Escondido OB-GYN Medical Group, Inc. dba
NORTH COUNTY
WOMEN'S SPECIALISTS
488 East Valley Parkway, Escondido, CA 92025

Dear Patient,

We appreciate you choosing ***North County Women's Specialists*** for your healthcare needs. We continually strive to provide the highest quality gynecologic and obstetric healthcare in a professional caring environment.

We want to understand your health concerns and goals. Enclosed is your new patient packet for completion—thank you for taking the time to begin our conversation by completing this information. **This packet needs to be completed and returned 1 week prior to your appointment. Failure to do so may result in your appointment being rescheduled.**

To be able to provide you with the best medical care possible, we recommend that if you have *children under the age of 8*, to please not bring them with you to your appointment.

We understand that English may not be the primary language of all of our patients. To alleviate any delays in your care related to language, we ask if you need a translator, that you please bring one with you to all your appointments. Please know that we do have some Spanish bilingual staff, however they may not be available at the time of your appointment.

You must bring your insurance card or proof of insurance to all appointments. Co-payments and/or deductibles, if applicable, are required to be paid at the time of your visit.

Lastly, we ask that you arrive ***15 minutes prior to your appointment.*** Please be advised that if you are late to your appointment, you may be rescheduled.

Thank you for your cooperation.
We look forward to caring for you,

North County Women's Specialists

Enclosures

Shannon Hart, DO *Paul Hinshaw, DO* *Peggy Ray, FNP* *Karen Gross, RNP*	*Brano Cizmar, MD, PhD* *Camela McGrath, MD* *Rachel Krochmal, FNP* *Karen Manchester, FNP* *Peggy Ray, FNP*	*Josue Leon, MD* *Victoria Young, MD* *Karen Gross, RNP* *Ultrasound Imaging*	*Business Office* *Dobrila Undheim,* *Director of Operations*
Suite 308 *PH 760-745-1363* *FX 760-745-9278*	*Suite 311* *PH 760-233-1896* *FX 760-233-1899*	*Suite 400* *PH 760-658-6101* *FX 760-658-6106*	*Suite 310* *PH 760-745-7060* *FX 760-294-7784*

www.ncwomensspecialists.com

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PATIENT REGISTRATION

How did you hear about us?

☐ Referred by provider ☐ ZocDoc ☐ Friend/Family ☐ Internet ☐ Other (please specify):_____

Are interested in cosmetic services (Botox, Juvederm, Latisse, Laser Hair/Skin Treatments, etc)? ☐ Yes ☐ No

PATIENT INFORMATION

Full Name: _____

Date of Birth: _____ SSN#: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Secondary Phone Number: _____

E-mail: _____ @ _____ Occupation: _____

Employer: _____ Business Phone: _____

EMERGENCY CONTACT INFORMATION

Full Name: _____ Relationship: _____

Phone Number: _____ Secondary Phone Number: _____

E-mail: _____ @ _____

INSURANCE INFORMATION

Primary Insurance: _____ Name of Policy Holder: _____

ID#: _____ Group #: _____

Secondary Insurance: _____ Name of Policy Holder: _____

ID #: _____ Group #: _____

RESPONSIBLE PARTY INFORMATION

(IF different than patient stated above)

Full Name: _____ Relationship: _____

Date of Birth: _____ SSN#: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ E-mail: _____ @ _____

PRIMARY CARE PROVIDER

Provider Name: _____ Clinic Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Reset Form

Suite 308
PH 760-745-1363
FX 760-745-9278

Suite 311
PH 760-233-1896
FX 760-233-1899

Suite 400
PH 760-658-6101
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ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The **Notice of Privacy Practices** provides information about how we may use and disclose protected health information. By signing this form, *I hereby acknowledge* that a copy of the **Notice of Privacy Practices** for Escondido OB/GYN *dba* North County Women's Specialists is available to me upon request.

A copy of this notice is posted in the reception area and may be viewed if so desired.

Reset Form

Print Name:_____ Date of Birth:_____

Signature:_____ Date:_____

*Relationship to patient (if signed by personal representative of patient):*_____

