DESERT WEST OBSTETRICS AND GYNECOLOGY

PATIENT INFORMATION

PLEASE PRINT

LAST NAME: _____ **FIRST NAME**: _____ **MI**: _____

NICKNAME: _____ **MAIDEN**:_____ **PREFIX**: _____

BIRTHDAY: _____/_____/_____ SS#: _____

MARITAL STATUS: □ **Single** □ **Married** □ **Divorced** □ **Widowed** □ **Other:** _____

HOME ADDRESS: _____ **Apt #:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

CELL #: _____ **WORK #:**_____ **EXT:** _____ **HOME #:** _____

PREFERRED DAY TIME PHONE: □ **Home** □ **Cell** □ **Work**

EMAIL: _____

PCP: _____

EMPLOYER: _____

We are required to ask for the following information per insurance reporting requirements

RACE: □ **Alaskan Native** □ **American Indian or Alaskan Native** □ **Asian** □ **African American** □ **Caucasian** □ **Greek** □ **Hawaiian** □ **Hispanic** □ **Indian** □ **Jewish** □ **Multi-racial** □ **Native American Indian** □ **Native Hawaiian** □ **Pacific Islander** □ **Other:** _____

ETHNICITY: □ **Hispanic/Latino** □ **Not Hispanic/Latino** □ **Other** □ **Unknown** □ **I decline to specify.**

PREFERRED LANGUAGE: □ **English** □ **Spanish** □ **Other**

_____ _____

Patient / Guarantor Signature Date

_____

Guarantor Printed Name (If patient is a minor)

Desert West Payment Policy and Benefit Assignment

We are committed to providing you with quality and affordable medical care. Please review our practice financial policy.

1. **Insurance.** We participate in most insurance plans. If you are not insured or have a plan that we do not participate in, payment is expected in full at the time of your visit. It is the patient's responsibility to make sure that our office is kept informed of insurance changes. If you have questions, please contact your insurance directly.
2. **Co-payment**. All co-payments are due at the time services are rendered. For your convenience we accept Visa, MasterCard, AMEX, Discover, Care Credit, checks and cash.
3. **Non-covered Services.** Some, and perhaps all, of the services you receive may not be covered by your insurance company or may not be considered reasonable or necessary. All "non-covered" services are the responsibility of the patient.
4. **Updates.** Our staff will ask you to verify your information at each visit. Current information is vital in order for us to contact you regarding your treatment and for obtaining timely payment from your insurance company.
5. **Claims submission.** Desert West will submit your claims and assist you in any way we can to help get your claims paid. Your insurance company may need information directly from you. It is your responsibility to comply in a timely manner to their requests. Please note that the balance of your claim is your responsibility, whether or not your insurance pays your claim. Your insurance benefit is a contract between you and your insurance company.
6. **Delinquent Accounts.** If your account is over 60 days past due, you will receive a letter stating that you have 10 days to pay your account in full. If a balance remains unpaid, we may refer your account to an outside collection agency. If an account is reported to our collection agency a collection fee of $50 will be added to any outstanding balance. Please inform our staff if you know your payment will be late in arriving or if payment arrangements are needed.
7. **Referrals and Authorizations:** If a referral is required by your insurance carrier, you will be asked to obtain the referral prior to your appointment. If a referral is not obtained, your appointment may be cancelled. Our office will obtain any necessary authorization from your insurance carrier, prior to scheduling your appointment. We suggest you contact your insurance carrier to verify your coverage, benefits and preauthorization requirements prior to having any procedure performed. Claims are paid based on medical necessity. Please be aware that authorizations and referrals are not a guarantee of payment.
8. **Missed appointments**. You may be charged for a missed appointment (min $50), if you do not notify us at least 24 hours prior to your scheduled office visit or 7 days prior to scheduled surgery (min $100).
9. **Returned checks (NSF).** You will be charged a $50.00 processing fee for any personal check returned for non-payment.

I hereby authorize Desert West OBGYN to provide such medical services, either regular or emergency, as may be determined by my provider to be in my best interest (or the best interest of my dependent if I am signing as a parent or guardian.)

I authorize payment of medical benefits to Desert West. I agree that all charges for medical services rendered that are not directly paid by my insurance will be my responsibility. I hereby authorize Desert West to release the necessary information regarding my care to my health plan in order to complete and process my insurance claims.

