Name: _____ Age _____ Date: _____

Primary Care Physician (PCP) Name: _____ Did your PCP refer you to our office? Y N

What is the reason for your visit today? _____

What was the first day of your last normal menstrual period? _____/_____/_____

Please update your past history. Since your last visit, have you?

Had Surgery? Y N _____

Been diagnosed or treated for a new illness? Y N _____

_____

Had any other events in your medical history? Y N _____

Had any important laboratory or diagnostic tests such as CAT scan, Ultrasound, Blood tests, etc? Y N

_____

What method of birth control do you currently use? (circle one or more)

Pills Patch Ring Condom IUD Shot Tubes Tied Vasectomy Timing Withdrawal Spermicide Abstinence Menopause

SOCIAL HISTORY: Do you use any tobacco product (Cigarettes, Cigars, Chewing Tobacco)? Y N

Have you had sex with a new partner in the past year? Y N

FAMILY HISTORY: (circle all that apply to any member of your immediate family)

Alzheimer's disease Birth Defects Blood Clot in Leg/Lung Breast Cancer Colon Cancer
Drug or Alcohol Problems Diabetes Heart Disease Hepatitis HIV High Cholesterol
High Blood Pressure Mental Illness Osteoporosis Ovarian Cancer Prostate Cancer Stroke
Tuberculosis Uterine Cancer

REVIEW OF SYSTEMS: (Please circle any of the following complaints that you are **currently** experiencing)

Constitutional: weight gain loss of appetite fever weakness weight loss fatigue

Breast: lump or mass nipple discharge pain

Respiratory: shortness of breath coughing wheezing pain with deep breathing

Gastrointestinal: nausea heartburn vomiting problem swallowing diarrhea constipation blood in stool

Urinary: difficulty urinating frequent urination incontinence (leaking) pain with urination
awake to urinate more than once at night

Reproductive: heavy periods pain with intercourse pelvic pain pain with period
vaginal itching or burning vaginal discharge

Endocrine: excessive thirst cold intolerance heat intolerance hot flashes

Current Medications: (please list the name and dosage, including over the counter and herbal products)

_____

_____

Medication Allergies: [] No Known Drug Allergies _____

_____

Is there any information you think the doctor should have that you have not already written down?

_____

_____

Patient Signature: _____

Name _____ Social Security # _____ Age _____

Birth Date _____ Driver's License # _____ DL State _____

e-mail address: _____@_____

Home Phone # _____-_____-_____ Cell Phone # _____-_____-_____ Work Phone # _____-_____-_____

Marital Status [] S [] M []W [] D Religion: _____ Primary Language [] English [] Other : _____

Street Address _____ Apt # _____

City _____ State_____ Zip _____

Employer/School _____ Title _____

Street Address _____ City _____ State_____ Zip _____

Spouse _____ Age _____ Birthdate _____

Spouse Employer _____ Title _____ Phone # _____

Street Address _____ City _____ State_____ Zip _____

Referred by: _____ Primary Care Physician: _____

Person to contact in an emergency who does not live with you:

Name _____ Phone # _____ Relationship _____

Street Address _____ City _____ State_____ Zip _____

Primary Insurance Information: Is this an employer plan? Y N

Company _____ Insured's Name _____ Insured's D.O.B. _____

Insured's SS # _____ ID # _____ Group # _____

Street Address _____ City _____ State_____ Zip _____

Phone # _____-_____-_____ Your relationship to insured [] Self [] Spouse [] Child [] Other

Secondary Insurance Information: Is this an employer plan? Y N

Company _____ Insured's Name _____ Insured's D.O.B. _____

Insured's SS # _____ ID # _____ Group # _____

Street Address _____ City _____ State_____ Zip _____

Phone # _____-_____-_____ Your relationship to insured [] Self [] Spouse [] Child [] Other

Guaranty of Payment: I fully understand that I am directly responsible for payment to Westside OB/GYN Group, L.L.C. for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay all collecting costs including reasonable attorney's fees in the event it becomes necessary to file suit for payment. I authorize payments to be made directly to Westside OB/GYN Group, L.L.C. Authorization to Release Information I hereby authorize Westside OB/GYN Group, L.L.C. to release any information acquired in the course of my visit or treatment to my insurance company for the purpose of processing any insurance claim. Assignment of Insurance Benefits If insurance claims are filed on my behalf, I hereby authorize direct payment of any benefits to Westside OB/GYN Group, L.L.C. for any treatment received by me. In this circumstance, I understand that I am financially responsible for any charges not covered by insurance. I permit a copy of this authorization to be used in place of the original. In addition, I authorize Westside OB/GYN Group, L.L.C. to access records of my prescription medications directly from the pharmacy whenever it is deemed necessary for my care.

