ASSOCIATES IN WOMEN'S HEALTH CARE
OBSTETRICS & GYNECOLOGY

5 Medical Plaza, Suite 250
Roseville, CA 95661
P: 916-782-2229
F: 916-797-9414
www.aiwhc.com

Welcome!

We know that you have choices when it comes to selecting a healthcare provider and we appreciate you selecting us.

Dear New Patient:

Welcome to Associates in Women's Health Care! Please complete the enclosed forms and bring them to your first appointment. **Please arrive for your first appointment 15 minutes early** so that your patient chart can be prepared with your completed enclosed paperwork packet. Out of respect to you and your provider's time together we ask that your paperwork be completed in full prior to your arrival. Please arrive **30 minutes** early if you have not completed the paperwork. Otherwise, you will be asked to reschedule your appointment.

Allow about 10 extra minutes for parking. Please be aware that parking is a challenge due to the medical offices that are in our building. You should allow at least an extra 10 minutes just for parking. Be advised that there is the main parking in front of our building along with 2 parking garages.

We have limited appointment times to allow children to accompany their parents. Thus, other than these limited appointments, no children over the age of 8 weeks are allowed in the office. If a child is brought with you to your appointment you will be asked to reschedule.

We look forward to seeing you. If you have any questions, please feel free to contact our office.

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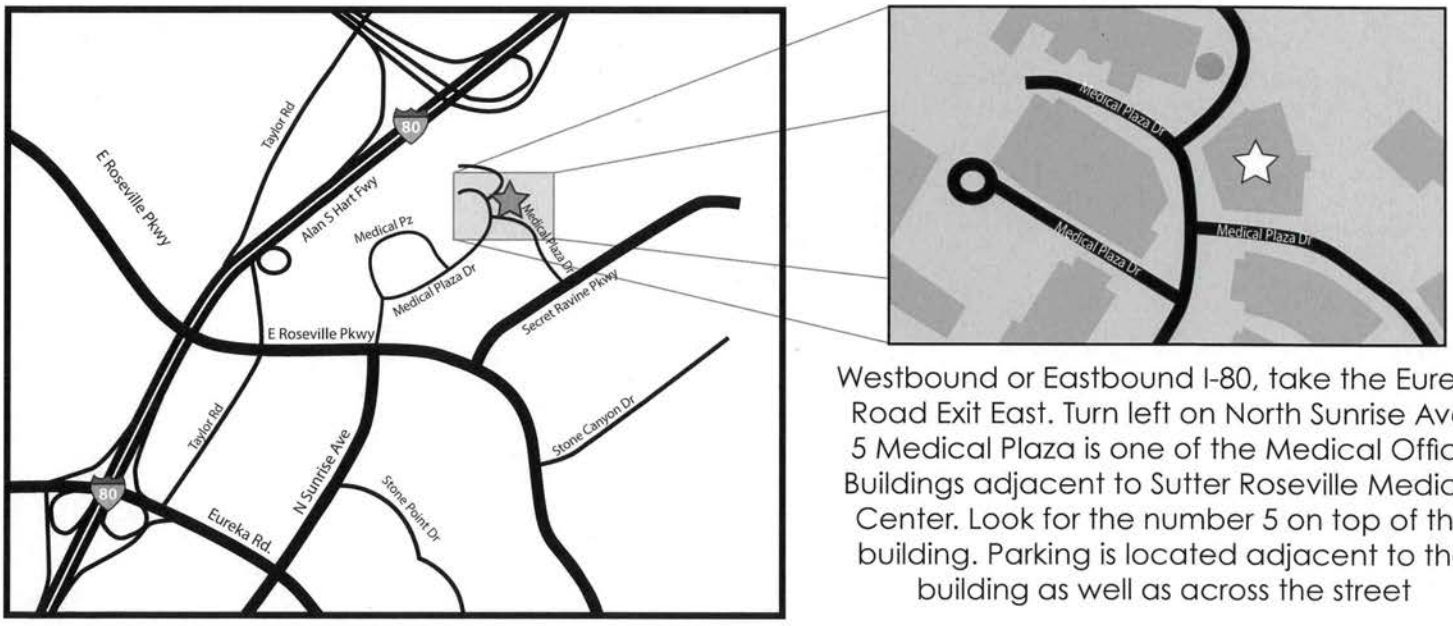

Westbound or Eastbound I-80, take the Eureka Road Exit East. Turn left on North Sunrise Ave. 5 Medical Plaza is one of the Medical Office Buildings adjacent to Sutter Roseville Medical Center. Look for the number 5 on top of the building. Parking is located adjacent to the building as well as across the street

