BEACH OBSTETRICS & GYNECOLOGY MEDICAL GROUP

☐ 19582 Beach Blvd. • Suite 202 • Huntington Beach, CA 92648
☐ 500 Superior Avenue • Suite 330 • Newport Beach, CA 92663
Ph (714) 841.9899 • Fax (714) 841.2729

Primary Physician _____ **Pharmacy Phone #** _____

PATIENT INFORMATION

Name _____ Social Security # _____
Last Name First Name Middle Initial

Address _____ Drivers Lic # _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for____years

Race ☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian-Alaskan Native ☐ Other Race

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino **Preferred Language** ☐ English ☐ Other _____

Religion _____

Preferred method of contact: ☐ Cell Phone ☐ Home Phone ☐ Work Phone Email _____

Home Phone (_____) _____ Approval to leave message? ☐ Y ☐ N

Cell Phone (_____) _____ Approval to leave message? ☐ Y ☐ N

Work Phone (_____) _____ Approval to leave message? ☐ Y ☐ N

Patient Employer / School _____ Occupation _____

Employer / School Address _____ Employer / School Phone (_____) _____

Whom may we thank for referring you? _____

EMERGENCY CONTACT

Name: _____ Phone _____ Relationship _____

Address: _____ City _____ State _____ Zip _____

SPOUSE INFORMATION

Name _____ Social Security # _____
Last Name First Name Middle Initial

Address _____ Drivers Lic # _____

City _____ State _____ Zip _____

Age _____ Birthdate _____

Cell Phone (_____) _____ Approval to leave message? ☐ Y ☐ N

Work Phone (_____) _____ Approval to leave message? ☐ Y ☐ N

Spouse Employer _____ Occupation _____

Employer Address _____ Employer Phone (_____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Phone (_____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (_____) _____

Insurance Company _____

ID # _____ Group # _____ Phone # (_____) _____

SECONDARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Insurance Company _____

ID # _____ Group # _____ Phone # (_____) _____

ASSIGNMENTS AND RELEASE

I directly assign all medical/ surgical benefits to Beach Ob/Gyn Medical Group, and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as original.

Signed: _____ Date: _____

TREATMENT OF A MINOR:

I authorize Beach Ob/Gyn Med. Group to treat _____, a Minor.
(Name of Minor)

Signed: _____ Date: _____
(Signature of Guarantor / Guardian)

Beach Obstetrics & Gynecology Medical Group

Name: _____ **Age:**_____ **Date**_____

Current Medications and Supplements: (Include dose if known.) _____

_____

_____

Allergies to Medications: _____

_____

Other Allergies: _____

GYN/Menstrual History:

Age of first period:_____ If menopausal, age of last period: _____

Do you have any problems with your periods? Yes / No

☐ Painful ☐ Irregular ☐Bleeding between periods

☐ Heavy ☐ PMS ☐ Bleeding longer than 5 days

Have you ever had any of the following STDs?

☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Syphilis

☐ Trichomonas ☐ HPV (warts) ☐ Hepatitis

☐ Pelvic Inflammatory Disease

Date of last PAP smear?_____ Any abnormal PAP smears? Yes / No

Have you ever needed any of the following for an abnormal PAP smear?

☐ Colposcopy ☐ Cryosurgery ☐ LEEP ☐ Cone Biopsy

Have you ever received Gardasil? Yes / No

Are you sexually active? Yes / No

☐ Heterosexual ☐ Homosexual ☐ Bisexual

Number of partners in the last year? _____

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

Do you have any problems with sexual relations?

☐ Decrease libido ☐ Pain ☐ Orgasm

If sexually active, method of birth control?

☐ Pill ☐ Nuvaring ☐ Nexplanon ☐ Diaphragm

☐ Depo-Provera ☐ IUD ☐ Vasectomy ☐ Tubal Sterilization

☐ Natural Family Planning

Breast History:

Any problems with your breast?

☐ Cysts/Lumps ☐ Abnormal Mammograms or Ultrasounds ☐ Infections

☐ Discharge ☐ Pain ☐ Fibrocystic Changes

☐ Surgeries (Augmentation, Lumpectomy, Mammopexy):_____

_____

Beach Obstetrics & Gynecology
Medical Group

Name: _____ **Date**_____

Obstetrical History:

Total number of pregnancies:_____
Vaginal Births:_____ Cesarean Deliveries:_____ Premature (<37 wks):_____
Terminations:_____ Miscarriages:_____ Etopics:_____
Number of children living:_____
Any pregnancy complications?_____
Any adopted children? Yes / No

Personal History:

Have you had any of the following?

