ESSAM TAYMOUR, M.D.
GYNECOLOGY & OBSTETRICS MEDICAL GROUP, INC.
3550 Linden Avenue Ste #1
Long Beach, California, 90807
Telephone (562) 595-5331
Fax (562) 595-1335

We are honored that you have chosen our practice to receive your obstetrics and/or gynecological care. We would like to simplify the processing of paperwork on the day of your visit by enclosing our patient information forms. Please complete these forms and bring them with you at the time of your visit.

If you have insurance, please bring your card with you on the day of your appointment as well as a picture ID. If you do not have insurance or you have a co-pay/cost share, we accept cash, Mastercard, Visa, Discover, and checks.

If you have any questions at any time, please feel free to contact our office.

Thank you for the opportunity to provide you with excellent medical care.

Sincerely,

Dr. Essam Taymour & Staff

ESSAM TAYMOUR, M.D.

3550 Linden Ave., #1, Long Beach, CA 90807

PATIENT INFORMATION (please print) Appointment Date:

Name: _____ Sex: ☐ Female ☐ Male

Address: _____ Date of Birth: _____ Age: _____

_____ Social Security #: _____

City, State, Zip: _____ Driver's License/ID #: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced Email Address: _____

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐ Yes ☐ No

Race: ☐ American/Alaskian Indian ☐ Asian ☐ Black ☐ Caucasian ☐ Pacific Islander ☐ Declined

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐Declined Language: _____

Home Phone: _____ Cell Phone : _____

Work Phone: _____ Other Phone: _____

Who referred you to us/How did you hear about us? _____

Primary Physician: _____ Phone: _____

Employer/Occupation: _____ Phone: _____

GUARANTOR RESPONSIBLE PARTY ☐ Patient ☐ Other: Relationship:

Name: _____ Employer: _____

Address: _____ Phone: _____

_____ Social Security #: _____

City, State, Zip: _____ Date of Birth: _____

INSURANCE~YOU MUST PROVIDE ANY & ALL INSURANCE INFO OR YOU WILL BE LIABLE FOR CHARGES NOT COVERED. INITIALS _____

Primary Ins Co: _____ Name of insured: _____

Relationship to patient: _____ Date of birth of insured: _____

Insured ID/Cert #: _____

Secondary Ins Co: _____ Name of insured: _____

Relationship to patient: _____ Date of birth of insured: _____

Insured ID/Cert #: _____

EMERGENCY CONTACT

Name: _____ Street Address: _____

_____ City, State, Zip: _____

Relationship: _____ Phone: _____

Durable Power of Attorney for Health Care (California civil code section 2500): Do you have or wish to have an appointed representative to carry out your wishes concerning your health care/treatment in the event of an emergency rendering you unable to make such decisions? ☐ Yes, I have a representative. Name of representative _____
Phone #: _____. Please provide copy of certificate.
☐ No, I do not have a representative. ☐ Please give me the information on how to appoint myself a representative.

I hereby **assign the insurance benefits** to which I am entitled, directly to Essam Taymour, M.D./Gynecology & Obstetrics Medical Group. I understand that I am financially responsible for all charges regardless of insurance verification, benefits and eligibility. I **authorize release of medical records** and information regarding medical history that is requested by the insurance company. A photocopy of this authorization is accepted with the same authority as the original.
I **consent to treatment** as necessary or desirable including but not restricted to whatever drugs, medicine, performance of operations or procedures and conduct of laboratory, x-rays or other studies that may be used by the attending physician or his/her nurse or qualified designate.
This agreement will remain valid from this day forward to include all future services relating to the above patient.

Signature of patient/guardian Date

Name: _____ Age _____ Date _____

Family History

	If living		If deceased		Has any relative ever had	No	Yes	Who
	Age	Health	Age	Cause				
Father					Cancer	☐	☐	
Mother					Tuberculosis	☐	☐	
Brother or Sister 1					Diabetes	☐	☐	
2					Heart trouble	☐	☐	
3					High blood pressure	☐	☐	
4					Stroke	☐	☐	
5					Epilepsy	☐	☐	
Husband					Suicide	☐	☐	
Son or Daughter 1					Mental illness	☐	☐	
2					Hysterectomy	☐	☐	
3					Cesarean section	☐	☐	
4					Kidney trouble	☐	☐	
5								

Menstrual History

Age of onset _____
Regular ☐ yes ☐ no
Cycle _____ days (from start to start)
Usual duration _____days
Flow ☐ light ☐ moderate ☐ heavy
Pains or cramps ☐ yes ☐ no
Date of last period _____

List pregnancies (include miscarriages)

Year	Weight	Sex	Hrs of labor	Anesthesia	Complications

PERSONAL HISTORY

Weight: Now _____ 1 yr ago _____ Highest _____When _____

Have you ever had:	No	Yes
German measles	☐	☐
Mumps	☐	☐
Chicken pox	☐	☐
Scarlet fever	☐	☐
Diphtheria	☐	☐
Pneumonia	☐	☐
Rheumatic fever	☐	☐
Heart disease	☐	☐
Heart murmur	☐	☐
Polio or meningitis	☐	☐
Kidney infections	☐	☐
Gonorrhea or syphilis	☐	☐
Anemia	☐	☐
Jaundice	☐	☐
Gallbladder disease	☐	☐
Epilepsy	☐	☐
Migraine headaches	☐	☐
Tuberculosis	☐	☐
Valley fever	☐	☐
Cancer	☐	☐
High or low blood pressure	☐	☐
Nervous breakdown	☐	☐
Diabetes	☐	☐

Do you now have or have you ever had:	No	Yes
Any eye diseases, injury, impaired sight	☐	☐
Any ear diseases, injury, impaired hearing	☐	☐
Any trouble with nose, sinuses, mouth, throat	☐	☐
Any head injury, fainting spells, convulsions	☐	☐
Frequent or severe headaches	☐	☐
Skin disease	☐	☐
Chronic or frequent cough	☐	☐
Chest pain or spitting up of blood	☐	☐
Night sweats	☐	☐
Shortness of breath	☐	☐
Swelling of hands, feet or ankles	☐	☐
Varicose veins	☐	☐
Kidney or bladder disease	☐	☐
Indigestion, stomach trouble or ulcer	☐	☐
Rectal bleeding, constipation or diarrhea	☐	☐
Loss of urine with cough or sneeze	☐	☐

Alcoholic Beverages ☐ never ☐ moderate ☐ daily
Cigarettes _____ pack per day
Surgery – what, when, where _____
_____
Allergies: _____
Transfusions ☐ no ☐ yes Number _____

HIPAA NOTICE OF PRIVACY PRACTICES
ESSAM TAYMOUR, M.D.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. WE may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, Public Health issues as required by law, communicable diseases; health oversight; abuse or neglect. Food and Drug Administration requirements: Legal Proceedings: law enforcement; coroners, funeral directors and organ donation; criminal activity, military activity, national security; workers' compensation: Inmates: required uses and disclosures: Under the law, we must make disclosures to you and when by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records, psychotherapy notes, information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health & Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**.

This notice was published and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print name _____ Signature _____ Date _____

PATIENT NAME: DATE:

CURRENT MEDICATIONS	REASON	CURRENT MEDICATIONS	REASON

**PREFERRED PHARMACY PHONE #:

REFILLS (FOR OFFICE USE)

DATE	RX NAME	DOSE	REFILS	REASON	# AND CONTACT	APPROVAL