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PATIENT FINANCIAL AGREEMENT

1. ___ (initial) **Co Payments:** Your insurance company requires us to collect co-payments *at the time of service*. Due to state and federal laws, co-payments will not be waived.
2. ___ (initial) **Claims Submission:** As a courtesy, North County Women's Specialists will bill your insurance.
   - A quote of benefits is not a guarantee of payment. We will submit your claims and assist you until the claim is resolved. Payment from your insurance company is usually expected within 45 days. After 45 days, we may look to you for full payment.
   - You are responsible for all *non-covered* services according to your insurance company's guidelines.
   - If we receive notification that you are not eligible for coverage or we are not contracted with your insurance, *you will be responsible* for all charges incurred and payment is due upon receipt of the bill.
   - Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request in a timely manner.
   - You are responsible to provide a copy of your most recent insurance cards for all applicable health plans.
   - Accounts that are 90 days past due may be referred to a collection agency.
3. ___ (initial) **Preventive Care Services:** Routine exams (a.k.a. annual exam, well woman exam) may be covered by your insurance. When a medical concern is addressed at that time of your preventive care visit, *preventive benefits will no longer apply*. Additional fees may incur including but not limited to co-pays, deductibles, and co-insurance.
4. ___ (initial) **Ancillary Services:** Laboratory and radiology procedures may be billed separately be an outside provider. Please contact them directly with any questions regarding your bill.
5. ___ (initial) **Missed Appointments:** If you **cancel** an appointment ***less than 24 hours*** prior to the scheduled appointment time or do not show up for an appointment (**No-Show**), you will be billed a **Cancellation/No-Show fee**. These fees will be billed directly to you.
   - Appointment Cancellation/No-Show fee: $25
   - Preoperative Appointment Cancellation/No-Show fee: $50
   - Procedure Cancellation/No-Show fee: $50
6. ___ (initial) **Assignment of Benefits**: Authorization is hereby granted to release information as may be necessary (in compliance with HIPPA guidelines) to process and complete my insurance claims and payment of medical benefits is to be paid directly to Escondido OB/GYN *dba* North County Women's Specialists for all services rendered.

Print Name:_____ Date of Birth:_____

Signature:_____ Date:_____

*Relationship to patient (if signed by personal representative of patient):*_____

Reset Form

Suite 308	*Suite 311*	*Suite 400*	*Suite 310*
PH 760-745-1363	*PH 760-233-1896*	*PH 760-658-6101*	*PH 760-745-7060*
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PERMISSION TO FURNISH MEDICAL INFORMATION

I hereby authorize Escondido OB/GYN *dba* North County Women's Specialists to **furnish medical information** about me (i.e. lab results, doctor's instructions, etc.) in the event that I am not immediately available. (*Select only ONE*)

☐ ***ONLY directly to me.*** In this instance, we will leave a message for you to call our office.

☐ ***Leave a message/voice mail.*** In this instance, we will leave a *detailed* message at the number you have on file. Please note, if your voicemail is not setup with your name, we will only be able to leave a message to call our office.

☐ *Leave a message with **individual(s)** listed below.* (This authorization will be in effect until revoked in writing).

	Approved Person(s) Name	Relationship to you	Contact Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Reset Form

Print Name:_____ Date of Birth:_____

Signature:_____ Date:_____

NORTH COUNTY WOMEN'S SPECIALISTS

This information is confidential and will not be revealed to anyone without your permission

Name:_____ **Date of Birth:**_____ **Age:**___ **Date:**_____

Height:__ft___in Weight:____lbs Preferred Language:_____Ethnicity:_____Marital Status:_____

A WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? ☐ Pregnancy ☐ Annual GYN Exam ☐ GYN Health Issue

Please describe GYN issue: ***How long have you had this GYN issue:***_____

B GYNECOLOGIC HISTORY

Age at first period:_____ **Date of *beginning* of last menstrual period**:_____ **Age at menopause**:_____

Frequency: ☐ Regular ☐ Irregular **Cycle Length** (#days between periods):_____ **Cycle Duration** (#days of bleeding):_____

Flow: ☐ Light ☐ Moderate ☐ Heavy ☐ Clots **Cramping**: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Sexually Active: ☐ Yes ☐ No ☐ Previously **Partners**: ☐ Men ☐ Women ☐ Both **Types of sex**: ☐ Vaginal ☐ Oral ☐ Anal

Contraceptive method: ☐Pills☐ Patch☐ Ring ☐ Shot☐ IUD ☐ Implant ☐ Tubal Ligation☐ Condoms ☐ None ☐ Other

Date of last Pap:_____Was it Normal: ☐ Yes ☐ No *What abnormality:*_____

Have you ever had an *abnormal* pap: ☐ Yes ☐ No *When:*_____*What abnormality:*_____

Have you ever had *treatment* for an abnormal pap: ☐ Yes ☐ No *When:*_____*What treatment:*_____

Date of last mammogram: ☐ N/A_____Was it normal: ☐ Yes ☐ No

C OBSTETRICAL HISTORY ☐ Have never been pregnant

(Please list all pregnancies in order, including miscarriages, premature births, abortions, ectopic (tubal), etc.)