3/11 **POS** Reorder # 1818523

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REGISTRATION

NEW PATIENT ☐ OR CHANGES ☐ TODAY'S DATE:_____ 20____

PATIENT INFORMATION

Name (Last/First/Middle)_____ Date of Birth_____ Sex_____

Social Security Number_____ AKA (Other Name)_____

Marital Status ____ Married ____ Single ____ Widow ____ Divorced

Ethnicity (Select all that apply): ____ Asian ____ Black/African ____ Caucasian ____ Hispanic/Latinx ____ Native American
____ Pacific Islander ____ Decline ____ Other_____

Mailing Address_____ City_____ State_____ Zip_____

Residence Address (If different than mailing address)_____

City_____ State_____ Zip_____

Home Telephone ( )_____ Cell Number ( )_____

Driver's Licence Number_____ Email Address_____

Employer Name_____ Occupation_____

Employer Address_____ City_____ State_____ Zip_____

Employer Telephone ( )_____ Referred By_____

RESPONSIBLE PERSON INFORMATION (COMPLETE ONLY IF PATIENT IS NOT FINANCIALLY RESPONSIBLE)

Responsible Person Name_____ Date of Birth_____ Sex_____

Social Security Number_____

Mailing Address_____ City_____ State_____ Zip_____

Home Telephone ( )_____

Employer Name_____

Employer Address_____ City_____ State_____ Zip_____

Employer Telephone ( )_____

Relationship to Patient ____ Spouse ____ Mother ____ Father ____ Guardian ____ Other_____

EMERGENCY INFORMATION

Name of person to contact in an emergency_____

Address_____ City_____ State_____ Zip_____

Home Telephone ( )_____ Cell Number ( )_____

Relationship to Patient ____ Spouse ____ Mother ____ Father ____ Guardian ____ Other_____

INSURANCE INFORMATION (COPY OF INSURANCE CARD IS REQUIRED)

Name/Primary Insurance Company_____

Address_____

City_____ State_____ Zip_____

Subsciber I.D. #_____

Plan #_____ Group #_____

Name of Subscriber_____

Subscriber Date of Birth_____

Employer Name_____

Relationship to Patient ____ Spouse ____ Mother ____ Father
____ Guardian ____ Other_____

Name of Primary Care Physician_____

Effective Date_____

Name/Secondary Insurance Company_____

Address_____

City_____ State_____ Zip_____

Subsciber I.D. #_____

Plan #_____ Group #_____

Name of Subscriber_____

Subscriber Date of Birth_____

Employer Name_____

Relationship to Patient ____ Spouse ____ Mother ____ Father
____ Guardian ____ Other_____

ARE YOU ENROLLED IN THE MEDICARE AUTOMATIC CROSSOVER PROGRAM FOR YOUR SUPPLEMENT INS? ____YES ____ NO

How did you hear about us? ___Health Plan ___Friend/Family ___Advertising ___Referral Service ___Other Physician

Patient Health History Form

Please fill in all information below

Name:_____ Date:_____ Referred by:_____

Reason for visit:_____

Age_____ Date of birth_____ Employer_____ Marital Status _____

CURRENT MEDICATIONS: *(List and provide information regarding all medications including over the counter, vitamins, herbal remedies, etc. You may use additional pages if necessary. Please bring a medications list with you to your appointment.)*

Medication	Strength	How Often	Prescribed By	Reason

ALLERGIES: *(List known allergies and reactions to medications or substances (e.g. latex, Iodine))*

Allergy:_____ Reaction_____

☐ **No Known Drug Allergies** Allergy:_____ Reaction_____

Do you require antibiotics prior to procedures/Dentist? Y or N

Vaccines that are current:

___Gardasil ___Tetanus(Tdap) ___Flu

___MMR ___Shingles ___Pneumonia

MENSTRUAL HISTORY: 1st Day of Last Period _____ **OR Postmenopausal OR Hysterectomy OR Ablation**

# of days between periods_____ ___Excessive bleeding ___No bleeding ___Pain

Length of period_____ ___Irregular bleeding ___Bleeding between periods ___PMS

CONTRACEPTIVE HISTORY:

Do you use some form of Birth Control? ☐ No ☐ Yes

☐ Birth Control Pills ☐ Birth Control patch ☐ Birth Control Ring ☐ Condoms ☐ Depo Provera ☐ Nexplanon ☐ Other _____

☐ IUD (Brand name)_____ Insert Date: _____ ☐ Tubal Ligation

Name of Birth Control Pill (if using)_____ Any problems? _____

Has your partner had a Vasectomy? ☐ Yes ☐ No

GYN HISTORY:

Have you had any of the following (check below)

_____ abnormal Pap smear

_____ cervical cryo/laser surgery/LEEP

_____ endometriosis

_____ ovarian cysts/tumors

_____ uterine fibroids

_____ pelvic inflammatory disease

_____ other GYN problems

Describe above_____

Have you been diagnosed with or treated for:

_____ Herpes(genital) _____ Gonorrhea

_____ Trichomonas _____ Bacterial Vaginosis

_____ Chlamydia _____ Genital Warts

_____ HPV _____ HIV _____ Syphillis

Sexual partner preference? ☐ Male ☐ Female ☐ Both

Number of sexual partners in the last year? _____

Have you had the following tests?