Signature _____ Date _____

(parent if patient is a minor)

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

Please note: you are not required to list any name if you do not so choose.

[] I do not wish my information to be released to anyone

I, _____, authorize Westside OB/GYN Group, L.L.C. to release or discuss information related to my medical condition (including information related to my treatment plan, medication, disease or diagnosis and/or billing information) to the following named persons (this negates all prior authorization):

1. _____ 2. _____

3. _____ 4. _____

Please list phone numbers where you would like us to contact you for:

- Results – Lab, Ultrasound, X-ray, Mammography, etc.
- Reminders for or changes of appointments

1. _____ [] OK to leave detailed message/text

2. _____ [] OK to leave detailed message/text

Patient's Name: _____

DOB: _____ SS # _____

Date:_____ Signature: _____

WESTSIDE OB/GYN GROUP, L.L.C.

Patient Name: _____ DATE: _____

CONSENT FOR CHLAMYDIA & GONORRHEA TESTING

It is recommended to test all women under the age of 26 for Chlamydia and Gonorrhea. Testing is done using the same specimen as your pap smear, a special swab or a urine specimen. Most insurance companies cover this important test. (For women 26 years old and older, testing should only be done if you have a risk factor such as a new sex partner or more than one sex partner**). If the laboratory receives an insurance denial for these tests, you will be responsible for payment.**

☐ **I agree to Gonorrhea and Chlamydia testing if recommended by my provider**

☐ **I decline Gonorrhea and Chlamydia testing even if recommended by my provider**

CONSENT FOR Routine Human Papilloma Virus (HPV) TESTING

Routine HPV testing is only for women over the age of 30 who have not had their cervix removed. The HPV test is performed from the Pap smear specimen. As far as we know, all insurance companies except Medicare are now covering this very important test. The HPV test detects activity of the HPV types that can cause abnormal Pap smears. If you have been exposed to HPV in the past, the test will tell you if the virus is currently active in your system. If it is active, you have a higher risk of an abnormal Pap and should have a Pap more often than someone who does not have the virus detectable in their system. Women with a normal Pap and a negative HPV test may be able to have a Pap smear less often than once a year. Like any other test, if the laboratory receives an insurance denial for these tests, you will be responsible for payment. Results will be available from the lab in approximately two weeks. You will receive your results by mail. If we do not do routine HPV testing as part of your Pap we always use HPV testing to help determine when mildly abnormal cells on your Pap are a risk for pre-cancer. This is called reflex testing.

Medicare does not cover routine testing for HPV. Medicare patients that choose to have routine HPV testing will receive a bill from the lab.

☐ **I agree to Routine HPV testing if recommended by my provider**

☐ **I decline Routine HPV testing and understand the test will be done only if indicated by my Pap results.**

CONSENT FOR COLON CANCER SCREENING

Everyone over 50 should have routine colonoscopy every 10 years (or more often if they are at increased risk). If it has been more than 3-4 years since your last colonoscopy or if you are 40-49 years of age and have not yet had a colonoscopy, we offer colon cancer screening using the FIT test. A rectal exam may be part of your annual GYN exam. Screening is done by testing the stool for blood. The test takes less than 2 minutes and you will have the result before your office visit is over. If you have had a test for blood in the stool within the last year, the test does not need to be done today. If you are planning colonoscopy within the next year, the test does not need to be done today. Most insurance companies are now covering this test. Like any other test, if we receive an insurance denial for the test, you will be responsible for payment. The cost of the test is $15. Coventry is the one insurance that we know does not cover the test. Coventry patients who choose to have the test will be charged $15 today.

☐ **I agree to FIT testing for blood in my stool if recommended by my provider**

☐ **I decline FIT testing for blood in my stool even if recommended by my provider**

X_____ _____

Patient Signature Date