

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

Second Insurance Information

Name of Ins. _____	Name of Ins. _____
IPA/Medical Group _____	IPA/Medical Group _____
Phone # _____	Phone# _____
ID# _____	ID# _____
Group# _____	Group # _____
Policyholder _____	Policyholder _____
Policyholder DOB: _____	Policyholder DOB: _____
Relationship: Self Spouse Other _____	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

PRENATAL FLOW RECORD

Date _____

Contact @ Home _____

Name _____ Birth Date _____ Age _____

Address _____ Phone _____ Wk Phone _____

Patient's Work Address _____ Occupation _____

Husband's Name _____ Occupation _____

Gynecologic History:

Last Pap _____ Number of Pregnancies _____

Number of Miscarriages or First Day of Last First Day of Previous

Live Births _____ Abortions _____ Menstrual Period _____ Menstrual Period _____

Age of First How Length of

Menstrual Cycle _____ Often _____ Cycle _____ Cramps ? Yes No

Contraceptive History _____

Medical History

_____ German Measles	_____ Thyroid Disease	_____ Blood Transfusions	Habits/Addictions
_____ DES Exposure	_____ Measles	_____ Heart Disease	_____ Coffee
_____ Genital Herpes	_____ Diabetes	_____ Migraines	_____ Alcohol
_____ Pelvic Inflammatory Disease	_____ Asthma	_____ High Blood Pressure	_____ Drugs
_____ Chicken Pox	_____ Thrombophlebitis	_____ Urinary Infections	_____ Smoker
_____ Rheumatic Fever			

Operations _____

Medication Allergies _____

Current Medications _____

Include all vitamins, supplements and over-the-counter medications

Family History Immediate Family _____ Nationality _____

Diabetes _____ Cancer _____ Heart Disease _____

Twins _____ Hereditary Disorders/Congenital Anomalies _____

Husband Age _____ Height _____ Weight _____ Blood Type and Rh _____

Previous Pregnancies

Name	Date	Weeks	Sex	Birth Weight	Complications of Pregnancy	Length of Labor	Complications of Labor	Anesthesia	Baby Diet	Post-partum Complications

Abortions

Date	Weeks	Spontaneous or Induced	Operation	Complications

Physical Examination

Height _____ Usual Weight _____ Thyroid _____ Lungs _____

Back _____ Breasts _____ Nipples _____

Heart _____ Abdomen _____

PELVIC: Cervix _____ Uterine Size _____ Adnexae _____

Pelvimetry : Shape _____ Adequacy _____

Name:

DOB:

Risk Factors & Problem List

1 _____
 2 _____
 3 _____
 4 _____

Age _____

G _____ P _____ SAB _____ Tab _____ SB _____ LC _____

Allergies _____

Breast Feeding _____ Yes _____ No _____

LMP _____ Height _____

EDC by LMP _____ EDC by first Exam _____

EDC by U/S _____ Composite EDC _____

Prenatal Classes _____ Instructor _____

Pediatrician _____

Spouse has met Doctor _____

Referring Doctor _____

Gender ♀ ♂ Does not want to know

Lab Results

Hg			
Hct			
Date			

Blood Type _____

And Rh _____ Rhogam _____ VDRL _____

PAP _____ Rubella _____

O'Sullivan _____ GTT _____

HIV _____ Hep C Ab _____

Herpes _____ Urine Culture _____

Hep B _____ GBS _____

Cx Culture _____ CF _____

AFP Protocol:

Book Given _____

Decision Made _____

Blood Drawn _____

Results _____

Amniocentesis _____ Date _____ Result s _____

Refused Date _____ Initials _____

Visit																			
Weeks Gestation																			
Fetus	Fundal Height																		
	Heart Rate																		
	Movement																		
	Est. Presentation																		
WT	Pre-Gravid	This Visit																	
		Cumulative																	
Blood Pressure																			
Urine	Sugar																		
	Albumin																		
Edema																			
Symptoms	Bleeding																		
	Discharge/Itching																		
	Dizziness/Fainting																		
	Headache/Blurred Vision																		
	Leg Cramps																		
	Nausea/Vomiting																		
Optional	Non Stress Test																		
	Cervical Exam																		
Pregnancy Risk Level																			
Next Appointment																			
Initials																			

Name: _____ DOB: _____

Date	Progress Notes

Pregnancy Risk Indicators			Genetic Screening Includes Patient, Baby’s Father, or Anyone in either Family with:		
	YES	NO		YES	NO
DRUG DEPENDENCIES			PATIENT’S AGE > 35 YEARS		
HABITUAL SMOKER (MORE THAN 1 PACK A DAY)			THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ORIENTAL BACKGROUND) MCV <80		
PREGNANCY WITHOUT FAMILY OR PARTNER’S SUPPORT			NEURAL TUBE DEFECT (MENINGOMYELOCELE, OPEN SPINE OR ANENCEPHALY)		
PRIOR TRANSFUSIONS			DOWN SYNDROME		
INCOMPETENT CERVIX			TAY SACHS (E.G. JEWISH BACKGROUND)		
HABITUAL ABORTION			SICKLE CELL DISEASE OR TRAIT		
UTERINE SURGERY (NON-CESAREAN)			HEMOPHILIA		
PRIMIGRAVIDA (IF “YES” SKIP TO “DIABETES”)			MUSCULAR DYSTROPHY		
CESAREAN SECTION			CYSTIC FIBROSIS		
FETAL DISTRESS			HUNTINGTON CHOREA		
NEONATAL DEATHS			MENTAL RETARDATION		
PREMATURE OR LBW INFANTS			IF YES, WAS PERSON TESTED FOR FRAGILE X?		
CONGENITAL OR CHROMOSOMAL ANOMALIES			OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
HBW INFANTS (MORE THAN 10 POUNDS)			PATIENT OR BABY’S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
DIABETES			≥3 FIRST-TRIMESTER SPONTANEOUS ABORTIONS OR STILLBIRTH		
HEART DISEASE			MEDICATIONS OR STREET DRUGS SINCE LAST MENSTRUAL PERIOD		
GENITAL HERPES			IF YES, AGENT(S)		
			OTHER SIGNIFICANT FAMILY HISTORY (SEE COMMENTS)		