Pap Smear/Pelvic Exam	Y N	When?	_____
Mammogram	Y N	When?	_____
Bone Density	Y N	When?	_____
Colonoscopy	Y N	When?	_____
Cholesterol Screen	Y N	When?	_____
Diabetes Screen	Y N	When?	_____
Thyroid Screen	Y N	When?	_____

Pregnancy History: (please enter numbers)

_____ Total pregnancies _____ Miscarriages

_____ # of living children _____ Abortions

_____ Multiple births (twins, etc.) _____ Vaginal deliveries

_____ Tubal pregnancies (ectopic) _____ C-Sections

SOCIAL HISTORY:

Alcohol Use: ☐ Never ☐ Social ☐ Daily

Tobacco Use: ☐ Never ☐ Current ☐ Packs per day ☐ Previous

Drug Use: ☐ Never ☐ Current ☐ Previous

Drugs Used: _____

Do you feel safe at home? ☐ Yes ☐ No

MEDICAL HISTORY: *(Check if you have ever had or been diagnosed with any of the following. Please add details in blank spaces if needed)*

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Birth Defects
- ☐ Bowel Troubles
- ☐ Cancer Type_____
- ☐ Chronic Lung Disease
- ☐ Clotting Disorders
- ☐ Deep Venous Thrombosis
- ☐ Depression
- ☐ Diabetes
- ☐ Other_____
- ☐ Diverticulosis
- ☐ Epilepsy / Seizures
- ☐ Eye Problems
- ☐ Fibrocystic Breast Disease
- ☐ Gallbladder Problems
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Infertility
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Infection
- ☐ Other_____
- ☐ Kidney Stones
- ☐ Mental Illness
- ☐ Migraine/Severe Headaches
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Transfusions (Blood)
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Uterine Fibroids
- ☐ Other_____

SURGICAL HISTORY	Year

FAMILY HISTORY: *(Please check if any of your **family members** have had the following and **what relation** they are to you.) Use additional boxes for medical conditions and family members not already listed.*

	Mother	Father	Brother	Sister	Son	Daughter	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Breast Cancer										
Uterine Cancer										
Ovarian Cancer										
Cervical Cancer										
Colon Cancer										
Pancreatic Cancer										
Brain Cancer										
Melanoma										
Lung Cancer										
Alcoholism										
Anemia										
Birth Defects										
Bleeding Disorders										
Diabetes										
Genetic Diseases										
Heart Disease / Attacks										
High Blood Pressure										
High Cholesterol										
Mental Illness										
Seizure Disorder										
Stroke										
Thyroid Disorder										

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the healthcare staff to perform the necessary services needed.

Patient signature: _____ Date: _____

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PATIENT/PHYSICIAN AGREEMENTS

_____ **CONSENT FOR TREATMENT:**
Initials

I authorize the physicians and/or nurse practitioners of Associates In Women's Health Care to perform and/or order such diagnostic procedures and screenings they deem necessary.

Note: All laboratory specimens will be sent to our regular laboratory providers unless you, the patient, advise us the name of the particular laboratory contracted by your insurance company.

_____ **RELEASE OF MEDICAL RECORDS**
Initials

I authorize Associates In Women's Health Care to release the following medical information and secure payment of charges from my insurance carrier or its intermediaries. I agree to be financially responsible for any services rendered if denied due to my direction to withhold this information from my insurance carrier.

_____ Medical condition

_____ Psychiatric/Mental Health

_____ **ASSIGNMENT OF BENEFITS**
Initials

I authorize my insurance carrier, or its intermediaries, to make payment directly to Associates In Women's Health Care any medical/surgical/benefits otherwise payable to me for medical services rendered. I understand that I am ultimately financially responsible for all charges not paid by my insurance carrier.

_____ **NO CHILDREN POLICY**
Initials

Office policy regarding children over 8 weeks of age is as follows: We have limited appointment days and times allowing children to accompany their parents. Please inquire when scheduling your appointment. Unless scheduled on one of these dates and times, ***NO CHILDREN over 8 WEEKS of age may be brought to our facility*** out of concern for the health and well-being of our expectant mothers so that they will not become exposed to childhood diseases.

