Minal Mehta, M.D. A Professional Corporation
Diplomate, American College of Obstetrics and Gynecology
18111 Brookhurst Street, Suite 4450, Fountain Valley, CA 92708
Phone: (714) 848-2383
Facsimile: (714) 848-4083

# PATIENT INFORMATION FORM

This information is confidential. We appreciate your cooperation in filling out this form as completely as possible.

Please Print Clearly

Your Full Name: _____ Date: _____

Home Address: _____ City/State/Zip: _____

Phone: Home: _____ Work: _____ ext: _____

Mobile: _____ E-Mail: _____

Birthdate: _____ Age: _____

Married: _____ Single: _____ Widowed: _____ Divorced: _____ Separated: _____

Social Security #: _____ Drivers License #: _____

Who referred you to us?: _____

Your Employer: _____ Occupation: _____

Your Work Address: _____ City/State/Zip: _____

Insurance Company: _____ ID#: _____ Group#:_____

Race/Ethnicity: _____ Language: _____

Spouse/Insured's information:

Name: _____ Relationship: _____

Home Address: _____ City/State/Zip: _____

Birthdate: _____ Age: _____

Social Security #: _____ Occupation: _____

Employer: _____ Phone: _____

Work Address: _____ City/State/Zip: _____

Medical Insurance: _____ ID #: _____ Group #: _____

Person to contact in case of emergency: _____ Phone: _____

Relationship to the patient: _____

I/We hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to Dr. Minal Mehta. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original. I understand that I am financially responsible for all charges to services rendered me whether or not paid by said insurance or in the event I am not eligible for insurance. I hereby authorize and assign to release all information necessary to secure payment.

_____ _____

Signature Date

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# GYNECOLOGY HEALTH HISTORY

PATIENT IDENTIFICATION (Please Print)

Patient's Name: _____
Address: _____
_____
Home Phone: ( ) _____
Work Phone: ( ) _____
Reason for Seeing Doctor_____

Date of Birth: _____ / _____ / _____ Age: _____ Religion: _____
Martial Status: ☐ S ☐ M ☐ D ☐ SEP ☐ W Race: _____
Education: _____ years Occupation: _____
Employer: _____
Type of Insurance: _____ Policy #: _____
Referring Physician: _____
Primary Physician: _____

**1. CURRENT MEDICATIONS** ☐ None

_____
_____
_____

**2. MEDICATION ALLERGY / SENSITIVITY**

List all medications allergic to: ☐ None

_____
_____
_____

**MEDICAL HISTORY** *(Check the appropriate box)*
Have you or any members of your family had:

| | | You | Your Family |
|---|---|---|---|
| **3.** | High Cholesterol | ☐ | ☐ |
| **4.** | Heart Disease | ☐ | ☐ |
| **5.** | Rheumatic Fever | ☐ | |
| **6.** | High Blood Pressure | ☐ | ☐ |
| **7.** | Asthma | ☐ | |
| **8.** | Tuberculosis | ☐ | |
| **9.** | Diabetes | ☐ | ☐ |
| **10.** | Thyroid Problems | ☐ | ☐ |
| **11.** | Liver Disease | ☐ | |
| **12.** | Stomach, Bowel or Gall Bladder Problems | ☐ | |
| **13.** | Kidney or Bladder Problems | ☐ | |
| **14.** | AIDS (HIV) | ☐ | ☐ |
| **15.** | Hepatitis (type ____) | ☐ | ☐ |
| **16.** | Anemia or Blood Disorder | ☐ | ☐ |
| **17.** | Blood Transfusion | ☐ | |
| **18.** | Allergies | ☐ | |
| **19.** | Breast Problems | ☐ | ☐ |
| **20.** | Cancer | ☐ | ☐ |
| **21.** | Infertility | ☐ | |
| **22.** | Female or Sexual Problems | ☐ | |
| **23.** | Chlamydia | ☐ | |
| **24.** | Gonorrhea | ☐ | |
| **25.** | Herpes (HSV) | ☐ | |
| **26.** | Syphilis | ☐ | |
| **27.** | Birth Defects or Inherited Diseases | ☐ | ☐ |
| **28.** | Sexual Abuse or Domestic Violence | ☐ | ☐ |
| **29.** | Other Medical Problems | ☐ | ☐ |
| **30.** | **No Known Medical Problems** | ☐ | ☐ |

**37. PREGNANCY HISTORY** *(Complete All Information)*

| # of Pregnancies | # of Premature Births | # of Miscarriages | # of Spontaneous Abortions | # of Induced Abortions | # of Living Children |
|---|---|---|---|---|---|
| | | | | | |

| # of Term Births | Born Month/Year | Baby's Sex | Weight at Birth | Weeks Pregnant (Term – 40Wks) | Hours In Labor | Type of Delivery | Type of Anesthesia | Complications Yes | Complications No |
|---|---|---|---|---|---|---|---|---|---|
| 1 | / | | lbs. oz. | | | | | ☐ | ☐ |
| 2 | / | | lbs. oz. | | | | | ☐ | ☐ |
| 3 | / | | lbs. oz. | | | | | ☐ | ☐ |
| 4 | / | | lbs. oz. | | | | | ☐ | ☐ |
| 5 | / | | lbs. oz. | | | | | ☐ | ☐ |

