Namaste OB/GYN

New Patient Information

NAME: _____ DATE _____

ADDRESS:_____

CITY: _____ STATE:_____ ZIP _____

SOCIAL SECURITY: _____ DOB: _____MARITAL STATUS:_____

E-Mail _____ CELL PHONE: _____

HOME PHONE: _____ WORK PHONE: _____

EMPLOYER: _____ Address:_____

OCCUPATION:_____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP _____

Home Phone _____ Work Phone_____ Cell Phone:_____

Please name all persons we may contact regarding your Protected Health Information:
We will only speak to the persons listed unless patient provides consent

Name _____ Phone_____ Relationship _____

Name _____ Phone_____ Relationship _____

Name _____ Phone_____ Relationship _____

PRIMARY INSURANCE: POLICY HOLDER (circle): Self Spouse Parent
Company: _____ ID #_____
GROUP #_____ PHONE # _____
If your not policy holder: Holder Name:_____
Holder DOB:_____ Holder SSN:_____

SECONDARY INSURANCE: POLICY HOLDER (circle): Self Spouse Parent
Company: _____ ID#_____
GROUP #_____ PHONE# _____
If your not policy holder: Holder Name:_____
Holder DOB:_____ Holder SSN:_____

I hereby authorize Namaste OB/GYN to furnish information to my insurance carriers regarding my condition and treatments, and I hereby assign to Namaste OB/GYN all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance and that I am responsible with my insurance company which services are covered.

_____ _____
Patient Signature Date

_____ _____
Signature of Legal Guardian or Power of Attorney Date

Current History Review

Name	Home Phone	Date
Street Address	Work Phone	Birthday
City, State, Zip	Insurance	Marital Status
Occupation	Spouse/Partner's Name	Education

What brings you to the office today?

- ☐ Annual Exam/Routine Care
- ☐ Problem/Issue (Please describe briefly)
- ☐ I was referred by _____

Past Hospitalizations and Surgery:

Current Medications:

Allergies to Medications:

Bad Habits

Yes	No	Describe
☐	☐	Smoking
☐	☐	Alcohol
☐	☐	Illegal Drugs

Gynecologic History

Last Menstrual Period:	Every_____Days. Lasting_____Days.
Last Pap Smear:	Normal?
Last Mammogram:	Normal?
Current Method of Contraception:	

Have you or anyone in your family suffered from: (Indicate relationship)

☐ Diabetes	☐ Heart Disease	☐ Drinking Problem	☐ Ovarian Cancer
☐ Stroke	☐ High Blood Pressure	☐ Breast Cancer	☐ Colon Cancer

Have you had problems with any of the following within the past year?

General
- ☐ Weight Loss or Gain
- ☐ Fevers
- ☐ Trouble Sleeping
- ☐ Chronic Fatigue
- ☐ Excessive Bleeding
- ☐ Easy Bruising
- ☐ Abnormal Thirst

Eyes
- ☐ Itchy, Red Eyes
- ☐ Vision Problems

Ears
- ☐ Ear Pain
- ☐ Ringing in Ears
- ☐ Hearing Loss

Nose
- ☐ Sinus Problems
- ☐ Nose Bleeds

Mouth
- ☐ Sore Throat
- ☐ Mouth Sores
- ☐ Dental Problems

Lungs
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Chronic Cough
- ☐ Blood Clot in the Lungs
- ☐ Painful Breathing
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Ankle/Hand Swelling

Gastrointestinal
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Bloody Stools
- ☐ Nausea/Vomiting
- ☐ Hemorrhoids

Urinary
- ☐ Incomplete Urination
- ☐ Loss of Urine
- ☐ Painful Urination
- ☐ Bloody Urine

Musculoskeletal
- ☐ Muscle Weakness
- ☐ Joint Pains
- ☐ Joint Swelling
- ☐ Clot in Leg Vein

Neurologic
- ☐ Frequent/Severe Headaches
- ☐ Dizziness
- ☐ Seizures
- ☐ Numbness
- ☐ Trouble Walking
- ☐ Fainting Spells

Skin
- ☐ Acne
- ☐ Unwanted Hair Growth
- ☐ Unusual Lump or Growth
- ☐ Dry Skin

Emotional
- ☐ Excessive Worry
- ☐ Depression
- ☐ Frequent Crying
- ☐ Serious thoughts of harming yourself or others