_____ **NO SHOW/CANCELLATION POLICY**
Initials

We require that you notify our office 24 hours prior to your scheduled appointment if you need to cancel or reschedule your appointment. There will be a $35.00 fee charged for appointments not cancelled within this time frame, as well as all "no show" appointments.

_____ As there are many insurance plans, all with their individual requirements, it is the patient's responsibility to understand the
Initials requirements and limitations of the plan. This includes knowing which facilities can be used for x-rays, laboratory, hospitalization, out-patient surgery or referral to another physician.

I have read and understand the above information.

With your signature you acknowledge that you have read this notice and agree to abide by these Associates In Women's Health Care Office Policies.

X_____ _____
Patient or Guardian Signature Date

PAYMENT POLICY

_____ When you come to your first appointment and all subsequent appointments at Associates In Women's Health Care, **please be**
Initials **sure to have your insurance card AND your co-payment with you**. If you do not have *both of these items*, your appointment will be rescheduled. While we make every attempt to assist you in fulfilling the requirements of your specific insurance plan, it is ultimately your responsibility to know what provisions, restrictions, and requirements that are included or excluded in your specific health insurance policy.

If you have a deductible, as some HMO and most PPO plans now have, your insurance company will be billed on your behalf, your insurance company will advise us what your financial responsibility is based on your deductible information. We will send you a statement for that balance which is due and payable upon receipt. You MUST pay your co-pay at the time of your visit. For your convenience, we do accept MasterCard and VISA for both co-pays and payments on any outstanding balances for services rendered. Associates In Women's Health Care does not extend credit and therefore prompt payment on all outstanding balances is expected.

Surgery and Maternity Patients: Your benefits and eligibility will be verified by Associates In Women's Health Care staff. At that time we will inquire about your deductible and the amount, if any. You will be expected to pay your financial responsibility for those prior to your surgery date or delivery date as Associates In Women's Health Care does not extend credit.

VERY IMPORTANT: If at any time your insurance carrier or coverage changes in any way, it is your responsibility to notify Associates In Women's Health Care IMMEDIATELY.

_____ I agree that payment in full is my ultimate responsibility despite insurance coverage or determination. Our billing office will pursue
Initials every effort to bill your insurance and collect for your services. I agree to be responsible for the portion that my insurance carrier deems my responsibility.

_____ Medicare will only pay for services it deems "reasonable and necessary" under Medicare law. If Medicare decides that a particular
Initials service is "not reasonable and necessary" under its program standards, Medicare will not pay for the services. I understand that I will be responsible for the charges incurred.

_____ **TELEPHONE CONSUMER PROTECTION ACT (TCPA):**
Initials I agree that the facility, Associates In Women's Health Care or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or otherwise associated with my account.

_____ **I agree to provide a valid referral/authorization should my insurance company so require.**
Initials

_____ I authorize the release of medical information necessary to process insurance claims and I authorize Associates In Women's Health
Initials Care OB/GYN to receive payment for services rendered from my insurance company.

_____ Associates In Women's Health Care is not currently accepting new Medi-Cal insurance for either Obstetrical or Gynecological
Initials services.

If you have Medi-Cal as a primary insurance **or** as a secondary insurance, please notify our office immediately. You will not be seen at Assoicates In Women's Healthcare and will need to transfer care to another office.

With your signature you acknowledge that you have read this notice and agree to abide by these Associates In Women's Health Care Office Policies.

X_____ _____
Patient or Guardian Signature Date

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RELEASE OF MEDICAL INFORMATION TO FAMILY MEMBERS

I authorize Associates In Women's health to discuss and release all medical information to family members named below, including medical records, x-rays, history, findings and prognosis pertaining to the medical condition, services rendered, or treatment given to me. This authorization complies with the confidentiality of Medical Information Act, section 56 et seq. of the California Civil Code.

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Patient Signature _____ Date _____

Acknowledgment of Receipt of Notice of Privacy Practices

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 2013 ("HIPAA"). Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

Therefore, I, _____ (printed name of patient or personal representative), acknowledge that Associates In Women's Health Care has provided a written copy of Notice of Privacy Practices for Protected Health Information to
(Check one)

_____ myself or _____ specify: _____

If you are signing as a personal representative, documentation of your legal right to do so must be provided.

_____ _____ _____
Signature of Patient or Personal Representative Date Printed Name

Relationship to Patient (if not self): _____

This Section is for the use of the office of Associates In Women's Health Care only

_____ We made a good faith attempt to provide the above named patient with a copy of our Notice of Privacy Practices for Protected Health Information, but we were not successful for the following reason:

_____

_____

_____ _____ _____
Signature of Representative Date Printed Name