CONFIDENTIAL HEALTH HISTORY

Name:	Age:	Date of birth:	Today's date:
Primary phone number:	Email address:		
Referring physician/person:	Primary care provider:		
Preferred pharmacy name:	Pharmacy phone number:		

Please describe any special problems or symptoms that you would like to discuss:

PREVENTIVE HEALTH

	Date of last:		Date of last:		Date of last:
Pap		Blood work		Bone density	
Mammogram		Colonoscopy			

History of abnormal pap? □ Yes □ No

Would you accept blood products? □ Yes □ No

MEDICAL HISTORY

Please check any past or current medical problems for yourself or immediate blood relative:
Yourself- **X** Mother - **M** Father; **F** Sister; **S** Brother - **B** **Maternal Grandparents; MGM or MGF** Paternal Grandparents - **PGM or PGF**

	You	Family		You	Family
Autoimmune disease (Lupus, MS, etc.)			Heart disease		
Alzheimer's			Hemorrhoids		
Anemia			Hepatitis		
Arthritis			High blood pressure		
Bleeding disorder			Irritable bowel syndrome		
Blood clots in legs			Kidney disease		
Blood clots in lungs			Lung disease, asthma		
Blood disorders			Mental illness, depression		
Cancer breast			Migraine headache		
Cancer - colon			Osteoporosis		
Cancer - ovarian			Seizure disorder		
Cancer - other			Skin disorders		
Diabetes			Stroke		
Drug/alcohol abuse			Thyroid disorder		
Frequent bladder infections			Tuberculosis		
Gallbladder disease or gallstones			Ulcers		
Hearing problems			Other:		

SURGERIES

Date:	Surgery:	Date:	Surgery:

HOSPITALIZATIONS (Non-Surgical)

Date:	Problem/Diagnosis:	Comments:

CURRENT MEDICATION

List any medications you *are* taking, to include *birth control* pills, *Tylenol, Advil, Aspirin,* other non-prescription medicine, vitamins, herbs.

Medication name	Dose	Frequency of dose	Medication name	Dose	Frequency of dose

Do you take calcium	☐ Yes □ No	If yes, amount:
Do you take Vitamin D?	☐ Yes □ No	If yes, amount:
Do you take a multiple vitamin or prenatal vitamin?	☐ Yes □ No	If yes, amount:

Name:	Date of Birth:	Today's date:

MEDICATION ALLERGIES

Do you have any medication allergies?	□ Yes □ No	If yes, to what?	What kind of reaction do you have?

FOOD ALLERGIES

Do you have any food allergies?	□ Yes □ No	If yes, to what?	What kind of reaction do you have?

ENVIRONMENTAL / LATEX ALLERGIES

Do you have any food allergies?	□ Yes □ No	If yes, to what?	What kind of reaction do you have?

MENSTRUAL HISTORY

First day of last normal menstrual period - Date		Is menstrual pain or cramping a problem for you?	□ Yes □ No
Age period began:		Do you ever have spotting or bleeding between your periods?	□ Yes □ No
Number of days between periods:			
Length of periods (how many days of bleeding)?		Is PMS a problem for you?	□ Yes □ No
Menstrual flow:	□ Light □ Mediur □ Heavy	Do you perform breast exams?	□ Yes □ No

How often do you change your pads / tampons on your heaviest day of menses? Every _____ Hours

Do your periods affect you life in a negative way?

Method of Birth Control

□ Condoms	□ Diaphragm	□ Implanon	□	□ Nuva Ring	□ Post Menopause	□ Vasectomy	□
□ Contraceptive Pills	□ Essure	IUD	□	□ Foam, Jelly, etc.	Same Sex Partner	□ Other	□ None
□ Depo Provera	□ Hysterectomy	Not Sexually Active		□ Patch	Tubal Ligation		

Are you interested in a different method of birth control? □ Yes □ No

OBSTETRICAL HISTORY

	Number		Number		Number
Pregnancies		Abortions		Miscarriages	
Pregnancies <37 weeks		Live Births		Living Children	

#	Birth date	Weight	Male / Female	Weeks Pregnant	Type of Delivery (vaginal, cesarean)
1					
2					
3					
4					
5					

Any pregnancy complications?