**38. MENSTRUAL HISTORY**

First Day of Last Menstrual Period _____ / _____ / _____

| Menarche (Age at First Period) | Interval (No. of Days Between Periods) | Length of Period |
|---|---|---|
| Years | Days | days |
| | | |

Abnormalities: ☐ Excessive Bleeding
☐ Discharge ☐ Pain ☐ None

**39. CONTRACEPTIVE HISTORY**

| Type | Dates Used |
|---|---|
| Oral Contraceptive Type(s) | ☐ _____ |
| IUD | ☐ _____ |
| Diaphragm | ☐ _____ |
| Norplant | ☐ _____ |
| Sponge | ☐ _____ |
| Spermicide | ☐ _____ |
| Condoms | ☐ _____ |
| Other | ☐ _____ |

Sterilization ☐ Male ☐ Female

**LIFESTYLE**

| | Yes | No |
|---|---|---|
| **40.** Did your mother take DES or any other hormones when pregnant with you? | ☐ | ☐ |
| **41.** Have you ever had a Pap test? If Yes: Date of your last Pap test? _____ / _____ / _____ Have you ever had abnormal Pap test results? | ☐ | ☐ |
| **42.** Are you sexually active? | ☐ | ☐ |
| **43.** Do you have one partner or many partners | ☐ | ☐ |
| **44.** Is intercourse painful for you? | ☐ | ☐ |
| **45.** Do you do a monthly self breast exam? | ☐ | ☐ |
| **46.** Have you ever had a mammogram? | ☐ | ☐ |
| **47.** Do you exercise on a regular basis? If Yes: Type of exercise Hours per week exercise | ☐ | ☐ |

Check and detail positive findings below. User reference numbers.

**31. HOSPITALIZATIONS** List those operations/serious illnesses that have required hospitalization. If more than six, check this box. Do not include pregnancies here.

| Month/Year | Illness or Operation | Complications Yes | Complications No |
|---|---|---|---|
| / | | | |
| / | | | |
| / | | | |
| / | | | |
| / | | | |
| / | | | |

**SUBSTANCE USE** *(Check only those you use)*

**32.** Alcohol ..... ☐
Type _____
Amt/Day _____

**33.** Tobacco ..... ☐
Type _____
Amt/Day _____

**34.** Caffeine ..... ☐
Type _____
Amt/Day _____

**35.** Non-Prescribed Drugs ..... ☐
Type _____
Amt/Day _____

**36.** Street Drugs ..... ☐
Type _____
Amt/Day _____

**Signature: _____**

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# PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Minal Mehta, M.D. A Professional Corporation may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Minal Mehta, M.D. A Professional Corporation's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Doctors of OGBYN reserves the right to revise it's Notice of Privacy at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer of Minal Mehta, M.D. at 18111 Brookhurst Street, Suite 4450, Fountain Valley, CA 92708.

With my consent, Minal Mehta, M.D. A Professional Corporation may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Minal Mehta, M.D. A Professional Corporation may mail to my home or other designated location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

By signing this form, I am consenting to Minal Mehta, M.D. A Professional Corporation's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Minal Mehta, M.D. A Professional Corporation may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Legal Guardian

_____ _____
Office Staff Signature Date

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# PAITENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Minal Mehta, M.D. A Professional Corporation to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below

This authorization permits Minal Mehta, M.D. A Professional Corporation to use or disclose to any laboratory, hospital, or other physicians or insurance company, the following individually identifiable health information (such as date(s) of service, level of detail to be released, origin of information, etc.): as it relates to my care at Minal Mehta, M.D. A Professional Corporation.

This authorization will expire on _____.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protect3ed by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Minal Mehta, M.D. has acted in reliance upon this authorization. My written revocation must be submitted to Minal Mehta, M.D. A Professional Corporation's Privacy Officer at 18111 Brookhurst Street, Suite 4450, Fountain Valley, CA 92708.

_____
Patient's Signature

_____ _____
Patient's Name (please print) Date

*Minal Mehta, M.D. OBGYN* *Phone (714) 848-2383*
*18111 Brookhurst St. #4450 Fountain Valley, CA 92708* *Fax (714) 848-4083*

# FINANCIAL POLICY

Thank you for choosing Dr. Mehta. We are committed to the success of your treatment. We hope you understand the payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read, agree to and sign, prior to any treatment. This financial policy applies to all services rendered by the doctor.

It is our policy that the patient, rather than the insurance company, is responsible for complete payment of our charges. All patients with insurance coverage are required to pay for non-covered services, any deductible amount not previously met and any copay amount due at the time of services are rendered. For patients with dual insurance coverage, we will bill both the primary and secondary insurance if you have provided us with the necessary information.

