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: _____

PRIMARY CARE PROVIDER: _____

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:_____

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.

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: _____

Risk Assessment for Hereditary Cancer Syndromes

Patient Name:_____ **Date of Birth:** _____ **Today's Date**: _____

Instructions: Please fill out the family history form below. If you circle Y, **please provide the family member's relationship to you, the part of the body where the cancer started, and age at diagnosis.** Consider your 1st, 2nd, and 3rd degree relatives.
1st degree relatives: Mother, Father, Sister, Brother, Children**; 2nd degree relatives:** Aunt, Uncle, Grandparent, Niece, Nephew, Half siblings; **3rd degree relatives:** Cousin, Great Grandparents, Great Aunts and Uncles

Have you or any family member ever had Hereditary Cancer Testing (BRCA, Lynch Syndrome, or Myriad myRisk)?
NO -or- YES If yes, what was the result?

Are you Ashkenazi Jewish? NO -or- YES

Hereditary Cancer Criteria			SELF (Age at Diagnosis)	FAMILY MEMBER	
				MOTHER'S SIDE & Age at Diagnosis	FATHER'S SIDE & Age at Diagnosis
Y	N	Any of the following cancers diagnosed at age 49 or younger: ☐ Breast ☐Endometrial ☐Colon ***(in yourself, first or second degree relative)***			
Y	N	Ovarian cancer at any age ***(in yourself, first or second degree relative)***			
Y	N	Male breast cancer at any age ***(in yourself, first-second-or third degree relative)***			
Y	N	Triple negative breast cancer at or under the age of 60 (receptor status negative for ER, PR and HER2) ***(in yourself, first or second degree relative)***			
			Specify Family Member, Cancer Type and Age at Diagnosis		
Y	N	Breast, ovarian, or pancreatic cancer at any age in Ashkenazi Jewish family members ***(in yourself, first or second degree relative)***			
Y	N	Three or more of the following cancers at any age on the same side of the family: breast, ovarian, pancreatic, or prostate ***(in yourself, first-second-or third degree relative)***			
Y	N	Three or more of the following cancers at any age on the same side of the family: colon, endometrial/uterine, ovarian, gastric/stomach, ureter/renal pelvis, biliary tract, small bowel, pancreatic, brain, sebaceous adenomas ***(in yourself, first-second-or third degree relative)***			

Patient's signature: _____Date: _____

Provider signature: _____ Date: _____

For Office Use Only: *Patient offered hereditary cancer genetic testing? □ Yes □ No □ ACCEPTED □ DECLINED*
Follow-Up appointment scheduled: □ Yes □ No Date of Next Appointment _____

Desert West Obstetrics and Gynecology, Ltd.
Confidential Medical History

Name _____ Birthdate_____ Age _____ Date_____

Allergies to medications/food/environment	Reaction

Current Medications (Prescription, Over the counter, Herbal)	Dose	Instructions

Pharmacy: _____

Are you currently using any contraceptives? (Circle answers)
Condoms Rhythm IUD Withdrawal Depo Provera Vasectomy Pills Essure/Tubal Ligation Nexplanon NuvaRing
Other _____

First day of last period: _____

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

Are your periods regular? Yes / No How often do your cycles occur? _____

Is there bleeding between periods? Yes / No For how many days do you bleed? _____

Flow is: scant / mild / mod / severe / incapacitating

Other symptoms with periods? _____

Date of last pap smear: _____
Have you had an abnormal pap smear? Yes / No Has this been treated? Yes / No How? _____

Do you examine your breasts regularly? Yes / No
When was your last Mammogram (if any)? _____ Result: _____
Do you have concerns about your breasts? _____

When was your last Bone Density (if any)? _____ Result: _____

Have you had:
Concerns about vaginal discharge? Yes / No Explain: _____
Leaking of urine? Yes / No Explain: _____
Pelvic infections? Yes / No Explain: _____
Sexually transmitted diseases or HIV? Yes / No Explain: _____

Total number of pregnancies

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

Pregnancy Details

Preg #	Sex	Month/Year of Delivery	Number of Weeks	Baby's Weight	Hours of Labor	Delivery Type	OB/Neonatal Problems	Delivery Doctor

Medical/Surgical History

Include injuries and conditions requiring medications i.e. high blood pressure, diabetes, seizures, etc.

Condition/Disease	Date	Treatment

Family History

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

Disease	Yes	No	Relation	Family Member's 1st Name	Age of Onset	Age of Death	Cause of Death (Yes or No)
Diabetes							
Tuberculosis							
Heart Disease							
High Blood Pressure							
Blood Clot/PE							
Other: (enter below)							

Desert West Obstetrics and Gynecology, Ltd.
Confidential Medical History

Name _____ Birthdate_____ Age _____ Date_____

Social History

Marital status _____

Do you have an Advanced Directive? Yes / No

Primary language spoken _____ Race _____

Do you smoke cigarettes? Yes / No If yes, pks/day _____ How many years _____

Do you use e-cigarretes or vape? Yes / No If yes, with nicotine? Yes / No How many mg? _____ How often? _____

Do you drink alcohol? Yes / No If yes, what kind? _____ How often? _____ Amount _____

Do you consume caffeine? Yes / No If yes, what kind? _____ Amount _____

Do you use medical marijuana? Yes / No If yes, what kind? _____ How often? _____ Amount _____

Do you use recreational drugs? Yes / No If yes, what kind? _____

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

Do you exercise? Never / Occasionally / Daily / 2-3 times per week / 4 or more times per week

How many sexual partners do you have? None / 1 / 2-5 / 5+

Have you been exposed to sexual or physical violence or abuse? Yes / No

Review of Systems

If you are experiencing any of the symptoms listed, PLEASE CIRCLE THE ONES THAT APPLY.

Respiratory: difficulty breathing or shortness of breath

Cardiovascular: chest pain

Gastrointestinal: constipation / diarrhea / blood in stool

Urinary: painful urination / leaking

Reproductive: painful periods / irregular periods / pain with intercourse

Breast: pain / lump