	No.		No.		No.		No.		No.
Pregnancies (# times pregnant)		**Term Births** (>37weeks)		**Premature Births** (20-36weeks)		**Abortions**		**Living Children**	
						Miscarriages			
						Ectopic/Tubal			

Mon/Day/Yr	Duration of Pregnancy (i.e. 40weeks)	Hours in Labor	Birth weight (pounds)	Sex M/F	Type of Delivery (vaginal, C-section, forceps, vacuum, miscarriage, etc.)	Epidural Y/N	Place of delivery or abortion	Comments/ Complications

Pregnancy Complications: **Diabetes** ☐ Yes ☐ No **Hypertension** ☐ Yes ☐ No **Pre-eclampsia** ☐ Yes ☐ No

D CURRENT MEDICATIONS (List all including hormones, vitamins, herbs, nonprescription medications, etc.)

Drug Name	Dose	Frequency (i.e. twice daily)	Drug Name	Dose	Frequency (i.e. twice daily)

E ALLERGIES **Food:** ☐Yes ☐No **Latex:** ☐Yes ☐No **Medications:** ☐Yes ☐No (If *Yes*, list all and reaction):

_____

_____

_____

Reset Page 1

NORTH COUNTY WOMEN'S SPECIALISTS

This information is confidential and will not be revealed to anyone without your permission

Name:_____ **Date of Birth:**_____ **Age:**___ **Date:**_____

F PAST MEDICAL AND FAMILY HISTORY *Please ☒check if you **or** a blood relative has had any of the following*

Indicate family member M=Mother; F=Father; B=Brother; S=Sister; GM= Grandmother; GF= Grandfather; O = Other (i.e. Aunt or Uncle)

		No	Yes	Self	*Family*			No	Yes	Self	*Family*
1.	alcohol or drug problems	☐	☐	☐		23.	fibroids	☐	☐	☐	
2.	anemia	☐	☐	☐		24.	gallbladder disease	☐	☐	☐	
3.	arthritis/joint pain/back problems	☐	☐	☐		25.	genital herpes	☐	☐	☐	
4.	asthma	☐	☐	☐		26.	headaches/migraines	☐	☐	☐	
5.	autoimmune disease (lupus)	☐	☐	☐		27.	heart attack/disease	☐	☐	☐	
6.	birth defects	☐	☐	☐		28.	hepatitis/liver disease	☐	☐	☐	
7.	bladder infections	☐	☐	☐		29.	hereditary disease	☐	☐	☐	
8.	bleeding problems	☐	☐	☐		30.	high blood pressure	☐	☐	☐	
9.	blood clots in lungs/legs (DVT/PE)	☐	☐	☐		31.	high cholesterol	☐	☐	☐	
10.	blood transfusions	☐	☐	☐		32.	HIV/AIDS	☐	☐	☐	
11.	bowel problems	☐	☐	☐		33.	kidney infections/ stones	☐	☐	☐	
12.	cancer - **breast**	☐	☐	☐		34.	mitral valve prolapse	☐	☐	☐	
13.	cancer - **cervical**	☐	☐	☐		35.	pelvic infection	☐	☐	☐	
14.	cancer - **colon**	☐	☐	☐		36.	pneumonia/lung disease	☐	☐	☐	
15.	cancer - **ovarian**	☐	☐	☐		37.	reflux/digestive problems	☐	☐	☐	
16.	cancer - **uterine**	☐	☐	☐		38.	rheumatic fever	☐	☐	☐	
17.	cancer - **other**	☐	☐	☐		39.	sickle cell anemia	☐	☐	☐	
18.	chickenpox	☐	☐	☐		40.	stroke	☐	☐	☐	
19.	chlamydia/gonorrhea/syphilis	☐	☐	☐		41.	thyroid problems	☐	☐	☐	
20.	depression/anxiety	☐	☐	☐		42.	tuberculosis	☐	☐	☐	
21.	diabetes	☐	☐	☐		43.	other	☐	☐	☐	
22.	epilepsy/seizure disorder	☐	☐	☐		44.	other	☐	☐	☐	

For any Yes, please indicate #, and explain: Clear Explanation

G SURGERIES/HOSPITALIZATIONS (not including hospitalization for childbirth)

Year	Procedure or Reason for Hospitalization	Year	Procedure or Reason for Hospitalization

H SOCIAL HISTORY

Do you smoke/have ever smoked?	☐ Yes ☐ No	*# packs/day*	*# years smoked*	*Quit when?*	*Do you want to Quit?* ☐ *Yes* ☐ *No* ☐ *N/A*
Do you drink alcohol?	☐ Yes ☐ No	*What do you drink?*	*How often do you drink?*	*How much do you drink?*	
Do you use/have ever used drugs?	☐ Yes ☐ No	*What substance?*	*How often?*	*Quit when?*	*Do you want to Quit?* ☐ *Yes* ☐ *No* ☐ *N/A*

I ***In case of an emergency, do you consent to **transfusion of blood or blood products**?* ☐ Yes ☐ No

J PHARMACY INFORMATION

Reset Page 2

Name:_____ Street:_____ City:_____ Phone:_____