Menstrual Problems
- ☐ Cramps/Pain
- ☐ Heavy Bleeding
- ☐ Too Frequent Periods
- ☐ Bleeding Between Periods
- ☐ Missed a Period
- ☐ Other Period Issue

Pre Menstrual Problems
- ☐ Bloating/Swelling
- ☐ Mood Changes
- ☐ Breast Changes
- ☐ Headaches
- ☐ Acne
- ☐ Other PMS Issue

Menopause Issues
- ☐ Hot Flashes
- ☐ Night Sweats

Breast Problems
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Nipple Discharge
- ☐ Other Breast Issue

Other Gynecologic Issues
- ☐ Vaginal Discharge
- ☐ Itching/Irritation
- ☐ Vulvar Pain
- ☐ Vulvar lump/growth
- ☐ Vulvar Sores

Sexual Problems
- ☐ Painful Intercourse
- ☐ Bleeding after Intercourse
- ☐ Decreased Desire
- ☐ Orgasm Problems
- ☐ Dryness
- ☐ Possible Exposure to STD
- ☐ Other Sexual Issue

Would you like to discuss any of the following?
- ☐ Contraception
- ☐ Menopause Issues
- ☐ Pregnancy Issues
- ☐ Self Breast Exam
- ☐ Sexuality Issues
- ☐ STD's
- ☐ Other

Signature:_____ Physician Signature:_____

Family History Questionnaire For Common Hereditary Cancer Syndromes

Patient Name:_____ DOB:_____

Physician:_____ Date :_____

Instructions: Please circle Y to those that apply to YOU and/or YOUR FAMILY (on both your mother's and father's side). Behind each statement, please list the relationship to you of the individual diagnosed (such as self, paternal uncle, maternal aunt, paternal grandmother, etc.) and their age at diagnosis. Each statement should be answered individually as you may list some cancer diagnosis more than once. This is a screening tool for the common features hereditary cancer syndromes, if you circle Y to any statements below, you MAY be appropriate for genetic testing. Ask healthcare provider for additional information.

	BREAST AND OVARIAN CANCER	RELATIONSHIP	AGE AT DIAGNOSIS
Y N	Breast cancer	_____	_____
Y N	Ovarian cancer	_____	_____
Y N	Breast cancer in both breasts Or multiple primary breast cancers	_____	_____
Y N	Pancreatic cancer	_____	_____
Y N	Male breast cancer	_____	_____
Y N	Ashkenazi Jewish ancestry		
	COLON AND UTERINE CANCER		
Y N	Uterine cancer before age 50	_____	_____
Y N	Colorectal cancer before age 50	_____	_____
Y N	Both uterine and colorectal cancer (in an individual or a family)	_____	_____
Y N	2 or more uterine or colorectal cancers (in an individual or a family)	_____	_____
Y N	Uterine and/or colorectal cancer AND ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer (in an individual or a family)	_____	_____
Y N	10 or more colon polyps found in a lifetime	_____	_____
	Melanoma		
Y N	Melanoma	_____	_____
Y N	Other Cancers	_____	_____

Candidate for further risk assessment and/or genetic testing: Patient offered genetic testing

Information given to patient to review: Accepted Declined

Follow up appointment scheduled: _____

_____ _____ _____

Patient Signature Date Healthcare Provider's signature

Health First

Physicians

CONSENT TO TREAT, INSURANCE ASSIGNMENTS, FINANCIAL AGREEMENT, AUTHORIZATION TO RELEASE INFORMATION AND PRIVACY NOTICE ACKNOWLEDGEMENT

1. CONSENT TO MEDICAL AND SURGICAL PROCEDURES The undersigned consents to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. Which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered the patient under the general and special instructions of the patient's physician._____ (initials)

2. ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION In consideration of services rendered, I hereby transfer and assign to Health First Physicians all rights, title and interest in any payment due to me for services described herein as provided in the above-mentioned policy or policies of insurance. The clinic may disclose all or any part of the patient's record (including psychiatric, alcohol and drug abuse, family member or employer of the patient for all or part of the clinic's charge, including but not limited to medical service companies, insurance companies, workman's compensation carriers, welfare funds or the patient's employer. _____ (initials)