Please note, all forms and policies can be found on Desert West's website at www.desertwestobgyn.com

_____ _____

Signed (patient or parent, if minor) Date

Desert West OBGYN
5601 W. Eugie, Ste. 100
Glendale, AZ 85304
602-978-1500

HIPAA FORM
AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

PATIENT NAME:_____DATE OF BIRTH:_____

I hereby Authorize Desert West OBGYN to release or disclose my medical or financial/ insurance information to:

Name:_____ Relationship:_____Phone:_____

Name:_____ Relationship:_____Phone:_____

Emergency Contact Name: _____Phone Number:_____

How can we contact you: (PLEASE CHECK ANY OR ALL THAT APPLY)
☐Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Yes No I grant permission to leave detailed test results or messages on my voicemail at Phone number:_____

Yes No I authorize the release of any records regarding Contraception, STD's or Substance Abuse to the person(s) listed above.

☐Check this box if you do not want your medical information discussed/ disclosed with any family members.

Do you have an Advance Directive (Living Will)? YES NO

PATIENT CONTACT

We may disclose your medical information to a family member or friend who is involved in your medical care, or to someone who helps pay for your care. (For example, we may leave messages with family regarding your treatment, appointment reminders and/ or test results when you are not available.) If you do not want us to disclose your medical information to family members, check the box above restricting release to only you.

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

Please be advised: Any health care record can contain personal and/ or private information you may not want divulged such as STD results. HIV/AIDS testing, whether negative or positive, requires a separate form. This information may be directly generated by Desert West OBGYN doctors as part of your care or it may be indirectly generated by requesting records from other treating doctors. All medical information contained in a patient's chart is necessary for complete and accurate treatment of your condition and will be released to the person(s) named above unless it is specifically stated only certain information may be released.

By signing below I acknowledge that I am aware of Desert West's NOTICE OF PRIVACY PRACTICES.

CONSENT FOR TREATMENT OF MINORS – By signing below, I hereby give my consent for medical treatment for the above named patient. This authorization shall remain in effect until the child turns 18 or until revoked by me in writing.

Patient/Parent Signature_____Date_____

Print Parent Name: _____

Desert West Obstetrics and Gynecology
Confidential Obstetrical History

Name _____ Birth Date _____ Age_____ Date _____

Current Medications (Prescription, over the counter, herbal)	**Prescribing Doctor**	**Dose**	**Instructions**	**Reason Used**

Allergies to medications/food/environment	**Reaction**

Gynecologic Health History

LMP (first day of your last period): _____

___ Definite
___ Unknown date
___ Approximate date

Were your periods regular before pregnancy? No____ Yes____

How often did your cycles occur? _____-(# of days from start of one cycle to start of next cycle)

Were you on Birth Control at time of conception? No___ Yes___
If yes, what type of Birth Control were you using? _____

What age were you when you started your first period? _____

Have you had a positive pregnancy test? No___ Yes___

Desert West Obstetrics and Gynecology
Confidential Obstetrical History

Name _____ Birth Date _____ Age_____ Date _____

If yes, when and where was the test done? _____

Was this a planned pregnancy? No ____ Yes ____

Was this pregnancy a result of In vitro fertilization? No____ Yes____

If yes, donor sperm? No ____ Yes ____

If yes, donor egg? No ____ Yes ____

If yes, what was date of conception? _____

Total number of pregnancies

Full Term	Premature	Cesarean Section	Vaginal Delivery	Living	Multiple births	Abortion	Miscarriage	Ectopic

Have you had a positive Group B Strep status with any pregnancies? No _____ Yes____ Unsure____

Pregnancy Details

Preg #	Sex	Month/ Year of delivery	Number of weeks	Babies Weight	Hrs of Labor	Delivery Type	OB/Neonatal Problems	Delivery Doctor

Desert West Obstetrics and Gynecology
Confidential Obstetrical History

Name _____ Birth Date _____ Age_____ Date _____

Symptoms since your last period?

_____

_____

What medications have you taken since your last period?

_____

_____

Medical History

Have you had or have any of the following conditions:

Disease/Condition	Yes	No	Onset date	Treatment
1. Diabetes				
2. Hypertension				
3. Heart Disease				
4. Autoimmune Disorder				
5. Kidney Disease/UTI				
6. Neurologic/Epilepsy				
7. Psychiatric				
8. Depression/Postpartum Depression				
9. Hepatitis/liver disease				
10. Varicosities/phlebitis/ blood clot				
11. Thyroid Dysfunction				
12. Trauma/Violence				
13. History of blood Transfusions				

	Pre Pregnancy	During Pregnancy	# years use
14. Tobacco(Packs per day)			
15. Alcohol (Amt. per day)			
16. Illicit/Recreational Drugs (Amt daily, weekly, etc)			

Disease/Condition	Yes	No	Onset date	Treatment
17. Rh sensitized				
18. Pulmonary (TB, Asthma)				
19. Seasonal allergies				
20. Drug/latex allergies/				

