

Doctors of Women Health Center

62 Corporate Park, #100
Irvine, CA 92606
Tel. (949) 559-1911 Fax (949) 559-4071

Print Name: _____ Date of Birth: _____

Hospital for Delivery

St. Josephs Hoag, Newport Beach

Pregnancy History

<u>Total Pregnancies</u>	<u>Total Full Term</u>	<u>Total Premature</u>	<u>Total Induced Abortion(s)</u>	<u>Total Spontaneous Abortion(s) (miscarriages)</u>	<u>Total Ectopic Pregnancies</u>	<u>Total Multiple Births</u>	<u>Children Living</u>

First day of last menstrual period: _____

Date of previous months menstrual period if known: _____

Describe your monthly cycle

Monthly? Yes No

Irregular? Yes No

Frequency? _____ Days or if other, describe _____

Date of first positive pregnancy test: _____

Taking birth control at time of conception? Yes No

Past Pregnancy

<u>Date of Delivery</u>	<u>Weeks at Delivery</u>	<u>Length of Labor</u>	<u>Birth Weight</u>	<u>Sex</u>	<u>Type of Delivery</u>	<u>Type of Anesthesia</u>	<u>Place of Delivery</u>	<u>Preterm Labor</u>

NAME: _____

Describe any complications related to past pregnancies

Infection History

	Yes	No
1. Live with someone with TB or exposed to TB		
2. Patient or partner has history of genital herpes		
3. Rash or viral illness since last menstrual period		
4. Hepatitis B or C		
5. History of Sexually transmitted disease		
6. History of Gonorrhoea		
7. History of Chlamydia		
8. History of HPV		
9. History of HIV		
10. History of Syphilis		
11. History of Chicken Pox		

Patients Medical History

	Yes	No		Yes	No
1. Diabetes			13. History of Blood Transfusion		
2. Hypertension			14. D (RH) Sensitized		
3. Heart Disease			15. Pulmonary (TB, Asthma)		
4. Autoimmune Disease			16. Seasonal Allergies		
5. Kidney Disease			17. Drug/Latex Allergies		
6. Neurologic/Epilepsy			18. Breast Problems		
7. Psychiatric			19. GYN surgery		
8. Depression			20. Anesthesia complications		
9. Hepatitis/Liver Disease			21. Uterine Abnormality		
10. Varicosities/Phlebitis			22. Infertility		
11. Thyroid Dysfunction			23. Advanced Reproductive Treatment/IVF		
12. Trauma/Violence			24. Do you have cats		

25. Operations/Hospitalizations? _____Yes _____No

If yes, date(s) of hospitalizations _____

Reason for hospitalization _____

26. Is it acceptable to give you blood products in a life threatening emergency?

_____Yes _____No

27. History of abnormal pap smear? _____Yes _____No

If yes, date(s) _____

Any treatment? _____

Normal since _____Yes _____No

NAME: _____

	Amount/day prior to pregnancy	Amount per day during pregnancy	# of years used
27. Tobacco			
28. Alcohol			
29. Illicit/Recreational Drug			

Family History

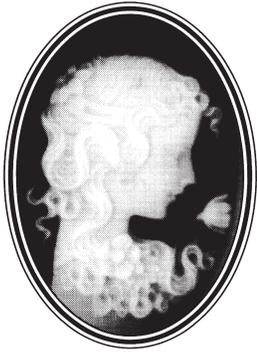
- 1. Hypertension ___Yes ___No
- 2. Diabetes ___Yes ___No
- 3. Heart Disease ___Yes ___No
- 4. Cancer ___Yes ___No

If yes, what type? Who? Approximate Age

- 1. _____
- 2. _____
- 3. _____

Genetic Screening/Teratology counseling – Includes patient, baby’s father, or anyone in either family with:

	Yes	No
1. Patients age 35 yrs or older as of estimated date of delivery		
2. Thalassaemia (Italian/Greek/Mediterranean/Asian) :MCV <80		
3. Neural Tube Defect (meningomyelocele/Spinal Bifida/Anencephaly)		
4. Congenital Heart Defect		
5. Down Syndrome		
6. Tay-Sachs (Ashkenazi Jewish/Cajun/French Canadian)		
7. Canavan Disease (Ashkenazi Jewish)		
8. Familial Dysautonomia (Ashkenazi Jewish)		
9. Sickle Cell Disease or Trait (African-American)		
10. Hemophilia or other blood disorders		
11. Muscular Dystrophy		
12. Cystic Fibrosis		
13. Huntington’s Chorea		
14. Mental Retardation / Autism (If yes, was person treated with fragile X?)		
15. Other inherited genetic or chromosomal disorder		
16. Maternal Metabolic Disorder (i.e., Type 1 Diabetes PKU)		
17. Patients or baby’s father has a child w/birth defects not listed above		
18. Recurrent pregnancy loss or a stillbirth		
19. Medications (including supplements, vitamins or over the counter drugs) illicit or recreational drugs/alcohol since last menstrual period?		
20. Any Other		



*DOCTORS OF WOMEN
HEALTH CENTER*

HIV testing is recommended for all pregnant women. It will be ordered as part of the routine prenatal panel unless you decline by opting out.