☐ Asthma	☐ High Blood Pressure	☐ Seizures
☐ Pneumonia	☐ Heart Disease/Attack	☐ Migraines
☐ Tuberculosis	☐ Stroke	☐ Thyroid Disease
☐ Kidney Infections	☐ High Cholesterol	☐ Eating Disorder
☐ Kidney Stones	☐ Blood Clots in legs/Lungs	☐ Depression/Anxiety
☐ Anemia	☐ Gall Bladder Disease	☐ Drug/Alcohol Problems
☐ Blood Transfusion	☐ Hepatitis	☐ Osteopenia/Osteoporosis
☐ Thalasemia	☐ Stomach Ulcers	☐ Arthritis
☐ Bleeding Problems	☐ Diabetes	☐ Skin Disease

☐ Any Cancers:_____
☐ Any other disease not listed:_____
_____

Surgical History:

Surgeries/Hospitalizations: (approximate year) _____
_____
_____
_____
_____

Family History:

	If yes, who:
☐ Heart Disease	_____
☐ High Blood Pressure	_____
☐ Stroke	_____
☐ Diabetes	_____
☐ Breast Cancer	_____
☐ Ovarian Cancer	_____
☐ Uterine Cancer	_____
☐ Colon Cancer	_____
☐ Osteopenia/Osteoporosis	_____
☐ Blood Clots	_____

Beach Obstetrics & Gynecology
Medical Group

Name: _____ **Date**_____

Review of Systems:

- ☐ Change in energy
- ☐ Sinus problems
- ☐ Chest pain
- ☐ Shortness of Breath
- ☐ Blood in Stool
- ☐ Heartburn/Reflux
- ☐ Leakage of Urine
- ☐ Abdominal Pain
- ☐ Depression
- ☐ Recent weight gain or loss
- ☐ Hearing loss
- ☐ Chronic cough
- ☐ Diarrhea
- ☐ Constipation
- ☐ Frequent Urination
- ☐ Urinary Urgency
- ☐ Joint/Muscle Pain
- ☐ Hair Loss

Social:

Do you smoke cigarettes? Yes / No
If you quit smoking, how many years did you smoke?_____
Do you drink alcohol? Yes / No Approximate drinks per week:_____
Recreational drug use? Yes / No Which type?_____
Do you exercise? Yes/ No How many times a week:_____
What type of exercise? _____
Do you have any problems at home? Yes/ No If yes, please explain:_____
_____
_____

Patient Consent for Use and Disclosure of Protected Health Information

With your consent, Beach Obstetrics and Gynecology Medical Group may use and disclose protected health information about you to carry out treatment, payment and health care operations. Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures. You have the right to review our Notice of Privacy Practices prior to signing this consent. We have the right to revise our Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Officer at 19582 Beach Blvd, Suite 202, Huntington Beach, CA 92648.

With your consent, Beach Obstetrics and Gynecology Medical Group may call your home or office and leave a message in reference to any items that assist the practice in carrying out treatment, payment, and health care operations such as appointment reminders, insurance items and any call pertaining to your clinical care.

With your consent, Beach Obstetrics and Gynecology Medical Group may mail to your home or office any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminder cards and patient statements.

I give my consent to electronically send or fax my records for the purpose of treatment, payment, or healthcare operations and understand that I may withdraw this consent at any time in writing. I understand that my medical records may be transmitted electronically or by fax and may be received in error by a third party. In the event that this should occur, I absolve Beach Obstetrics and Gynecology Medical Group of all liability.

You have the right to request that we restrict how we use or disclose your protected health information to carry out treatment, payment, and health care operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

By signing this form, you are consenting to our use and disclosure of your protected health information to carry out treatment, payment and health care operations. This consent may be revoked in writing except to the extent that we have already made disclosures in reliance upon your prior consent. If you decline to sign this consent, we may decline to provide treatment for you.

Signature of Patient or Legal Guardian_____Date_____

This Authorization Will Remain Standing Until Revoked in Writing.

Patient's Name_____Date of Birth_____

Print Name of Patient or Legal Guardian_____Date _____

ONLY SIGN BELOW IF YOU ARE DECLINING THIS CONSENT

I, _____, decline to the use and disclosure of my protected health information to carry out treatment, payment, and health care operations.

Beach Obstetrics and Gynecology Medical Group
Financial Policy

Dear Patient,

Please take a few minutes to read the following. We have implemented these financial policies to help us function in today's increasingly difficult health care environment. These policies apply to all patients. We appreciate your understanding.