Desert West Obstetrics and Gynecology
Confidential Obstetrical History

Name _____ Birth Date _____ Age_____ Date _____

reactions				
21. Breast problems				
22. GYN surgery				
23. Operations/Hospitalization				
24. Anesthetic complications				
25. History abnormal pap				
26. Uterine anomaly/DES				
27. Infertility				
28. ART Treatment				
29. Relevant family history				
30. Received HPV vaccine				

(We do recommend that you discontinue use of nicotine, alcohol, caffeine, and recreational drugs)

Infection History

	Yes	No	Onset Date	Treatment
1. Exposed to/live with someone with TB				
2. Patient/Partner with History genital Herpes				
3. Rash/viral Illness since Last period				
4. Hepatitis B or C				
5. **History of:**				
STD				
Gonorrhea				
Chlamydia				
HPV/Warts				
HIV				
Syphilis				
6. Have you had Chicken pox				

Desert West Obstetrics and Gynecology
Confidential Obstetrical History

Name _____ Birth Date _____ Age_____ Date _____

Medical / Surgical History *(Include injuries and conditions requiring medications i.e.-high blood pressure, diabetes, seizures, etc)*

Condition/Disease	Date	Treatment

If medically necessary, would you agree to a transfusion? No_____ Yes_____

Do you desire sterilization after pregnancy? No ___ Yes ___

Will you be breast feeding? No ____ Yes___
Will you be bottle feeding? No ____ Yes ___
Will you be breast and bottle feeding? No ___ Yes ___

Family History

Please complete if any of your close relatives have had any of the following:

Disease	Circle Yes/No	Family Member	Family Members 1st Name	Age of Onset	Age of Death	Cause of Death (Circle)
Cancer of Breast	Yes No					Yes No
Cancer of Ovary	Yes No					Yes No
Cancer of Uterus	Yes No					Yes No
Cancer of Cervix	Yes No					Yes No
Cancer of Colon	Yes No					Yes No
Diabetes	Yes No					Yes No
Tuberculosis (TB)	Yes No					Yes No
Heart Disease	Yes No					Yes No
High Blood Pressure	Yes No					Yes No
Blood clot/PE	Yes No					Yes No
Other:						Yes No
						Yes No
						Yes No
						Yes No

Desert West Obstetrics and Gynecology
Confidential Obstetrical History

Name _____ Birth Date _____ Age_____ Date _____

Social History

Primary LanguageSpoken_____Race_____

Education_____ Degree Obtained_____

Baby's father _____ Baby's father race _____

Support person for pregnancy _____

Pediatrician _____

Do you smoke? No_____ Yes_____ If yes, type of tobacco?_____ Pks/day_____ Number of years_____
If yes, amount during pregnancy? _____
Second hand smoke exposure? No _____ Yes _____

Do you drink alcohol? No_____ Yes_____ If yes, type of alcohol _____
How often? _____ Amount _____Last drink_____
If yes, amount during pregnancy? _____

Do you consume caffeine? No_____ Yes_____ If yes, amount daily? _____ Type _____

Do you use recreational drugs? No_____ Yes____ If yes, what type? _____ Amount _____
If yes, amount during pregnancy? _____

(We do recommend that you discontinue use of nicotine, alcohol, caffeine, and recreational drugs)

Exercise frequency? Daily_____ Never_____ Occasional_____ 2-3times/wk_____ 4 or more times/wk_____

Are there animals in the home? No_____ Yes_____ If yes, what kind? _____

Is the patient the individual who cleans up after the animals? No_____ Yes_____

Do you have smoke detectors in your home? No____ Yes____

How many sexual partners do you have? None_____ One_____ 2-5_____ 5+_____

Have you been exposed to sexual or physical violence or abuse? No_____ Yes_____
If yes, please explain _____

_____

Desert West Obstetrics and Gynecology
Confidential Obstetrical History

Name _____ Birth Date _____ Age_____ Date _____

Genetic History
(Includes patient, baby's father, or anyone in either family)

	Yes	No	Mother(patient)	Father(baby's)	Other relative and relationship
1. Patient's age 35 or older at delivery					
2. Thalassemia					
3. Neural tube defect					
4. Congenital heart defect					
5. Down syndrome					
6. Tay-sachs					
7. Canavan disease					
8. Familial dysautonomia					
9. Sickle cell disease or trait					
10. Hemophilia or other Blood disorders					
11. Muscular dystrophy					
12. Cystic fibrosis					
13. Huntington's chorea					
14. Mental retardation/ Autism					
15. Other inherited genetic or chromosomal disorder					
16. Metabolic Disorder (e.g. PKU, Type 1 Diabetes)					
17. Patient or baby's father had a child with birth defects not listed above					
18. Recurrent pregnancy loss or stillbirth					
19. Other					