Beach Obstetrics and Gynecology Medical Group

•19582 Beach Blvd. Suite 202 Huntington Beach, CA 92648 Phone: (714) 841-9899
•500 Superior Ave Suite 305 Newport Beach, CA 92663 Phone: (949) 438-2440
Fax: (949) 999-8148

Patient Information:

Name: ______________________ Date of Birth: __________ Age: _______ Sex: M/F

SS#: ______________ Religion: ______________________

Address: ____

City: ______________________ State: __________ Zip: __________

Home Phone#: ______________________ Ok to leave message? Y/N

Cell Phone#: ______________________ Ok to leave message? Y/N

Email: ____

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
Marital Status: □Married □Widowed □Single □Minor □Separated □Divorced □Partnered for ___ years
Employer address: ______________________ Employer/School Phone#: ______________

Employer/School: ______________________ Occupation: ______________

Spouse's Name: ______________________ Spouse's Date of Birth: ______________

Spouse's Employer: ______________________ Spouse's Occupation: ______________

Emergency Contact: ______________________ Phone#: ______________

Medical Insurance Information

Primary Subscriber Name: ______________________ Date of Birth: ______________

Insurance Company: ____________________________________ PPO/HMO

Insurance Subscriber ID#: ______________________ Group#: ______________

Secondary Insurance: ____

Insurance Subscriber ID#: ______________________ Group#: ______________

I directly assign all medical/surgical benefits to Beach OB/GYN Medical Group, and understand 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 be valid as original.

Signed: ____________________________________ Date: ______________

Treatment of a Minor:

I authorize Beach OB/GYN Medical Group to treat ______________________, a minor.
(Name of minor)

Guarantor/Guardian Signature: ______________________ Date: ______________

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Name: ______________________________Date of Birth: ______________ Date: ____________

Current Medications and Supplements: (include dose if known) ____________________________

____

Allergies to Medications: (include reaction if known) ____________________________________

____

Other Allergies: ____

____

GYN/Menstrual History:

Age of your fist 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 STD's?
○ Chlamydia ○ Gonorrhea ○ Herpes ○ Syphilis
○Trichomonas ○ HPV (warts) ○ Hepatitis ○Pelvic Inflammatory Disease

Date of last PAP smear? _____________Any abnormal PAP smears? Yes/ No If yes when? _______
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 ○ Other ________________
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?
○ Decreased libido ○Pain ○Orgasm

If sexually active, method of birth control?
○ Pill ○Nuvaring ○Nexplanon ○ Diaphragm
○ Vasectomy ○Depo-Provera ○ IUD ○ Tubal Sterilization
○ Natural Family Planning

Name: ______________________ Date of Birth: ______________ Date: __________

Breast History:

Any problems with your breast?

- ○ Cysts/Lumps ○ Abnormal Mammograms or Ultrasounds ○ Infections
- ○ Discharge ○ Pain ○ Fibrocystic Changes
- ○ Surgeries (Augmentation, Lumpectomy, Mamopexy):______________________

Obstetrical History:

Total number of pregnancies: ________

Vaginal births: ________ Cesarean Deliveries: ________ Premature (<37 weeks): ________

Terminations: __________ Miscarriages: _____________ Ectopic: ______________

Number of living children: __________

Any pregnancy complications? ____

Any adopted children? Yes / No

Personal History:

Have you had any of the following?

- ○ Asthma
- ○ Pneumonia
- ○ Tuberculosis
- ○ Kidney Infections
- ○ Kidney Stones
- ○ Anemia
- ○ Blood Transfusion
- ○ Thalassemia
- ○ Bleeding Problems
- ○ High Blood Pressure
- ○ Heart Disease/Attack
- ○ Stroke
- ○ High Cholesterol
- ○ Blood Clots in Legs/Lungs
- ○ Gall Bladder Disease
- ○ Hepatitis
- ○ Stomach Ulcers
- ○ Diabetes
- ○ Seizures
- ○ Migraines
- ○ Thyroid Disease
- ○ Eating Disorder
- ○ Depression
- ○ Drug/Alcohol Problems
- ○ Osteopenia/Osteoporosis
- ○ Arthritis
- ○ Skin Disease
- ○ Anxiety
- ○ Any Cancer: ____
- ○ Any other disease not listed: ______________________________________

Surgical History:

Surgeries/Hospitalizations: (approximate year) ______________________________

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Name: ______________________ Date of Birth: ______________ Date: ____________

Family History:

	If yes: Relationship?	Age?	Cause of death Yes	No
o Heart Disease	______	______	o	o
o High Blood Pressure	______	______	o	o
o Stroke	______	______	o	o
o Diabetes	______	______	o	o
o Breast Cancer	______	______	o	o
o Ovarian Cancer	______	______	o	o
o Uterine Cancer	______	______	o	o
o Colon Cancer	______	______	o	o
o Osteopenia/Osteoporosis	______	______	o	o
o Blood Clots	______	______	o	o

Review of Systems:

- o Change in energy
- o Sinus problems
- o Chest pain
- o Shortness of breath
- o Blood in stool
- o Heartburn/Reflux
- o Leakage of Urine
- o Abdominal Pain
- o Depression
- o Recent weight gain or loss
- o Hearing loss
- o Chronic cough
- o Diarrhea
- o Constipation
- o Frequent Urination
- o Urinary urgency
- o Joint/Muscle pain
- o 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: ______________________________________

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Financial Policy

Please initial each line after you have read and understand each individual policy. If you have any questions, please ask a member of our staff.

