

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
(First, Middle, Last)

SS#: _____ Religion: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Email: _____

Referred by: _____ PCP: _____

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: _____ Date of Birth: _____ Relationship: _____

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: _____

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. If you decline to sign this consent, we may decline to provide treatment to you.

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.

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: _____

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

Allergies to Medications: (include reaction if known) _____

Other Allergies: _____

GYN/Menstrual History:

Age of your first period: _____ if menopausal, age of last period: _____

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

- Painful
- Heavy
- Irregular
- PMS
- Bleeding between periods
- 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
- Condoms

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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 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
- Anemia Gall Bladder Disease Drug/ Alcohol Problems
- Blood Transfusion Hepatitis Osteopenia/Osteoporosis
- Thalassemia Stomach Ulcers Arthritis
- Bleeding Problems Diabetes 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	
<input type="checkbox"/> Heart Disease	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High Blood Pressure	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stroke	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Diabetes	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Breast Cancer	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ovarian Cancer	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Uterine Cancer	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Colon Cancer	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Osteopenia/Osteoporosis	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Blood Clots	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

Review of Systems:

- | | |
|--|---|
| <input type="checkbox"/> Change in energy | <input type="checkbox"/> Recent weight gain or loss |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Chronic cough |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Heartburn/Reflux | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Leakage of Urine | <input type="checkbox"/> Urinary urgency |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Joint/Muscle pain |
| <input type="checkbox"/> Depression | <input type="checkbox"/> 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: _____

Notice of Privacy Practices

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 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 acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reason why the acknowledgment 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)

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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?
- 2. Do you or the baby's father or anyone in either of your families have,
 - Chromosome disorder (for example, Down Syndrome)
 - Spina Bifida (Open Spine)
 - Mental Retardation
 - Bleeding disorder (for example hemophilia)
 - Birth defects (such as cleft lip, heart defect)
 - Cystic Fibrosis
 - Bone or Skeletal Disorder
 - Sickle Cell Anemia
 - Nerve or Muscle Disorder
 - 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, Thalassemia, Caravan Disease or Tay-Sachs Disease?

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?

Name of medication(s): _____ Dates taken: _____

- 6. Have you taken Recreational Drugs?

List drug and amount of 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:
- 9. Have you had any X-rays or hospitalizations?
- 10. Cigarettes or Alcohol use?

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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 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: _____