Ventura County OB/GYN Medical Group, Inc

Richard A. Reisman, MD, John C. Gustafson, MD, Steven G. Coyle, MD
Wendy Steiger, RN, CNM, Wendy Margolis, CNP, MSN, Anne Chezar-Garnett, RN, CNM
2795 Loma Vista Road, Ventura, CA 93003 Phone: 805-643-8695 Fax: 805-643-2087

Patient Name: _____ DOB: _____

PRENATAL DIAGNOSIS SCREENING QUESTIONNAIRE

1. Will you be age 35 or older when the baby is due? Yes No
 Age When Due
2. Have you or the baby's father, or anyone in either of your families, ever had:
 - a. Down syndrome or mongolism? Yes No
 - b. Spina bifida or meningomyelocele (open spine)? Yes No
 - c. Hemophilia (bleeding disorder)? Yes No
 - d. Muscular dystrophy? Yes No
 - e. Cystic fibrosis? Yes No
3. Have you or the baby's father had a child born dead or alive with a birth defect not listed in #2 above? Yes No
If yes, describe: _____
4. Do you or the baby's father have any close relatives who are mentally retarded? Yes No
5. Do you or the baby's father, or a close relative in either of your families, have an inherited genetic or chromosomal disorder not listed above? Yes No
If yes, describe: _____
6. Have you had two or more spontaneous pregnancy losses? Yes No
7. Do you or the baby's father have any close relatives descended from Jewish people who live in Eastern Europe (Ashkenazi Jews)? Yes No
8. Are you or the baby's father of African descent? Yes No
Have you or the baby's father been screened for sickle cell trait and found to be positive? Yes No
9. Are you or the baby's father of Southeast Asian, Greek, Italian, or Mediterranean descent? Yes No
Have you been screened for thalassemia? Yes No

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, RNP, 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

An Open Letter to our Patients

We feel very blessed that you have chosen our medical group for your care. We do not take the trust that you have placed in us lightly, and we all strive to do our best to meet your expectations. As physicians in private practice who have decided to contract with multiple insurance companies, we find ourselves faced with a most difficult and unfortunate reality. The insurance companies have over the past several years reduced their level of contracted compensation, and we have continued to accept these reduced rates in order to remain in their networks and to be able to accept the insurance that you have purchased. In most cases, you have a deductible to meet before the insurance payments begin, and you have a share of cost for all medical services. One of the consequences of the Affordable Care Act (Obamacare) is that insurance companies have had to offer more expensive policies with more comprehensive benefits in all cases.

The first rule of insurance underwriting is to preserve the generous profit margin for the insurance company. With a mandate to cover more at a greater expense, the insurance companies require us physicians to accept less for our services, AND, so as to keep their premiums competitive in the marketplace, they have very significantly raised your deductibles and shares of cost. In some cases these deductibles are as great as \$5,000 and your subsequent shares of cost may represent up to 50% of our total payment. The insurance company only pays the physician their portion of the discounted rate with the assumption that the patient portion makes up the difference. This creates a terrible burden for you as well as our office. Unfortunately many of you have a much greater out-of-pocket expense, and we must spend hours determining your eligibility and patient share of cost. We then must collect this amount from you if we are to remain solvent. This has often created an unpleasant relationship between our office and our patients as we are required to collect these larger amounts. We regret that we must now collect your portion at the time that medical services are provided.

We will expect payment of your financial liability at the time of service, prior to scheduling any procedures or surgery, and by the sixth month of your pregnancy. We have recently expanded our credit card services and have added another unique medical credit option for your convenience. Only then can we meet our financial obligations that now represent over 60% of our revenue. This overhead has doubled over the past 30 years due to the reduced reimbursement and the increased costs associated with an expended staff necessary to obtain authorizations, validate eligibility, and to compute and collect patient shares of cost. We are committed to your care and to providing the same quality medical care that you have associated with our medical group over the past 37 years. We thank you for your understanding and cooperation as we navigate through these difficult times together.

The Physicians and Staff of Ventura County Obstetric and Gynecologic Medical Group, Inc.

I acknowledge and will abide by this policy.

Patient Name Printed

Patient Signature

Date

Ventura County OB/GYN Medical Grp. Inc.
Patient Health Questionnaire-2 (PHQ-2)

DATE: _____ Name: _____ DOB _____

Instructions:

Please respond to each question.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Give all answers as 0 to 3, using this scale:

0=Not at all; 1=Several days; 2=More than half the days; 3=Nearly every day

1. Little interest or pleasure in doing things: _____ (0-3)
2. Feeling down, depressed, or hopeless: _____ (0-3)

Instructions

Clinical personnel will follow standard scoring to calculate score based on responses.

Total Score: _____

PHQ-2 score obtained by adding for each question (total points)

Interpretation:

A PHQ-2 score ranges from 0-6. The authors identified a score of 3 as the optimal cut point when using the PHQ-2 to screen for depression.

If the score is 3 or greater, major depressive disorder is likely.

Patients who screen positive should be further evaluated with the PHQ-9, other diagnostic instruments, or direct interview to determine whether they meet criteria of depressive disorder.

Providers Signature: _____ Date: _____