Patient Information (Please Print)

Name _____ Date of Birth ____/____/____
Last First Middle

Address _____ Age _____

City _____ State _____ ZIP _____

Home # □ _____ Cell # □ _____ Cell Carrier _____

Please check preferred number for contact

Email _____

Social Security Number _____ DL # _____

Occupation _____ Employer _____

Work Address _____ Work# _____

Marital Status: Single Married Divorced Widow Child

Preferred Language: English Spanish Other _____

Spouse Information OR Policyholder Information(if not patient) Relation _____

Name _____ Date of Birth _____
Last First Middle

Occupation _____ Employer _____

Work Address _____ Work Phone _____

Social Security Number _____ Cell Phone _____

Referred By _____

Emergency Contact _____ Phone _____

Primary Care Physician _____ Phone _____

Other: _____

Preferred Pharmacy #1 _____ Phone _____

Preferred Pharmacy #2 _____ Phone _____

Primary Insurance Information

Name of Ins. _____

IPA/Medical Group _____

Phone # _____

ID# _____

Group# _____

Policyholder _____

Policyholder DOB: _____

Relationship: Self Spouse Other _____

Second Insurance Information

Name of Ins. _____

IPA/Medical Group _____

Phone# _____

ID# _____

Group # _____

Policyholder _____

Policyholder DOB: _____

Relationship: Self Spouse Other _____

_____ Initial **Release of Protected Health Care information** via telephone or answering machine or voice mail. I give my consent with authorization to the medical and billing staff of my physician's office to leave protected health care information about me or for me on my answering machine or voice mail via the telephone # I have listed below. I understand I may revoke this privilege at any time by submitting my request in writing to this office.

Home Telephone # _____ Cell phone #_____ Other # _____

Authorization of Benefits to Physician:

I hereby authorize payment directly to Ventura County Obstetric & Gynecologic Medical Group, Inc. of the surgical and/or medical benefits, if any, otherwise payable to me for the services as described on the attached claim.

Authorization to Release Information:

I hereby authorization Ventura County Obstetric & Gynecologic Medical Group, Inc. to release any information, acquired in the course of my examination of treatment, to my insurance company(s).

_____

Signature Date

Ventura County Obstetric & Gynecologic Medical Group, Inc.

Richard A. Reisman, M.D. John C. Gustafson, M.D. Steven G. Coyle, M.D
Wendy Steiger, C.N.M. Wendy Margolis, NP, M.S.N. Anne Chezar-Garnett, C.N.M.
Tax ID # 953152550
2795 Loma Vista Road
Ventura, CA 93003
805-643-8695 Fax 805-643-2087

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

_____ I hereby acknowledge that I have been informed that I may obtain the Notice of Privacy
Initials
Statement of Ventura County Obstetric and Gynecologic Medical Group, Inc.

LAB DISCLAIMER

All specimens are sent to outside laboratories. You may be responsible for additional monies for these tests. We do not know what your ultimate financial responsibility will be. We will send your specimen to the contracted lab designated by your insurance carrier for processing and they will bill accordingly.

_____ I understand that it is my responsibility to contact my insurance to determine
Initials what laboratory services are covered under my specific plan.

WELL-WOMAN AND PAP SMEAR DISCLAIMER

_____ ►Most insurance companies allow one well-woman exam/pap smear in a twelve month period.
Initials

_____ ►Your signature below signifies your acknowledgement of the benefit limitations (one exam/pap smear
Initials per twelve months).

_____ ►You are stating that, to the best of your knowledge, you have not had a well-woman
Initials exam/pap smear within the past twelve months.

_____ ►If you have already received a well-woman exam/pap smear in the past twelve month period,
Initials you will be responsible for payment of today's visit.

_____ _____ _____
Patient Name (please print) Patient Signature Date

Ventura County Obstetric & Gynecologic Medical Group, Inc.
2795 Loma Vista Road
Ventura, CA 93003
805-643-8695 Fax 805-643-2087

NAME: _____DOB:_____AGE_____ DATE: _____

ALLERGIES: _____

GYNECOLOGIC HISTORY

Last normal menstrual period: _____ Age at first menstrual period: _____
Length of periods _____ Number of days between periods _____
Do you have clots? Yes No Do you have painful periods? Yes No
Do you bleed between cycles? Yes No Do you have painful intercourse? Yes No
Last Pap test _____ Any abnormal results? Yes No If so, when? _____
Last Mammogram _____Any abnormal results? Yes No If so, when? _____
Last Colonoscopy _____
Last bone density (if applicable) _____
Method of contraception: ___sterilization (partner, self) ___Depo Provera ___IUD ___pills
___ natural family planning ___diaphragm ___ foam/gel
___ other _____
Do you leak urine? Yes No ___all the time ___ with lifting/coughing ___ only occasionally
Do you wear incontinence pads often ? Yes No Do you have difficulty stopping or starting your urine stream? Yes No
Do you leak stool? Yes No

