Psychiatry/Mental Illness/Depression			
Breast				Pulmonary			
Colon				Renal			
Ovarian				Stroke			
Uterine				Tuberculosis			
Diabetes				Thyroid			
Other:							

Obstetrical History

Pregnancy History: **Never been pregnant** **Currently pregnant** **# of times you have been pregnant before?** _____
Number of: **Vaginal deliveries:** _____ **C-sections:** _______ **Miscarriages:** _______ **Ectopic pregnancies:** _______
Elective abortions: _______ **Premature births:** _______ **Stillbirths:** _______

Date of Delivery	Gest. Age	Labor Lngth.	Wt.	Sex	Delivery Type (Vag., C-section)	Anesth. Type (Epidural, Spinal)	Name	Location	MD

Any pregnancy complications? **Yes** **No** If 'yes,' please explain: ________________________________
Any history of depression before or after pregnancy? **Yes** **No** How was it treated? _________________

Patient Name: Date of Birth:

Menstrual History

Age periods began: _______ Menstrual periods come every _______ days and last for _______days.

Period pattern is: **Regular** **Irregular** Menstrual flow is: **Light** **Moderate** **Heavy**

Do you have pain with periods? **No pain** **Mild** **Moderate** **Severe**

Pain symptoms: **Cramping** **Throbbing** **Nausea** **Diarrhea** **Headache** **Other:** ________________________

Do you have premenstrual symptoms (PMS)? **Yes** **No** ____

Gynecological History

Have you ever had an abnormal Pap? **Yes** **No** If 'yes,' explain: ________________________________

Have you ever had a sexually transmitted disease? **Yes** **No** ___________________________________

Have you been treated for infertility? **Yes** **No** ____

Do you have any urinary problems? **No** **Loss of urine** **Frequent urination** **Other:** ___________________

Do you have pain with sexual relations? **Yes** **No** ____

Do you have recurrent vaginal infections? **Yes** **No** ____

IF Menopausal:

When did you stop having periods? ____________________

Have you used/taken hormone replacement? **Yes** **No** If 'yes,' what type, dose, and when? __________

____

Have you had any vaginal bleeding since menopause? **Yes** **No** When and how much? ______________

Do you have...

Hot flashes?	**Yes**	**No**	Decreased libido?	**Yes**	**No**
Night sweats?	**Yes**	**No**	Anxiety?	**Yes**	**No**
Trouble sleeping?	**Yes**	**No**	Depression?	**Yes**	**No**
Decreased memory?	**Yes**	**No**	Vaginal Dryness?	**Yes**	**No**

Optional

Have you been physically or mentally abused by your spouse or partner? **Yes** **No**

Have you ever been sexually abused or raped? **Yes** **No**

Do you have any other questions or concerns?

____

____

____

____

Patient Name: Date of Birth:

Please circle any symptoms you have experienced in the last month.

CONSTITUTIONAL
Unexplained weight loss
Unexplained weight gain
Fever
Fatigue

EYES
Double vision
Spots before eyes
Vision changes

EAR / NOSE / THROAT / MOUTH
Ear aches
Ringing in ears
Sinus problems
Sore throat

RESPIRATORY
Wheezing
Shortness of breath
Chronic cough

CARDIOVASCULAR
Chest pain
Difficulty breathing on exertion
Heart palpitations

GASTROINTESTINAL
Frequent diarrhea
Blood in stool
Nausea / vomiting
Constipation
Black / tarry stool

GENITOURINARY
Blood in urine
Pain w/ urination
Leaky urine
Urgency
Frequency of urination
Vaginal discharge
Heavy periods
Painful periods
Irregular vaginal bleeding
Painful intercourse
Vaginal itching / irritation

BREASTS / SKIN
Pain in breasts
Nipple discharge
Breast mass
Skin rash or lesion

HEMATOLOGICAL/ LYMPHATIC
Frequent bruises
Cuts do not stop bleeding
Enlarged lymph nodes

MUSCULOSKELETAL
Muscle weakness
Joint pain

NEUROLOGICAL
Dizziness
Frequent headaches
Significant memory problems

PSYCHIATRIC
Depression
Frequent crying
Anxiety

ENDOCRINE
Dry skin
Abnormal thirst
Hot flashes

ALLERGIC/IMMUNOLOGIC
Environmental allergies
Hives

The Patient Health Questionnaire-2 (PHQ-2)

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

We appreciate the time and effort you have taken to complete this questionnaire.
Thank you!