

*Doctor's of Women Health Center*  
**Patient Information Form**

This information is confidential. We appreciate your cooperation in filling out this form in its entirety.

**Please Print Clearly**

---

Your Full Name:		Date:			
Home Address:		City/State/Zip:			
Phone: (Home)	Work:	Cell:			
Birthdate:	Age:	Birthplace:			
Married:	Single:	Widowed:	Divorced:	Separated:	Email:
Maiden Name:		Social Security #:	Driver's License #:		
Who referred you to us?					
Your Employer:		Occupation:			
Your Work Address:		City/State/Zip:			

**Spouse/Responsible Party Information:**

---

Name:		Relationship:
Home Address:		City/State/Zip:
Birthdate:	Social Security #:	Employer:

**Person to contact in case of an emergency:**

---

Relationship:	Phone:
---------------	--------

---

*Doctor's of Women Health Center*  
**Patient Information Form**

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

IN ORDER TO CONTROL YOUR BILLING COSTS, WE REQUEST THAT YOUR PATIENT RESPONSIBILITY BE PAID AT THE CONCLUSION OF EACH VISIT, or are on the Obstetrical Care Fee Schedule. If you cannot pay at time of service, you must discuss other payment arrangements PRIOR to your visit, with our Billing Department. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records.

I/We hereby assign all medical benefits, to include major medical benefits to which I am entitled, including MediCare, private insurance, and other health plans to DOCTOR'S OF WOMEN HEALTH CENTER, INC.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed: _____		Date: _____
Patient:		
Signed: _____		Date: _____
Responsible Party:		

DOCTORS OF WOMEN HEALTH CENTER  
4050 Barranca Parkway, Suite 160  
Irvine, CA. 92606  
949-559-1911 Fax 949-559-4071

Dear Patient:

As physicians of Doctors of Women, we feel it is very important that you receive all laboratory results including blood work, Pap smears, mammograms, etc. It is standard procedure for our office to notify our patients by either phone or mail of their results. However, in the unlikely event that a laboratory result is not received by our office, standard procedure for notification of our patients may not take place. We therefore ask our patients to share in the responsibility of obtaining their laboratory results by calling for results if not notified after a reasonable time period, i.e., thirty days for Pap smear and mammogram, two weeks for biopsy results, seven days for culture results, two weeks for routine blood work and 24 to 48 hours for all STAT or emergent laboratory work. Your physician or nurse practitioner will let you know during your visit what testing will be done so you are aware of what results are pending. Your health care is our number one priority.

Thank you for partnering with us in your care.

Sincerely,  
Doctors of Women

If my caller ID blocks Doctors of Women's number, I understand that you will not attempt to leave a message.

I will take responsibility for calling for my laboratory results if not notified in a reasonable amount of time.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

AUTHORIZATION TO LEAVE MESSAGES

I give my permission for the staff of Doctors of Women to leave messages regarding my health care, normal test results, appointments, or authorizations.

If a family member answers the phone I give Doctors of Women permission to leave your name and phone number.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name



# Gynecology Health History

ID No.: \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## PATIENT IDENTIFICATION (Please print)

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Telephone No: ( ) \_\_\_\_\_

Work Telephone No: ( ) \_\_\_\_\_

Reason for Seeing Doctor: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Religion: \_\_\_\_\_

Marital Status:  S  M  D  SEP  W Race: \_\_\_\_\_

Education: \_\_\_\_\_ years Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Type of Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

## 1. CURRENT MEDICATIONS

 None

## 2. MEDICATION ALLERGY / SENSITIVITY

List all medications allergic to:  None

## MEDICAL HISTORY (Check the appropriate box)

Have you or any members of your family had:

You  Your Family 

- 3. High Cholesterol.....
- 4. Heart Disease.....
- 5. Rheumatic Fever.....
- 6. High Blood Pressure.....
- 7. Asthma.....
- 8. Tuberculosis.....
- 9. Diabetes.....
- 10. Thyroid Problems.....
- 11. Liver Disease.....
- 12. Stomach, Bowel or Gall Bladder Problems.....
- 13. Kidney or Bladder Problems.....
- 14. AIDS (HIV).....
- 15. Hepatitis (type \_\_\_\_\_).....
- 16. Anemia or Blood Disorder.....
- 17. Blood Transfusion.....
- 18. Allergies.....
- 19. Breast Problems.....
- 20. Cancer.....
- 21. Infertility.....
- 22. Female or Sexual Problems.....
- 23. Chlamydia.....
- 24. Gonorrhea.....
- 25. Herpes (HSV).....
- 26. Syphilis.....
- 27. Birth Defects or Inherited Diseases.....
- 28. Sexual Abuse or Domestic Violence..
- 29. Other Medical Problems.....
- 30. No Known Medical Problems.....