Patient signature

Date

I am opting out from being screened for HIV.

Patient signature

Date

DOCTORS OF WOMEN HEALTH CENTER
62 Corporate Park, Suite 100
Irvine, CA 92606
949-559-1911 Fax: 949-559-4071

Dear Patient:

As physicians of Doctors of Women, we feel it is very important that you receive all laboratory results including blood work, Pap smears, mammograms, etc. It is standard procedure for our office to notify our patients by either phone or mail of their results. However, in the unlikely event that a laboratory result is not received by our office, standard procedure for notification of our patients may not take place. We therefore ask our patients to share in the responsibility of obtaining their laboratory results by calling for results if not notified within 2 weeks for Pap smear, mammogram, culture results, routine blood work and 24 to 48 hours for all STAT or emergent laboratory work. Your physician or nurse practitioner will let you know during your visit what testing will be done so you are aware of what results are pending. Your health care is our number one priority.

Thank you for partnering with us in your care.

Sincerely,
Doctors of Women

If my called ID blocks Doctors of Women's number, I understand that you will not attempt to leave a message.

I will take responsibility for calling for my laboratory results if not notified in a reasonable amount of time.

Patient Signature

Date

AUTHORIZATION TO LEAVE MESSAGES

I give my permission for the staff of Doctors of Women to leave messages regarding my health care, normal test results, appointments, or authorizations.

If a family member answers the phone, I give Doctors of Women permission to leave your name and phone number.

Patient Signature

Date

Print Name

DOCTORS OF WOMEN

Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your **best possible health** requires a “partnership” between you and your doctor. As our “partner in health,” we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Patient Signature

Date

Physician Signature

Doctors of Women

Dear Valued Patient,

With all the changes in Healthcare we feel the need to communicate the following information regarding your insurance healthcare coverage:

- 1) Doctors of Women does not quote or guarantee coverage for services provided by our practice
- 2) Doctors of Women bills your insurance company as a courtesy on your behalf for services provided however this does not imply that you will have no out of pocket costs associated with your care
- 3) Doctors of Women are legally bound by our PPO and HMO contracts to collect your co-pay at the time service is rendered. We do not bill patients for co-pays
- 4) Doctors of Women provides a courtesy service of verifying your benefits and eligibility. We rely on the information provided by your insurance company to be current and complete, however we do not guarantee that the information provided by your insurance company is accurate.
- 5) Ultimately, it is the patient (Insured's) responsibility to know the plan coverage and limitations of their own health insurance policy.
- 6) Doctors of Women do not guarantee that your insurance will be considered "In-Network" with your plan or policy. If you are unsure if services rendered here will be covered by your insurance, please call your member services department directly and give them our Tax ID # 33-0580598 and ask them to verify if we are "In" or "Out" of network.
- 7) For Obstetrical patients, someone from our office will discuss with you your financial responsibilities, which will need to be paid to our office by the 6th month of your pregnancy. Failure to pay your financial responsibility will result in being discharged from the practice.
- 8) For Surgical patients, someone from our office will discuss with your your financial responsibilities, which will need to be paid to our office prior to your surgery.

We acknowledge that dealing with Healthcare coverage issues can be confusing as well as frustrating. Doctors of Women makes every attempt to verify the specifics of your coverage, however, as physicians specializing in your healthcare needs, any assistance our office provides to obtain insurance information is simply as a courtesy and not an obligation.

We thank you in advance for understanding our role in your Healthcare. We invite you to partner with us by obtaining your individual insurance plan coverage specifics prior to receiving services with our organization.

Thank you kindly for your cooperation with this matter.

Patient Signature

Date

DOCTORS OF WOMEN

Prior Authorization Policy

As your physician we make every effort to ensure that you receive the safest, most effective and reasonably priced prescription drugs, treatments, laboratory tests and imaging studies we feel is best suited for your healthcare. We must also abide by regulations set by your insurance companies and government agencies. Over the last year, many health insurance companies or plans are requiring Prior Authorization or approval for an increasing number of drugs, treatments, imaging studies and laboratory tests.

As this is an additional and labor-intensive service our nursing staff completes, Doctors of Women will begin charging a fee of \$25.00 per authorization fee for medications. This cost is an out-of-pocket expense to you and is not covered by insurance. You can be assured that your provider will take every step necessary to provide you with cost effective treatments and alternatives. We will fully evaluate your medical needs, and if appropriate, recommend a medication that does not require Prior Authorization. Prior authorizations for drugs required as a result of telephone requests from patients will always be charged a \$25.00 fee. Please note: **this still does not guarantee approval from your insurance company.**

Please feel free to contact our office at 949-559-1911 with any questions.

Patient Name: _____

Patient Signature: _____

Date: _____