□ Diabetes □ Hypertension / High Blood Pressure □ Pre-eclampsia / Toxemia

□ Other

Any history of depression before or after pregnancy? □ Yes □ No

If yes, how was it treated?

SOCIAL HISTORY

Marital status: □ Divorced □ Engaged □ Married □ Partnered □ Separated □ Single □ Widowed		Race □ African American □ Asian □ Caucasian □ Hispanic □ Other:	
Patient occupation?		Husband / Partner occupation?	
Do you exercise? □ Yes □ No	If yes, how many times per week:	Number of children living at home"	
Do you drink alcohol? □ Yes □ No	How much per week?	How many drinks per day?	Is alcohol or drug use a problem for you? □ Yes □ No
Do you / did you ever use tobacco? □ Yes □ No	If yes, what type? □ Chewing Tobacco □ Smoking / Cigarettes / Vaping	For how many years?	How much per day? When did you stop?
Do you / did you ever use any recreational drugs or abuse prescription drugs? □ Yes □ No		If yes, what type?	

Have you ever been sexually abused?	□ Yes □ No	If you have experienced abuse, have you received counseling?	□ Yes □ No
Have you ever been physically abused?	□ Yes □ No		
Have you ever been emotionally abused by someone important to you?	□ Yes □ No	Is this something you would like to discuss today?	□ Yes □ No

RENO TAHOE
Women's Health

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Date of Birth: _____ Age: _____

Please indicate if there is a **personal or family history** of any of the following cancers. If yes, then **indicate family relationship** and **AGE at diagnosis** in the appropriae column. Consider parents, childredm borhters, sisters, grandparents, aunts, uncles and cousins.

Example: Colon Cancer Brother 36 yrs Aunt 44 yrs Grandfather 65 yrs

Breast and ovarian cancer (HBOC)

			You	Siblings / Children	Mother's Side	Father's Side
Y	N	Breast Cancer				
Y	N	Breast Cancer in both breasts OR Multiple primary breast cancers				
Y	N	Ovarian Cancer				
Y	N	Male Breast Cancer				
Y	N	Are you of Ashkenazi Jewish decent? Please circle:	YES / NO			

COLON AND UTERINE CANCER (LYNCH)

			You	Siblings / Children	Mother's Side	Father's Side
Y	N	Uterine (endometrial cancer				
Y	N	Colon cancer				
Y	N	Ovarian, Stomach, Kidney, brain OR small bowel cancer (circle)				
Y	N	10 or more colon polyps in a lifetime				
Y	N	Prostate Cancer (HBOC)				
Y	N	Melanoma (HBOC)				
Y	N	Pancreatic Cancer (HBOC/Lynch)				
Y	N	Other Cancers				

Patient Signature: _____ Date: _____

Have you or a family memer ever been tested for a hereditary syndrome? _____ If so, specify: _____

FOR OFFICE USE ONLY

Patient offered hereditary cancer testing?

☐ YES ACCEPTED DECLINED HEALTHCARE PROVIDER SIGNATURE: _____

☐ NO

HBOC - Personal or Family History

One person with: (out to 2nd degree)

Breast CA (diagnosed < 50)
Ovarian CA, any age
Male Breast CA, any age
Breast CA with Ashkenazi Jewish heritage, any age
Bilateral Breast CA (diagnosed ≤ 50)
Triple Negative Breast CA (diagnosed ≤ 50)

Two persons with: (out to 3rd degree

Breast CA (1 diagnosed ≤ 50)
Breast CA & Ovarian CA, any age

Three Persons with: (out to 3rd degree)

Breast and/or Pancreatic and/or Ovarian CA any age

Lynch* Personal or Family History

One person with: (out to 2nd degree)

Endometrial or Colorectal Cancer (1 diagnosed < 50)
1 Lynch* cancer (< 50 with an Endometrial or CRC CA any age

Three Persons with: (out to 2nd degree)

Lynch* cancers with 1 being Endometrial or Colorectal any age

*Endo, CRC, Ovarian, Stomach, Brain, Pancreas, Small Bowel, Ureter / Renal Pelvis Biliary Tract, Sebaceous Adenomas

RENO TAHOE
Women's Health

(WOMEN ONLY - PLEASE FILL OUT)