## 37. PREGNANCY HISTORY (Complete all information)

# of Term Births	# of Pregnancies	Born Month/Year	Baby's Sex	Weight at Birth	Weeks Pregnant (Term=40Wks)	Hours in Labor	Type of Delivery	Type of Anesthesia	# of Living Children	
									Yes	No
1	/	/		lbs.oz.					<input type="checkbox"/>	<input type="checkbox"/>
2	/	/		lbs.oz.					<input type="checkbox"/>	<input type="checkbox"/>
3	/	/		lbs.oz.					<input type="checkbox"/>	<input type="checkbox"/>
4	/	/		lbs.oz.					<input type="checkbox"/>	<input type="checkbox"/>
5	/	/		lbs.oz.					<input type="checkbox"/>	<input type="checkbox"/>

## 38. MENSTRUAL HISTORY

First Day of Last Menstrual Period \_\_\_\_/\_\_\_\_/\_\_\_\_

Menarche (Age at First Period)	Interval (No. of Days Between Periods)	Length of Period
yearsdaysdays		

Abnormalities:  Excessive Bleeding  
 Discharge  Pain  None

## 39. CONTRACEPTIVE HISTORY

Type	Dates Used
Oral Contraceptive <input type="checkbox"/>	_____
Type(s) _____ <input type="checkbox"/>	_____
IUD..... <input type="checkbox"/>	_____
Diaphragm..... <input type="checkbox"/>	_____
Norplant..... <input type="checkbox"/>	_____
Sponge..... <input type="checkbox"/>	_____
Spermicide..... <input type="checkbox"/>	_____
Condoms..... <input type="checkbox"/>	_____
Other..... <input type="checkbox"/>	_____
Sterilization <input type="checkbox"/> Male <input type="checkbox"/> Female	

## LIFESTYLE

- 40. Did your mother take DES or any other hormones when pregnant with you?.....
- 41. Have you ever had a Pap test?.....
- If Yes: Date of your last Pap test? \_\_\_\_/\_\_\_\_/\_\_\_\_
- Have you ever had abnormal Pap test results?.....
- 42. Are you sexually active?.....
- 43. Do you have one partner or.....  one many partners.....  many
- 44. Is intercourse painful for you?.....
- 45. Do you do a monthly well breast exam?.....
- 46. Have you ever had a mammogram?....
- If Yes: Date of your last mammogram? \_\_\_\_/\_\_\_\_/\_\_\_\_
- 47. Do you exercise on a regular basis?....
- If Yes: Type of exercise \_\_\_\_\_  
Hours per week exercise \_\_\_\_\_

Check and detail positive findings below. Use reference numbers.

## 31. HOSPITALIZATIONS

List those operations/serious illnesses that have required hospitalization. If more than six, check this box.  Do not include pregnancies here.

Month/Year	Illness or Operation	Complications	
		Yes	No
/		<input type="checkbox"/>	<input type="checkbox"/>
/		<input type="checkbox"/>	<input type="checkbox"/>
/		<input type="checkbox"/>	<input type="checkbox"/>
/		<input type="checkbox"/>	<input type="checkbox"/>
/		<input type="checkbox"/>	<input type="checkbox"/>
/		<input type="checkbox"/>	<input type="checkbox"/>

## SUBSTANCE USE (Check only those you use)

- 32. Alcohol.....  Type \_\_\_\_\_ Amt/day \_\_\_\_\_
- 33. Tobacco.....  Type \_\_\_\_\_ Amt/day \_\_\_\_\_
- 34. Caffeine.....  Type \_\_\_\_\_ Amt/day \_\_\_\_\_
- 35. Non-Prescribed Drugs.....  Type \_\_\_\_\_ Amt/day \_\_\_\_\_
- 36. Street Drugs.....  Type \_\_\_\_\_ Amt/day \_\_\_\_\_

Signature: \_\_\_\_\_



# Initial Gynecology Profile

Patient's Name: \_\_\_\_\_

ID No.: \_\_\_\_\_

INITIAL PHYSICAL EXAM				Check and detail all positive findings below. Use system numbers.	LABORATORY PROCEDURES		
1. Height _____ 2. Weight _____ 3. Blood Pressure _____					Test	Date	Result
<b>Pelvic Exam</b>				Normal	Abn.	N.E.	30. Hgb /
4. Ext. Genitalia							31. Hct /
5. Urethral Meatus							32. WBC /
6. Urethra							33. Differential /
7. Bladder							34. Pregnancy Test /
8. Vagina							35. Urinalysis /
9. Cervix							36. HIV /
10. Uterus (describe)							37. Gonorrhea /
11. Adnexa/Parametria							38. Chlamydia /
12. Rectum (Digital Exam)							39. HSV /
13. Anus and Perineum							40. VDRL Serology /
14. Other							41. Hepatitis ___ /
<b>General Physical</b>				Normal	Abn.	N.E.	42. Pap Test /
15. Skin							43. Wet Mount /
16. HEENT							44. Culture /
17. Neck							45. Stool Occult Blood /
18. Chest							46. Blood Glucose /
19. Breasts							47. Cholesterol /
20. Heart							48. Thyroid Screen /
21. Lungs							49. Biopsy /
22. Abdomen							50. Mammogram /
23. Musculoskeletal							51. /
24. Extremities							52. /
25. Neurological							53. /
<b>Nutritional Assessment</b>							54. /
26. Not performed ..... <input type="checkbox"/>							
27. Apparently adequate ..... <input type="checkbox"/>							
28. Apparently inadequate ..... <input type="checkbox"/>							
29. Excessive caloric intake ..... <input type="checkbox"/>							
<b>Diagnosis and Treatment Plans</b>							
<b>CALIFORNIA GYN CANCER PAMPHLET GIVEN</b> <input style="width: 50px; height: 15px;" type="text"/>							
Next Appointment: ___ / ___ / ___    Signature: _____							