3. FINANCIAL AGREEMENT The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an attorney for collections, the undersigned should pay reasonable attorney's fees and collection expense. The undersigned certifies that he/she has read the foregoing receiving a copy thereof and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms. _____ (initials)

4. MEDICARE / MEDICAID Patient's certification authorization to release information and payment request. I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize that any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the clinic treating me. _____ (initials)

5. USE OF COPIES I permit a copy of these authorizations and assignments to be used in place of the original, which is on file at the clinic. _____ (initials)

6. PAYMENT RESPONSIBILITY I understand that certain insurance claims may be filed as a courtesy. However, if a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the physician for services rendered to the patient. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. I understand it is my responsibility to pay any CO-PAY, DEDUCTIBLE, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE OR THIRD PARTY PAYOR WITHIN A REASONABLE PERIOD OF TIME NOT TO EXCEED 60 DAYS.
_____ (initials)

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I have received on this, or a prior occasion, the Health First, Notice of Privacy Practice and acknowledge that I have a copy of the notice or that I requested, and was given a copy.

Received Copy This Date: Yes ☐ No ☐ Previously Received Copy: Yes ☐ No ☐

Patient /Legal Representative: _____ Witness:_____

Patient unable to acknowledge receipt of the Notice of Privacy: ☐

Patient refused to Sign Acknowledgment: ☐ Reason: _____

DATE: _____ PATIENT'S SIGNATURE _____

SUBSCRIBER SIGNATURE (if different then patient) _____

Urinary Incontinence Questionnaire

(only use if applicable)

Do you have the sudden urge to urinate?	Y	N
Do you urinate more than 8 times a day?	Y	N
Do you have occasional wetting accidents?	Y	N
Do you avoid social situations for fear of leaking urine?	Y	N
Do you plan activities knowing the location of bathrooms?	Y	N
Do you wear pads to protect your clothing from wetting accidents?	Y	N
Do you lose urine while coughing, laughing, sneezing?	Y	N
Have you tried 2 or more medications to control your bladder?	Y	N
Do you wake 2 or more times a night to urinate?	Y	N
Do you have fecal/stool leaking accidents more than once a week?	Y	N

What is your level of frustration? (Circle 1-10)

(Not) 1 2 3 4 5 6 7 8 9 10 (Very)

If better control of these problems are possible, would you like to talk to your physician about options?	Y	N

For OB Patients Only

Patient Name: _____

Date of Birth: _____

Prenatal Genetics Screen (Ages 45 and under)
Circle yes or no

1. Will you be 35 years or older when your baby is due? Yes No
2. Have you; the baby's father, or anyone in either of your families ever had any of the following:
   - Downs Syndrome (mongolism) Yes No
   - Chromosomal Abnormality Yes No
   - Neural Tube Defect (spine bifida, anencephaly) Yes No
   - Hemophilia Yes No
   - Muscular Dystrophy Yes No
   - Cystic Fibrosis Yes No
   - Huntington's Chorea Yes No

If yes to any of the above please indicate the relationship to you or your baby's father: _____

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3. Did you or the baby's father have a birth defect? Yes No
4. In any previous pregnancy have you or the baby's father had a child born, dead or alive, with a birth defect not listed in question 2? Yes No
5. Do you or the baby's father have any close relative with mental retardation? Yes No
6. In any previous pregnancies have you or the baby's father had a stillborn child or three or more first trimester miscarriages? Yes No
7. Are you or the baby's father of Jewish ancestry? Yes No
   - If yes, have either of you been tested for Tay-Sachs Yes No
8. Are you or the baby's father African American? Yes No
   - If yes, have either of you been tested for sickle cell trait? Yes No
9. Are you or the baby's father of Italian, Greek, or Mediterranean background? Yes No
   - If yes, have either of you been tested for B-thalassemia Yes No
10. Are you or the baby's father of Philippine or southwest Asian ancestory? Yes No
    - If yes, have either of you been tested for A-thalassemia? Yes No
11. Excluding irons and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period? Yes No

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Patient Signature:_____ Date:_____

Physician Signature: _____ Date:_____