Lifetime Risk of Breast Cancer Questionnaire

Patient Name: _____

Patient Date of Birth: _____

Height: _____ **feet** _____ **inches**

Weight: _____ **pounds**

Ethnicity: _____

Age at first menstruation (your first period) _____

Age at delivery of first child (if applicable) _____

Circle one: Premenopausal Perimenopausal Postmenopausal

Age at Menopause (if applicable): _____

Hormone Replacement Therapy (circle one below)

Current
Less than 5 years ago
More than 5 years ago
Never

If you have taken Hormone Replacement Therapy (circle one below)

Estrogen only
Combination (estrogen/progesterone)

How many sisters do you have? _____

How many Aunts (on father's side) do you have? _____

How many Aunts (on mother's side) do you have? _____

RENO TAHOE
Women's Health

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name - Last - First - MI		Patient Mailing Address	
City - State	Zip Code	Home Phone	Cell Phone
Date of Birth		Social Security Number	
Email Address		Marital Status	
Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino □ Refused to Report	Language □ English □ Spanish □ Hindi □ Other, Please Specify:	Race □ American Indian □ Asian □ Native Hawaiian □ Black or African American □ White □ Hispanic □ Other Pacific Islander □ Other Race □ Refused to Report	
Patient Employer Name	Patient Employer Address	Employer Phone Number	

INSURED INFORMATION		Relation to Patient □ Spouse □ Parent □ Guardian	
Patient Name - Last - First - MI		Address (if different from patient)	
Home Phone	Work Phone	Birthdate	Employer

INSURANCE INFORMATION			
Primary Insurance Name	Address		Telephone Number
Group Number	Subscriber Name		Subscriber ID
Secondary Insurance Name	Address		Phone Number
Group Number	Subscriber Name		Subscriber ID
In case of Emergency contact	Relationship		Phone Number

RENO TAHOE
Women's Health

CONSENT TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT'S NAME: _____ BIRTHDATE: _____

- **How we may use and disclose your health information.**
  Your protected health information will be used by Reno Tahoe Women's Health or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.
- **The notice of privacy practices.**
  Reno Tahoe Women's Health is required to provide you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the **"Notice of Privacy Policies and Practices"** brochure provided to you. Please review it carefully.
- **You may place restrictions on the use or disclosure of your health information.**
  You may request a restriction on the use or disclosure of our protected information. However, Reno Tahoe Women's Health may or may not agree to your request to restrict the use or to activate this request. Please consult with a practice representative or the Privacy Officer if you would like additional information or clarification.
  It is a violation of the federal privacy standards if Reno Tahoe Women's Health ***agrees*** and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information prior to the date of your request. If you still have questions after reviewing the Notice of Privacy Brochure, please consult with a practice representative or the Privacy Official at the location and contact information listed on the back of the brochure.
- **You may revoke this consent at any time.**
  You may revoke this consent at any time; however, Reno Tahoe Women's Health requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect the use and disclosure prior to the date of your request.
- **Changes to privacy practices.**
  Reno Tahoe Women's Health reserves the right to change or modify the privacy practices outlines in the **Notice of Privacy** brochure. Reno Tahoe Women's Health will notify you of any changes of privacy practices either by mail, at your next appointment, or another pre-approved method that you request.

I have reviewed this consent form, received the brochure entitled **"Notice of Privacy Policies and Practices"** and give my permission to Reno Tahoe Women's Health to use and disclose my health information in accordance with this consent and the notice provided.

I understand that I was provided with an option to receive a copy of the Privacy Practices and have waived that option. This is posted in the practice waiting area and can be located on the website.

Patient's Name: _____

Patient's Signature: _____ Date: _____

Guardian's Name is patient is a minor: _____ Relationship to patient: _____

Guardian's Signature: _____ Date: _____

CONSENT FORM FOR ePRESCRIBE PROGRAM

- **ePrescribe Program**

ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.
- **Fill status notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at Reno Tahoe Women's Health as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS.

***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information*.**

By signing this consent form, you are agreeing that your provider at Reno Tahoe Women's Health may request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes. You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits.

Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it. This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Reno Tahoe Women's Health to enroll me in this ePrescribe Program. I have had the chance to ask questions and all my questions have been answered to my satisfaction.