**DOCTORS OF WOMEN**  
**INSURANCE ELIGIBILITY CERTIFICATION**

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Subscriber's ID and DOB: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Group #: \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

Co-pay: \_\_\_\_\_ Deductible: \_\_\_\_\_

Primary Care Physician (If applicable): \_\_\_\_\_

Medical Group/IPA (If applicable): \_\_\_\_\_  
(HMO, PPO, POS, CHOICE)

**I agree that if the above is not true, I (or the person financially responsible for me) will pay in full, all such charges related to services provided to me. Also, patient is responsible for knowing laboratories their insurance uses.**

Which of the following laboratories will your insurance cover? Please check one.

- Westcliff Medical Laboratories
- Quest Diagnostic (Formerly Smith Kline)
- Unilab
- Lab Corp

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **DOCTORS OF WOMEN Notice of Privacy Practices**

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

**DOCTORS OF WOMEN** is permitted to make uses and disclosures of protected health information for treatment, payment and health care operations, as described in the following examples:

- a.- **For treatment** – *Doctors of Women can disclose your PHI (Protected Health Information) to physicians and other licensed health care providers who provide you with health care services or are involved in your care. For example, if you're being treated by a Urologist, Doctors of Women can disclose your PHI in order to coordinate your care.*
- b.- **For payment** – *Doctors of Women can use and disclose your PHI to bill and collect payment for the treatment and services provided by Doctors of Women to you. For example, Doctors of Women may send your PHI to your insurance company or health plan to get paid for the health services that Doctors of Women have provided to you.*
- c.- **For health care operations** – *Doctors of Women can disclose your PHI to operate the practice. For example, Doctors of Women might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you.*

**DOCTORS OF WOMEN** is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization.

- a.- **Protected health information: When Disclosure is required by federal law, state or local law; judicial or administrative proceedings; or, law enforcement.**
- b.- **For Public health activities.**
- c.- **To avoid harm.**
- d.- **For specific government functions.**
- e.- **For workers' compensation purposes.**
- f.- **Appointment reminders and health related benefits or services.**

Other uses and disclosures will be made only with the Individual's written authorization, and the individual may revoke such authorization.

**DOCTORS OF WOMEN** intends to engage in (n)one or more of the following activities:

- a. **DOCTORS OF WOMEN may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.**
- b. **A group health plan, or a health insurance issuer or HMO with respect to a group health plan, may disclose protected health information to the sponsor of the plan.**

The Individual has the following rights regarding

- a. **The right to request restrictions on certain uses and disclosures of protected health information. DOCTORS OF WOMEN is not required to agree to a requested restriction, however.**
- b. **The right to receive confidential communications of protected health information, as applicable.**
- c. **The right to inspect and copy protected health information, as provided in the Privacy Regulation.**
- d. **The right to amend protected health information, as provided in the Privacy Regulation.**
- e. **The right to receive an accounting of disclosures of protected health information.**
- f. **The right to obtain a paper copy of the Notice from the covered entity upon request. The right extends to an individual who has agreed to receive the Notice electronically.**

**DOCTORS OF WOMEN** is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and Privacy practices with respect to protected health information.

**DOCTORS OF WOMEN** is required to abide by the terms of the Notice currently in effect.

**DOCTORS OF WOMEN** reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.

Individuals may complain to **DOCTORS OF WOMEN** and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. A brief description of how the individual may file a complaint follows: *If you think that Doctors of Women may have violated your privacy rights or you disagreed with a decision Doctors of Women made about access to your PHI, you may file a complaint with Doctors of Women's Administrator. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave. SW, Washington D.C. 20201. Doctors of Women will not take retaliatory action against you if you file a complaint about our privacy practices.*

This Notice is first in effect on *April 14, 2003*.

I hereby acknowledge that I have received a copy of **DOCTORS OF WOMEN'S** Notice of Privacy Practices.

\_\_\_\_\_  
Individual's Name

\_\_\_\_\_  
Date