Patients insured with plans which we are **NOT contracted** with or **DO NOT have insurance** will be required to pay as a "Out of Pocket Patient" for the initial consultation in full. For any follow up visits, patients will need to pay accordingly. There may be 30% or more down payment prior to any surgery needed.

**For prescriptions,** if you are in need of a refill, please have your pharmacy fax a request to **714-848-4083**. (Please allow 48 to 72 hrs.) No pain medication will be given to post operative patients after 90 days of surgery. Our physician **DOES NOT** prescribe pain medications to chronic pain patients. Patients with chronic pain syndrome are referred to pain management specialists for long term management.

**FEES AND PAYMENTS**
Physicians share the concern of their patient regarding the increasing cost of medical care. Our fees are within the customary range for this area and reflect the high level of care you will receive. We have standardized charges for various procedures, but these can vary depending on unforeseen circumstances that might arise. If you have any questions about fees, we encourage you to discuss them with our business office. The fees for obstetrical care include all routine obstetrical care from your first visit through your prenantal care, your delivery and your post partum visit six weeks following delivery. If a cesarean birth is necessary there will be additional charges.

**ALL MEDICAL BILLS ARE DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED FOR CASH PATIENTS**
We accept payments by cash, personal checks, Mastercard and Visa. This will help control the expensive process of billing and collections. If your medical services are greater than anticipated, we will be happy to arrange a payment plan with you. If you are having financial difficulty, please contact our business office.

**INSURANCE**
Please remember that your insurance coverage is a contract between you and your insurance carrier. Please contact your insurance company to verify that your doctor is a provider with your insurance. If you wish to file an insurance claim, we will furnish you with an itemized statement of your services and diagnosis, if one is established, and you can forward this statement on to your insurance company. Payment for services rendered is expected at the time of each visit, regardless of your insurance coverage. In some cases, your insurance company will only cover a portion of our fees. Since our relationship is with you and not your insurance company, our bill is your responsibility. We would appreciate it if you would give it a prompt attention. We will be glad to help you if you have a problem with your claim.

**PPO INSURANCE**
If you are a member of a Preferred Provider Organization (PPO) and our office has signed a contract to provide services for your PPO, we will handle all the billing of your insurance. You MUST provide us with a copy of your insurance card at the time of service. You are REQUIRED to pay any co-payments at this time. If you require lab work it will be sent to an outside lab. Certain PPO's have contracts with specific labs. You will be given a referral slip and you may go to that lab for your test. If you do not ask for a referral, we will send your specimen to our usual lab and we WILL NOT be responsible for any outside lab fees that you may be charged. We realize this can be confusing and we will work with you in any way we can to maximize your insurance benefits.

**HMO INSURANCE**

If you are a member of a Health Maintenance Organization (HMO) and our physicians have signed a contract to provide services for your HMO, we will handle all the billing of your insurance services. Our doctors, in this practice, cannot be listed as you primary care physician. They are SPECIALISTS. You are required to pay any co-payments at the time of service. Please be aware that due to specific policies in HMO contracts, ALL LABS AND ULTRASOUNDS MUST be done outside our office to be covered.

Dr. Mehta has financial interests in certain facilities/companies she operates with. These include but are not limited to: CordTrack, Surgical Center of Irvine, and Memorial Care Surgical Center at Orange Coast.

There will be a fee of $100 for any surgery cancellation. These fees will offset the surgical preparations which are separate from the surgical facilities.

If you are insured with a plan, which we ARE contracted with (including Medicare), you will need to pay for any non-covered services, any outstanding deductible and your copay amount at time of each visit.

There is a fee of $25.00 or more for all disability, FMLA and any other forms/paperwork that you need to have filled out by the physicians. We may ask that you make an appointment to complete these forms.

There is a fee for any reports or medical records requested by attorneys, insurance companies, disability companies, etc… This charge will be determined by the information requested.

Our accepted methods of payment are VISA and MasterCard, cash and checks. There will be a $45 fee for any bounced checks, thereafter, patients are required to pay with “cash”. If requested a short payment schedule may be arranged for those patients who have special financial conditions.

It is the patient’s responsibility to verify their benefits for their particular plan and to make sure all proper authorizations have been obtained. Some insurance plans will reduce benefits if the insured is treating the doctors outside of the designated network or if the proper authorizations have not been obtained.

Again, thank you for trusting us with your gynecological and obstetrical care. If you have any questions regarding financial responsible or payment options, please contact our office.

_____ _____

Signature Date

*Minal Mehta, M.D. OBGYN* *Phone (714) 848-2383*
*18111 Brookhurst St. #4450 Fountain Valley, CA 92708* *Fax (714) 848-4083*

# Disability Form Policy

We require a one-time fee of $25.00 for all disability forms.

I have read the disability form policy and I understand that there is a fee for all disability forms.

_____
Date

_____
Signature

_____
D.O.B.

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# CANCELLATION POLICY

We require a 24 hour cancellation notice for all appointments. There will be a $25.00 charge for missed appointments unless you have notified the office in advance.

I have read the cancellation policy and I understand that there will be a charge for all missed appointments.

_____
Date

_____
Your Signature