PRINT PATIENT NAME _____ PATIENT DOB_____

SIGNATURE OF PATIENT OR GUARDIAN _____

RELATIONSHIP TO PATIENT _____ TODAY'S DATE _____

FINANCIAL POLICY

Thank you for choosing Reno Tahoe Women's Health to participate in your medical care. To provide you with a full understanding of your financial obligations, an important aspect of your medical care, we have developed the following policies:

All patients are financially responsible for services provided.

- Our office requires that you provide a copy of your current insurance card and photo ID at every visit.
- It is the patient's responsibility to know their insurance policies terms, conditions and limitations.
- As a requirement of both our office and your insurance company, co-payments are due at the time of service.
- Payment of co-insurance or any charges not covered by your plan is required at the time of service. Medicare recipients are expected to update the National File with any changes by calling 1-800- MEDICARE.
- Payment is required in full at the time of service from uninsured patients unless arrangements have been made in advance.
- If previous arrangements have not been made, any account balance over 90 days will be turned over to a collection agency.
- A fee of $25 will be charged to you for returned checks, plus any bank fees incurred.

Appointments

- A $35 fee will be assessed for canceled appointments without 24 hours' notice.
- Patients who accumulate a total of three "no Shows" in a calendar year may be terminated from the practice.
- If you are more than 15 minutes late, your appointment will be rescheduled.

Referrals/Authorizations

- It is the patient's responsibility to ensure that any referrals or authorizations for treatment are provided to the office prior to your appointment. If the authorization or referral is not obtained prior to your visit, you will be expected to pay for all charges at the time of your visit.

Collection Agency

- In the event your overdue account is referred to a collection agency, you will be assessed a ***35%*** collection fee. I also understand that if this account is assigned to a collection agency in addition to the collection fees assessed I could be held liable for additional expense such as interest and legal fees in attempt to collect this debt.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about our Financial Policy should be directed to the front desk personnel.

I have read and understand the Financial Policy and agree to comply and accept responsibility for services provided by Reno Tahoe Women's Health.

_____
Date

_____
Signature of financially responsible party

_____
Printed Name

RENO TAHOE
Women's Health

Acknowledgment of Possible Lab/Pathology Charges

Please be advised that if you have a preventative office visit or an in-office procedure (i.e. pap smears, colposcopy, LEEP, biopsies, Strep B testing etc.) you may receive a bill from an outside source such as a pathologic lab, Quest Diagnostic, Lap Corp or Renown Lab.

Our charges for services rendered do not include any cost or fee's associated with lab/specimen testing.

These services may or may not be a covered benefit by your insurance even if the lab is contracted. It is patient responsibility to know their lab benefits and inform the practice of any preferred or in network labs.

I have read and understand the above statement that I may receive a bill from an outside company for test results from procedures that I receive.

_____

Patient Signature:_____

Printed Name: _____

Date:_____

HIPAA and Release of Information

Patient Name: _____

It is the policy of Reno Tahoe Women's Health to make confirmation phone calls to patients two days before their appointment. Because of the health Insurance Portability and Accountability Act of 1996 (HIPAA), it is necessary for us to get your authorizaiton on certain items. Please see below and mark accordingly.

Also, if I am not available, I authorize the staff of Reno Tahoe Women's Health to ***speak with*** and release information to the individual(s) regarding:

Name	Relationship	Phone	Appointment	Medical/Results	Accounting / Billing
_____	_____	_____	□ Yes □ No	□ Yes □ No	□ Yes □ No
_____	_____	_____	□ Yes □ No	□ Yes □ No	□ Yes □ No
_____	_____	_____	□ Yes □ No	□ Yes □ No	□ Yes □ No
_____	_____	_____	□ Yes □ No	□ Yes □ No	□ Yes □ No

I authorize the staff of Reno Tahoe Women's Health to call my **work number**, if I am otherwise not available. □ Yes □ No

I authorize the staff of Reno Tahoe Women's Health to **leave a message on my voicemail at my work number.** □ Yes □ No

Patient or Guardian Signature: _____ Date: _____

RENO TAHOE
Women's Health

STATE OF NEVADA MEDICAID PATIENTS MEDICAID RESPONSIBILITY

Reno Tahoe Women's Health accepts State of Nevada Medicaid members. We also accept HMO plans that are contracted with the State of Nevada for the Medicaid members.