- At the initiation of each visit, a patient is required to show a copy of their current insurance card. If no card is available, the appointment will be canceled or will be a cash visit. If we already have a card on file, we will check your benefits prior to the visit.
- All co-payments, percentages, and deductibles will be collected at the time of the visit. We will then bill your insurance in a timely fashion, and dispense a refund if credit is due. Appointments may be canceled for failure to make co-payments.
- It is the patient's responsibility to understand their insurance benefits and what is covered. For services or medications not covered by insurance, payment in full will be necessary at the time of service.
- If an account remains delinquent after two months, a letter will be sent of our intent to send the account to a collection agency.
- Any payment not received by an insurance company within 60 days of billing becomes the responsibility of the patient, and is payable within another 30 days. If there is a problem with the insurance company or claim, we will gladly help the patient to correct the problem.
- For patients having surgery or in office procedures, we will check your insurance benefits. You will be responsible for estimated co-pays or deductibles prior to the procedure. Certain procedures will be canceled if the estimated payment is not received.
- For obstetrical patients, we will check your maternity benefits at the initiation os your pregnancy. Our billing department will discuss all potential charges, and give you an estimate of your portion. The amount will be collected by the 7th month of pregnancy. Payment plans will be created if necessary.

I have read and agree to the above financial policy.

_____ _____

Signature Date

NOTICE OF PRIVACY PRACTICES:
Acknowledgement of Receipt

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices*** of Beach Obstetrics and Gynecology Medical Group

Our ***Notice of Privacy Practices*** provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our ***Notice of Privacy Practices*** is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Privacy Officer at 714-841-9899.

I acknowledge receipt of the ***Notice of Privacy Practices*** of Beach Obstetrics and Gynecology Medical Group.

Signature:_____ Date:_____
(parent/patient/conservator/guardian)

FOR OFFICE USE ONLY

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained:

Signature of provider representative:_____ Date:_____

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please Specify)

_____

_____

_____

All prescriptions are now sent electronically. Please fill out form below in order to serve you more efficiently. Thank you!

Patient Name: _____

Date of Birth: _____

Pharmacy Name: _____

Pharmacy Phone #: _____

Or

City and Cross Streets: _____

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19582 Beach Blvd. Suite 202
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Phone (949) 438-2440

Fax (714) 841-2729

Name:_____ DOB:_____

Prenatal Diagnosis Screening Questionnaire

		Yes	No
1.	Will you be age 35 or older when the baby is due?	☐	☐
2.	Do you or the baby's father or anyone in either of your families have,		
	a. Chromosome disorder (for example, Down Syndrome)	☐	☐
	b. Spina Bifida (Open Spine)?	☐	☐
	c. Mental Retardation?	☐	☐
	d. Bleeding disorder (ie: hemophilia)	☐	☐
	e. Birth defects (such as cleft lip, heart defect)?	☐	☐
	f. Cystic Fibrosis?	☐	☐
	g. Bone or Skeletal Disorder?	☐	☐
	h. Sickle Cell Anemia?	☐	☐
	i. Nerve or Muscle Disorder?	☐	☐
	j. Polycystic Kidney or other Kidney Disorder?	☐	☐

If yes to any of the above, please list relative. Explain:_____

_____

3.	Have you had two or more spontaneous pregnancy losses?	☐	☐
4.	Have you or the baby's father ever been screened for Sickle Cell anemia, Cystic Fibrosis, Thalasemia, Caravan disease or Tay-Sachs disease? If yes, please explain:_____		
	_____		
5.	Excluding iron, vitamins and Tylenol, have you taken any medications (prescribed or over the counter) or recreation drugs since becoming pregnant?	☐	☐
	Name of Medication(s):_____		
	Dates taken:_____		
6.	Have you taken Recreational Drugs?	☐	☐
	List Drug and amount use:_____		
7.	Have you had a fever of 101 or greater since conception of this pregnancy?	☐	☐
8.	Have you had any infections, rashes, or viral illnesses?		
	If yes, please explain:_____		
9.	Have you had any X-rays or hospitalizations?	☐	☐
10.	Cigarettes or alcohol use?	☐	☐

_____

_____

_____

_____

Date: _____

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SENATE BILL 889-PREGNANCY HIV TESTING

On October 13, 1995, S.B. 889 was enacted in the California State Senate. This bill concerns the testing of the pregnant women and newborns for the HIV virus. The following is a summary of the bill:

- *Requires every health care provider to offer a human immunodeficiency virus (HIV) test and HIV risk assessment counseling that includes providing preventative information to every pregnant woman patient during prenatal care; requires every health care provider to maintain records documenting the offering of the HIV test to each pregnant patient.*

It is important that information and counseling from the providers cover the following:

++ Methods of HIV transmittal
++Lowering possibility of perinatal transmission
++Abatement of HIV risk factors
++Additional HIV-related services referrals; plus test site locations, (if needed). Offer of HIV test; rationale, benefits, risk factors and patient's freedom of choice to receive test.

I would like an HIV test during my pregnancy, and I agree to have this done.

YES

Signature: _____ Date: _____

Print Name: _____

I have declined an HIV test during my pregnancy and I understand the importance of this test in pregnancy.

NO

Signature: _____ Date: _____

Print Name: _____