# DAVID AHDOOT, M.D., F.A.C.O.G.

Obstetrics, Gynecology, Infertility, and Urinary Incontinence
191 S. Buena Vista St. #340
Burbank, CA 91505
818-559-7500
818-559-6453 (fax)


| **Best Phone Number a message can be left for test results:** | Today's date: |
|---|---|

## PATIENT INFORMATION

| Patient's last name: | First: | Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
|---|---|---|---|---|---|

| Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ❑ M ❑ F |
|---|---|---|---|---|---|

| Street address: | Social Security no.: | Home phone no.: ( ) |
|---|---|---|

| P.O. box: | City: | State: | ZIP Code: |
|---|---|---|---|

| Occupation: | Employer: | Employer phone no.: ( ) |
|---|---|---|

| **Chose clinic because/Referred to clinic by (please check one box):** | **❑ Dr.** | | | |
|---|---|---|---|---|
| **❑ Family** | **❑ Friend** | **❑ Hospital** | **❑ Internet** | **❑ Other** |

| Spouse Name: | Email Address: |
|---|---|

## INSURANCE INFORMATION

| Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( ) |
|---|---|---|---|

Is this person a patient here? ❑ Yes ❑ No

| Occupation: | Employer: | Employer address: | Employer phone no.: ( ) |
|---|---|---|---|

| Please indicate primary insurance | ❑ [Insurance] | ❑ [Insurance] | ❑ [Insurance] | ❑ [Insurance] | ❑ [Insurance] |
|---|---|---|---|---|---|
| ❑ [Insurance] | ❑ [Insurance] | ❑ [Insurance] | ❑ Welfare *(Please provide coupon)* | ❑ Other | |

| Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $ |
|---|---|---|---|---|---|

| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |
|---|---|---|---|---|

| Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.: |
|---|---|---|---|

| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |
|---|---|---|---|---|

## IN CASE OF EMERGENCY

| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( ) |
|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature: Date

Name____________________________

Age________ Date of birth____________________

Any concerns/issues you would like to discuss today?

________________________________________________

________________________________________________

## GYNECOLOGY HISTORY G___ P_____

| First day of last menstrual period? | |
|---|---|
| Age at 1st period | |
| # of days between periods (from 1st day of period to 1st day of next period) | |
| Length of period (# of days of bleeding) | |
| Heavy bleeding? | Y / N |
| Cramps? | Y / N |

| Birth control method ☐ N/A | |
|---|---|
| Number of sexual partners in last year | |
| Are you currently sexually active? | Y / N |
| Have you had any sexually transmitted diseases? If yes, which ones? | Y / N |
| Would you like to be tested today? | Y / N |

| When was your last pap smear? | |
|---|---|
| Any history of abnormal pap smears? When was this? What treatment was performed? | Y / N |
| When was your last mammogram? ☐ N/A | |
| Any history of abnormal mammograms? | Y / N |
| Do you do self-breast exams? | Y / N |

| Any history of sexual abuse or domestic violence? | Y / N |
|---|---|
| Would you like to talk about this today? | Y / N |

**If you are in menopause:**

| When did this begin? | |
|---|---|
| Which hormone replacement therapy are you taking? ☐ N/A | |
| What symptoms are you having? Please circle<br>Hot flashes, Vaginal dryness, Night sweats<br>Vaginal bleeding, Low libido, Insomnia<br>Mood changes | |

## OBSTETRIC HISTORY- ☐No changes

List all previous pregnancies

## PAST MEDICAL HISTORY - ☐No changes

List all medical problems

## PAST SURGICAL HISTORY- ☐No changes

List all previous surgeries

## MEDICATIONS

List all medications, herbs or supplements

## ALLERGIES

## SOCIAL HISTORY- Do you do any of the following:

| Marital staus | | | |
|---|---|---|---|
| Smoke? | Y/ N | How many packs a day? | |
| Drink alcohol? | Y/ N | How many drinks a week? | |
| Do drugs? | Y/ N | Which drugs? | |

## FAMILY HISTORY-Please circle if you have any family members with the following:

Breast cancer, Uterine cancer, Ovarian caner
Colon cancer, Stroke, High blood pressure
Heart attacks, Blood clots, Diabetes
Osteoporosis, Birth defects, Other:

## PREVENTATIVE

| Do you exercise? | Y / N | What kind and how often? | |
|---|---|---|---|
| Use sunscreen? | Y / N | | |
| Use a seatbelt? | Y/ N | | |
| Calcium in your diet? | Y / N | | |

| Have you had the following test? | When was this test last done? |
|---|---|
| Cholesterol (≥45 y/o, q5y) | |
| Diabetes (≥45y/o, q3y) | |
| Thyroid | |
| Colonoscopy (≥50y/o, q10y) | |
| Bone density | |

## REVIEW OF SYSTEMS- Please circle if you have any of the following

☐ NONE OF THE BELOW

Fever, Fatigue, Hair loss
Chest pain, Cough, Shortness of breath
Palpitations, Feeling hot/cold
Breast pain, Breast lump, Nipple discharge
Diarrhea, Constipation, Blood in stools
Pain with urination, Frequent urination
Urge to urinate, Blood in urine
Loss of urine/incontinence, Change in height
Cuts that don't stop bleeding, Weight loss/gain

# Patient Responsibility Notice on Insurance

**Financial Responsibility Agreement**: I, ___________________________ hereby accept full responsibility for any and all charges related to diagnosis and treatment, whether or not my insurance company covers these services. I agree to pay in full within 30 days of receipt of notice all balances due such as, non –covered services, co-insurances, deductibles, co-payments not paid by my insurance company and legal fee if any. In addition to any return check fee and late fee. I understand that if such balances are not paid in full within 30 days there may be a finance charge of 1.5% of the total balance due each month. If these obligations are not met and payment arrangements have not been made with Dr. Ahdoot, legal/collections proceeding will commence without further notice. In the event litigation is necessary, I agree to pay court costs and reasonable attorney fees.

________ Initials

**Timely Insurance Payment**: I understand that CA State Law requires insurance companies to either pay or deny a medical claim within 30 days of receipt. Should my insurance company not comply with the State Law, I understand that I will become fully liable for the full balance due of all past and current claims. ***If my insurance company sends me the checks for the services provided by Dr. Ahdoot, I shall endorse all checks or make payment to Dr. Ahdoot within 7 days*. I also authorize that my credit card on file be charged within 7 days of receipt for any balances due. Failure to meet these obligations will result in legal/collections** proceedings. We reserve the right to charge you a 3% credit card fee on all credit card transactions.

________ Intial

CC #:_____________________________ Expiration date:__________ zip_____________

Initials

**Non-Sufficient Fund Checks/Returned Checks**: I understand and agree to pay a returned check fee of $25.00 if payment by check is returned due to non-sufficient funds in my checking/savings account.

________ Initials

**Forms Needing Completion:** All forms including, but not limited to FMLA or State disability, school/work physical will be subject to a $25.00 administrative fee for each form. The patient may need to schedule an appointment with the physician in order for him/her to complete these forms.

________ Intials

I have read and understand the above statements. By signing this notice, I agree to all terms.

_______________________________ _______________

Patient Signature Date

**BURBANK**
191 S. Buena Vista St. #340
Burbank, CA 91505
PH (818) 559-7500
FAX (818) 559-6453

**PALMDALE**
41210 11TH St. Suite A
Palmdale, CA 93551
PH (661) 222-7822
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