Namaste OB/GYN
Patient Update Sheet

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:_____

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) _____