Name: ____ Age ________ Date: ________________

Primary Care Physician Name: ____________________________________ Did your Primary Care Physician refer you for today's visit? Y N

What is the reason for your visit today? ____

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

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

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

SOCIAL HISTORY Do you Smoke Cigarettes? Y N If so, how many packs per day? __________

Do you use any other tobacco product? Cigars? Y N Chewing Tobacco? Y N

FAMILY HISTORY (Circle all that apply to your close relatives: parents, siblings & grandparents)

Alzheimer's Disease Birth Defects Blood Clots 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 Tuberculosis Uterine Cancer Other ___________________________________

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) awake to urinate at night pain with urination

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 # _________________________ e-mail address ____________________

Birth Date _________________ Age _________ Driver's License # ______________________________ DL State __________

Home Phone # ______-______-__________ Cell Phone # ______-______-___________ Work Phone # ______-______-__________

Marital Status [] S [] M []W [] D Religion: ____________________________ Primary Language [] English [] _________________

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.

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

2. ____________________________________ [] OK to leave detailed message

Patient's Name: ____

DOB: ______________________ SS # ______________________________________

Date:______________________ Signature: ____

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

CONSENT FOR CHLAMYDIA & GONORRHEA TESTING

It is recommended to test all women under the age of 26 for Chlamydia and Gonorrhea. For women 26 years old and older, we strongly recommend testing if you have a new sex partner or more than one sex partner. Testing is done using the same specimen as your pap smear. Most insurance companies cover this important test. Like any other test, if the laboratory receives an insurance denial for these tests, you will be responsible for payment.

 I request Chlamydia and Gonorrhea testing **I decline Chlamydia and Gonorrhea testing**

CONSENT FOR Human Papilloma Virus (HPV) TESTING

The HPV test is performed from your Pap smear specimen. As far as we know, all insurance companies except Medicare are now covering this very important test. **Every** woman over the age of 30 should be tested for HPV routinely, along with her Pap smear. All women of any age who have ever had an abnormal Pap in the past should be tested. The 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, you have a higher risk of an abnormal Pap and should be seen more often than someone who does not have the virus detectable in their system. Like any other test, if the laboratory receives an insurance denial for these tests, you will be responsible for payment.

Medicare does not cover screening with the test for HPV. Medicare may cover HPV testing for patients with a recent history of an abnormal Pap. **Medicare patients that choose to have HPV testing will receive a bill from the lab.**

Results will be available from the lab in approximately two weeks. You will receive your results by mail.

 I REQUEST HPV TESTING and agree to pay the lab if I receive a bill

 I DECLINE HPV TESTING

CONSENT FOR COLON CANCER SCREENING

Everyone over 50 should have routine colonoscopy every 10 years (or more often if they are at increased risk). For our patients over 40 years of age, we recommend annual colon cancer screening using the FIT test. Screening is done by testing the stool for blood. The test takes 5 minutes and you will have the result before your office visit is over. If you have had the FIT test or a colonoscopy within the last year, it does not need to be done today, if not, we can perform the test for you. As far as we know, insurance companies are now covering this very important 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

 I HAVE HAD THE FIT TEST OR COLONOSCOPY WITHIN THE LAST YEAR AND DO NOT NEEDTHE FIT TEST TODAY

 I REQUEST THE FIT TEST **I DECLINE THE FIT TEST**

X____ ____________________

Patient Signature Date