Confidential Patient Information Application

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Phoenix, Arizona 85013
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www.bellawomenscare.com

500 W Thomas Rd #480
Phoenix, Arizona 85013
602-264-1771
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51 E Monterey Way
Phoenix, Arizona 85012
602-240-2401
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Last Name:_____ **First:**_____ **Middle**_____
Birthdate:____/____/____ **Ethnicity:** ☼Black/☼White/☼Hispanic/☼Asian/☼Arab, Middle-Eastern, ☼Choose to not answer

How did you hear about us? ☼Friend-Who can we thank?_____ ☼Internet/ ☼Website/ ☼Physician/ ☼Other_____

Address:_____ **Unit #**_____ **City**_____ **State**_____ **Zip**_____

Phone ( ) _____-_____ **EMAIL:**_____@_____._____

Emergency Contacts 1. _____ **Relationship:**_____ **Phone:**_____

2. _____ **Relationship:**_____ **Phone:**_____

Primary Insurance: _____ **Telephone:**_____ **Policy #**_____

Policyholder Name:_____ **Birthdate:**_____ **Group#**_____

Secondary Insurance: _____ **Telephone:**_____ **Policy #**_____

Policyholder Name:_____ **Birthdate:**_____ **Group#**_____

Employment Status: ☼FT/☼PT/☼Unemployed/☼Retired/☼Active Military/☼Self-Employed/☼Minor Child

Employer Name:_____ **Address:**_____ **Zip** _____ **Phone:**_____

Pharmacy Name:_____ **Address:**_____ **Zip**_____

Your Primary Care Physician Name:_____
Facility:_____ **Address:**_____
City_____ **State:**_____ **Zip**_____ **Telephone:**_____

I certify that I have read and understood the above information to the best of my knowledge. I have completed this form with accurate information. I authorize Bella Women's Care to use or disclose any information for treatment, payment and healthcare operations. I also authorize Bella Women's Care to release any medical information necessary to process Medicare and/or any insurance claims. I authorize payment of medical benefits to Bella Women's Care. I also understand that regardless of my insurance status I am responsible for any due balances on my account for medical services rendered to me. I understand that I am responsible for any deductible, co-pays or co-insurance amounts not covered by my insurance carrier. I also understand that any collection or attorney fees will be my responsibility.

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Bella Women's Care, PC as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that have been or will be rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by Healthcare Provider. A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Patient Signature_____ Date:_____

Legal Guardian:_____ Date:_____ Relationship:_____

OBSTETRICAL MEDICAL HISTORY

Patient Name _____ Date Form Completed _____

PERSONAL HEALTH HISTORY

1. Are you allergic to any medications? ☐ Yes ☐ No
   If yes, please list: _____
2. Please mark any condition that you have or have had in the past:

☐ Arthritis or Lupus	☐ Depression	☐ Hepatitis	☐ Recurrent Urinary Tract Infections
☐ Asthma	☐ Diabetes	☐ Herpes	
☐ Blood Disease	☐ Epilepsy	☐ High Blood Pressure	☐ Thyroid Disorder
☐ Bowel Disease	☐ Headaches	☐ Kidney Disease	☐ Other
☐ Chicken Pox	☐ Heart Disease	☐ Migraine Headaches	

   Describe, if needed: _____
3. Please indicate any surgery that you have had: _____
4. Please describe any health problems or symptoms that you are having at this time:

EXPOSURES AFFECTING HEALTH

1. Do you smoke cigarettes? ☐ Yes ☐ No If yes, how many packs per day? _____
2. Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how often? _____
   What type of drink(s)? _____
3. Please list any medications taken since your last period: _____
4. Please list any "recreational" drugs used since your last period (i.e. cocaine, marijuana, etc.): _____
5. Do you have a history of blood transfusion, intravenous drug use, multiple sexual partners or sexual exposure to a gay or bi-sexual male, exposure to an intravenous drug user, or have any other reason to believe you may have been exposed to AIDS?
6. Please list any sources of chemical or radiation exposure that you encounter:
7. If you are on a restricted diet, please describe: _____

GYNECOLOGIC HEALTH HISTORY

1. When was your last Pap Smear? _____ Have you ever had an abnormal Pap Smear? ☐ Yes ☐ No If yes, when and where were you treated?
   What was the diagnosis?
2. Have you ever had gonorrhea, chlamydia or pelvic inflammatory disease? ☐ Yes ☐ No
   If yes, when and where were you treated?
3. Have you ever had herpes? ☐ Yes ☐ No
4. Have you ever used an IUD (intrauterine device) for contraception? ☐ Yes ☐ No
   If yes, please indicate when: _____
   Did you have any problem with the IUD? ☐ Yes ☐ No Please describe:
5. Do you have a history of infertility? ☐ Yes ☐ No If yes, please describe when and treatment received: _____
6. Please list any other concerns you have related to your past health history:

Patient Signature _____ Print Name _____ Date _____

PHYSICIAN NOTES

Patient Name _____ **ALLERGIES** _____

OBSTETRICAL MEDICAL HISTORY, PAGE 2

7. Do you have any religious objections to any form of medical treatment that you would like to make us aware of (i.e. refusal of blood transfusion)? _____
8. Do you have any special needs for: Hearing ☐ Yes ☐ No Vision ☐ Yes ☐ No Language ☐ Yes ☐ No

FAMILY HISTORY & GENETIC HISTORY

1. Have either you or the baby's father had a child born with a birth defect? ..... ☐ Yes ☐ No
   If yes, please describe: _____
2. Did either you or the baby's father have a birth defect yourselves? ..... ☐ Yes ☐ No
   If yes, please describe: _____
3. Please describe any abnormalities that have occurred in children in your family or the baby's father's family (for example, mental retardation, birth defects, deformities, or inherited diseases like hemophilia, muscular dystrophy or cystic fibrosis). _____
   _____
   How is the affected child/person related to you? _____
4. Do either you or the baby's father have a history of pregnancy losses (miscarriages or stillborn)? ..... ☐ Yes ☐ No
   If yes, have either of you had genetic counselling? ..... ☐ Yes ☐ No
   If yes, have either of you had chromosomal studies? ..... ☐ Yes ☐ No
   Where and results: _____
5. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if either you or the baby's father is of one of these backgrounds:

   Jewish ancestry? ☐ Yes ☐ No — If yes, have you had Tay-Sachs screening tests? ..... ☐ Yes ☐ No
   Date: _____ Result: _____

   African-American? ☐ Yes ☐ No — If yes, have you had Sickle Cell screening? ..... ☐ Yes ☐ No
   Date: _____ Result: _____

6. Please mark if anyone in your family or the baby's father's family has:

Diabetes	☐ Yes ☐ No	If yes, how is that person related to you? _____
Bleeding disorder	☐ Yes ☐ No	If yes, how is that person related to you? _____
Hypertension	☐ Yes ☐ No	If yes, how is that person related to you? _____
Cancer	☐ Yes ☐ No	If yes, how is that person related to you? _____

7. Please list any other concerns you have about birth defects or inherited disorders:
   _____
   _____
8. Will you be 35 or older at the time the baby is born? ..... ☐ Yes ☐ No
9. Will the father be 50 or older? ..... ☐ Yes ☐ No

_____ _____ _____
Patient Signature Print Name Date

Physician Notes: _____
_____
_____
_____

Patient Account #: _____

Patient Medical History

Patient Name: _____ **Date of Birth:** _____

Pharmacy Name: _____ **Phone Number:** _____

Medication Allergy List

Medication	Reaction	Medication	Reaction	Medication	Reaction

Medical Problems

1	2	3	4
5	6	7	8

Medications

Medication Name	Strength	Quantity	Frequency
1			
2			
3			
4			
5			
6			
7			

Advance Directives

	On File Date
Advance Directive	
Do Not Resuscitate	
Living Will	
Durable Power of Attorney	
Health Care Surrogate	
Other (Please specify)	

Receipt of Privacy Notices/Health Insurance Portability and Accountability Act (HIPAA)
I acknowledge that I have received a copy of Bella Women's Care Notices of Privacy Practices.

Patient/Legal Guardian Signature: _____ Date: _____
Printed Name: _____ Relationship: _____

IT IS THE OFFICE POLICY OF BELLA WOMEN'S CARE AND STAFF NOT TO DISCLOSE CONFIDENTIAL AND/OR UNAUTHORIZED INFROMATION TO INDIVIDUALS OTHER THAN THE PATIENT.

I _____ AUTHORIZE BELLA WOMEN'S CARE AND/OR THEIR STAFF TO LEAVE MEDICAL INFORMATION PERTAINING TO MY CARE BY THE FOLLOWING METHODS AND WILL ASSUME RESPONISIBLITY TO NOTIFY THEM WHENEVER THIS INFORMATION CHANGES.

HOME TELEPHONE	YES_____	NO_____
ANSWERING MACHINE	YES_____	NO_____
WORK TELEPHONE	YES_____	NO_____
VOICEMAIL	YES_____	NO_____
CELL PHONE	YES_____	NO_____

FAX MEDICAL RECORDS TO PRIMARY CARE PHYSICIAN OR OTHER MEDICAL PROVIDERS YES_____ NO_____

IF YOU WOULD LIKE TO HAVE ANY INFORMATION RELEASED TO SOMEONE OTHER THAN YOURSELF PLEASE COMPLETE THE FOLLOWING

NAME AND RELATIONSHIP OF AUTHORIZED PEOPLE TO RELEASE INFORMATION TO:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PATIENT/GUARDIAN SIGNATURE_____ DATE_____