____ Payments are due at the time of service. Our office works with a billing department who will file your insurance claim as a courtesy to you.

____ Co Pays, deductibles and co-insurances are estimated according to your policy coverage. Non-covered services or services which insurance eligibility cannot be confirmed are due and payable at the time of service. We will issue a refund if credit is due.

____ Your insurance policy is a contract between you and your insurance company. You are responsible for knowing the terms of your policy. It is not the responsibility of our office to know the policy details. As a courtesy, our office attempts to verify eligibility and benefits, however, we do not obtain the exact details of payment until the claim is processed.

____ We will bill your insurance company at the time of service. If coverage is denied or there is a remaining patient balance, you will be responsible for payment in full the time of statement or the at the time of your next appointment.

____ Outstanding balances are due prior to your visit with a provider.

____ If an account remains delinquent after 60 days, the account will be sent to a collection agency.

____ Any payment not received by an insurance company within 60 days of billing become your responsibility and is payable within 30 days. If there is a problem with the insurance company or claim, we will gladly help you correct the problem.

____ For surgical patients or in office procedures, your insurance benefits will be checked. You will be responsible for estimated co pays, deductibles or co-insurances prior to your procedure.

____ For Obstetrical patients, your maternity benefits will be checked at the beginning of your pregnancy. Our office staff will discuss potential charges and give you an estimate of your financial responsibility. The amount of your responsibility will be collected by the 28th week of your pregnancy. Payment plans are available.

____ Disability/FMLA forms to be filled out will cost $25 for each form. Payment is due at the time forms are given to the office. Please allow 7 business days for forms to be completed.

Name:______________________ Signature:__________________________ Date:__________

Patient Consent for Use and Disclosure of Protected Health Information

With your consent, Beach Obstetrics and Gynecology Medical Group may use and disclosure 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 used 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 our requested restriction, 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. <u>If you decline to sign this consent, we may decline to provide treatment to you.</u>

Signature of Patient or Legal Guardian: ______________________________ Date: ______________
This Authorization Will Remain Standing Until Revoked in Writing.

Patient 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.

Notice of Privacy Practices

By signing this form, your 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 Practices* of Beach Obstetrics and Gynecology Medical Group.

Signature: ____ Date: ______________
(Parent/Patient/Conservator/Guardian

For Office Use Only

INABILITY TO OBTAIN ACKNOWLEGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the Individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, 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)

____

____

____

Pharmacy Information

All prescriptions are 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: ______________________________________

NextMd Patient Portal

Name: ______________________________ Date of Birth: _____________ Date: __________

Our office uses NextMd patient portal, a safe and secure way to connect with our providers.

Through the portal you can:

- Receive test results
- Communicate with your provider or staff
- Easier access to your medical records
- Access Test requisitions
- Look up future appointments

If you would like to sign up for NextMd please provide us with your email address.

Email: ____

☐ Please check box if you **do not** wish to sign up for the NextMd.

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Name: ______________________ Date of Birth: ______________ Date: ____________

Prenatal Diagnosis Screening Questionnaire Yes No

1. Will you be age 35 or older when the baby is due? .... O O
2. Do you or the baby's father or anyone in either of your families have,

- Chromosome disorder (for example, Down Syndrome) .... O O
- Spina Bifida (Open Spine) .... O O
- Mental Retardation .... O O
- Bleeding disorder (for example hemophilia) .... O O
- Birth defects (such as cleft lip, heart defect) .... O O
- Cystic Fibrosis .... O O
- Bone or Skeletal Disorder .... O O
- Sickle Cell Anemia .... O O
- Nerve or Muscle Disorder .... O O
- Polycystic Kidney or other Kidney Disorder .... O O

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

3. Have you had two or more spontaneous pregnancy losses? .... O O
4. Have you or the baby's father ever been screened for Sickle Cell Anemia, Cystic Fibrosis, Thalassemia, Caravan Disease or Tay-Sachs Disease? .... O O

If yes, please explain: ______________________

5. Excluding iron, vitamins and Tylenol, have you take any medications (prescribed or over the counter) or recreation drugs since becoming pregnant? .... O O

Name of medication(s): ______________________ Dates taken: ______________

6. Have you taken Recreational Drugs? .... O O

List drug and amount of use: ______________________

7. Have you had a fever of 101 or greater since conception of this pregnancy? .... O O
8. Have you had any infections, rashes, or viral illnesses: .... O O
9. Have you had any X-rays or hospitalizations? .... O O
10. Cigarettes or Alcohol use? .... O O

Beach Obstetrics and Gynecology Medical Group

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 for HIV transmittal
- Lowering possibility of perinatal transmission
- Abatement of HIV risk factors
- Additional HIV related services referrals: plus test site locations, (if needed). Offer the 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: ______________

Name: ______________________________ Date of Birth: ______________

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

NO

Signature: ______________________________ Date: ______________

Name: ______________________________ Date of Birth: ______________