As a member, you must present Reno Tahoe Women's Health's staff with proof of Medicaid coverage each time you visit the office. Medicaid eligibility will be verified before each visit by the office.

If Medicaid shows that you have another insurance the claim for services rendered will be rejected, it is your responsibility to correct it. Medicaid may audit a claim at a later time, if that happens and they find that another insurance was on file they will request for a refund from the office, if that happens the services rendered at the time will become your responsibility.

In the event that you are not eligible during the month of your appointment, you will be responsible for the services rendered, if you are unable to provide payment for those services, your appointment will be cancelled. If you are pregnant and you are not eligible you will be responsible for the services rendered,

If you are unable to provide payment your care with Reno Tahoe Women's Health will be terminated immediately. Any further care with your pregnancy will need to be through another physician and Reno Tahoe Women's Health is no longer responsible for your care.

PLEASE NOTE: IT IS YOUR RESPONSIBILITY TO KEEP YOUR MEDICAID COVERAGE CURRENT.

In the event that your Medicaid is reinstated, your care, with Dr. Veeraswamy's approval and proof of eligibility may continue.

APPOINTMENTS: If you are unable to make any scheduled appointments you will need to call us and let us know. If you have more than 2 missed appointments, you will be discharged from Reno Tahoe Women's Health.

PATIENT NAME:_____**DATE:** _____

PATIENT'S SIGNATURE: _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION ("Authorization")

NOTE: ALL sections must be completed

Patient Name: _____ Birth Date: _____
Printed (First) (MI) (Last Name)
Address: _____ Telephone #: _____
Street Address City State Zip Code

I authorize: Reno Tahoe Women's Health to *(circle one)* SEND TO *-or-* RECEIVE FROM the below entity:

_____ Telephone #: _____ Fax: _____
Full Name/Entity
Address: _____
Street Address City State Zip Code

Purpose of Request to Release:
□ Treatment □ Personal/Patient Request □ Legal/Attorney □ Insurance □ Other (*specify*):
_____

For Date(s) of Service from: _____ **to** _____ **[Dates MUST be specified]**

Information To Be Disclosed:
□ History & Physical □ Obstetric Records □ Consultations □ Operative Reports
□ Progress Notes □ Radiology & X-Ray Reports □ Radiology Films/CDs □ Laboratory Reports
□ Billing Records □ Entire Record □ Other: _____

I Specifically Authorize Release of These Records (these records will NOT be released unless you initial & check the box to consent to release):
Initial: _____ □ Release Drug, Alcohol & Substance Abuse Records
Initial: _____ □ Release Communicable Disease Records, including without limitation, HIV/AIDS Records
Initial: _____ □ Release Genetic Testing Records
Initial: _____ □ Release Psychiatric & Mental Health/Behavioral Health Records. Treating provider approval is required for release of Psychiatric & Mental Health/Behavioral Health Records.

I UNDERSTAND THAT:
- This Authorization will become effective immediately and will expire on _____ [*Date*]. If no date is specified, this authorization will expire one (1) year from the signature date.
- I may revoke this Authorization at any time, in a written revocation sent to the Custodian of Records. However, I understand that my health information might have already been released.
- Information released by this Authorization might be re-disclosed by the recipient and might not be protected by state and federal privacy laws. I agree to release Renown Health from liability for release and disclosure of the released information.
- I am not required to sign this Authorization as a condition to obtain treatment, services or for eligibility of benefits. My signature on this Authorization is voluntary.

Signature of PATIENT ONLY: _____Print Name:_____ Date: _____

Signature of Person Who Is NOT the Patient: _____ Date: _____
Print Name: _____ **Authority to Sign**: _____
Proof of Authority MUST be attached (except for parents)
Address: _____ Tel No: _____

*****Completed by Staff Member Fulfilling & Verifying Authorization & Completeness *****

Date: _____ Time: _____ Verified By: _____

MR #: _____ Account #: _____

Provider Signature for Release of Psychiatric/Mental Health Records: _____
Printed Provider Name: _____ Date: _____

RENO TAHOE
Women's Health