OB HISTORY

Pregnancies _____Births _____ Miscarriages _____ Cesareans _____Abortions_____None _____

MEDICAL HISTORY

__Asthma	__Mitral valve prolapse	__Breast Cancer	__Fibroids
__Anemia	__Arthritis	__Endometriosis	__Condyloma/warts
__Diabetes	__Hepatitis	__Fibrocystic breasts	__Ovarian cysts
__High blood pressure	__Deep vein thrombosis	__Thyroid Disease	__Gonorrhea/Chlamydia
__High cholesterol	__Fibromyalgia	__Bleeding disorder	__Genital herpes
__Heart attack	__Frequent bladder infect.	__Ulcerative colitis	__Ulcer/ GERD
__Stroke	__Depression/anxiety	__Blood transfusion	__HIV/AIDs

Other:_____

SURGICAL HISTORY:

Type of Surgery	Reason for Surgery	Date of Surgery

MEDICATIONS, VITAMINS, SUPPLEMENTS, AND OVER-THE-COUNTER MEDICATIONS (including herbs)

Name, dosage and frequency

NAME: _____DOB:_____AGE_____ DATE: _____

SOCIAL HISTORY

Occupation_____How many hours do you work/week? _____

Have you ever been sexually active? Yes No Are you currently sexually active ? Yes No

Have you ever been raped or abused? Yes No Are you currently safe in your relationship? Yes No

Do you smoke? Yes No If yes, packs per day? _____ How many years? _____

Are you interested in smoking cessation? Yes No Maybe next year

How much alcohol do you drink? _____

How much coffee / tea do you drink? _____

Any recreational drugs? Yes No If yes, what kind _____

How much do you exercise? _____

FAMILY HISTORY

Mother (age, health status) _____Father_____

Sisters _____Brothers _____

__Breast Cancer (mother, aunt, sister) __ Ovarian Ca __Uterine Ca __ Cervical Ca

__Colon Ca __ Diabetes __ Heart Disease __ High Cholesterol __Hypertension __ Osteoporosis

REVIEW OF SYSTEMS *Circle any persistent symptoms you currently have.*

ENDOCRINE
Thyroid Disease(Goiter, nodules, Hashimoto, Graves' Disease, Hyperthyroidism, Thyroid cancer, Thyroid surgery)
Parathyroid (Hyperparathyroidism, hypoparathyroidism, Parathyroid Cancer, Surgery)
Diabetes: Year Diagnosed: _____
Complications?
_____
Pituitary Disease
Adrenal Disorder

CONSTITUTIONAL SYMPTOMS
Chills
Weight Loss
Appetite Change
Cancer
Depression

SKIN
Shingles
Rashes/Hives

NEPHROLOGICAL
Renal Disease
Nephritis

HEMATOLOGICAL
Hepatitis/Jaundice
Bleeding tendency
Swollen Glands
Anemia
HIV (AIDS)

RESPIRATORY
Bronchitis
Emphysema
Shortness of Breath

CARDIOVASCULAR
Arrhythmia
Heart Murmur
Valve Disease
High Blood Pressure
Heart Attack
Peripheral Vascular Disease
(angioplasty, stents, femoral-
Popliteal bypass, amputations)
Stroke
Angina
Phlebitis
Circulatory Problems
Rheumatic Fever

GASTROINTESTINAL
Hiatal Hernia
Ulcers
Colitis
Abdominal Pain
Blood in Stool
Colon Cancer
Nausea
Vomiting

UROLOGICAL
Cancer:
_____
Stones
Trouble Emptying Bladder
Are you having pain?
Yes No
Urgency
Frequency
Burning with urination

NEUROLOGICAL
Headaches
Migraines
Seizures
Stroke
Parkinson's Disease

MUSCULOSKELETAL
Joint Pain
Fractures
Gout
Arthritis

GYNECOLOGIC
Ovarian cyst/ Cancer
Uterine or Cervical Cancer
Heavy Menses
Irregular Periods
PCOS
Menopause
Hormone Replacement
Breast Cancer

OTHER
_____
_____
_____
_____

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_____
Physician Signature Date